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

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

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

INSTRUCTIONS FOR UPDATING THE IOWA ADMINISTRATIVE CODE

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

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

Insurance Division[191]

Replace Chapter 50

Accountancy Examining Board[193A]

Replace Analysis
Replace Chapter 1
Replace Chapter 3
Replace Chapters 5 to 8
Replace Chapters 10 and 11
Replace Chapters 13 and 14

Human Services Department[441]

Replace Analysis
Replace Chapters 24 and 25
Replace Chapters 77 to 80
Replace Chapter 83
Replace Chapter 88
Replace Chapter 90
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Replace Chapter 170

Inspections and Appeals Department[481]

Replace Analysis
Replace Chapter 51
Replace Chapter 56

Public Health Department[641]

Replace Chapter 108

SECURITIES**CHAPTER 50****REGULATION OF SECURITIES OFFERINGS AND THOSE WHO ENGAGE
IN THE SECURITIES BUSINESS**

[Appeared as Ch 17, 1973 IDR]

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

**DIVISION I
DEFINITIONS AND ADMINISTRATION**

191—50.1(502) Definitions. For the purposes of this chapter, the definitions in Iowa Code chapter 502 and the following definitions shall apply unless the context otherwise requires:

“*Act*” means Iowa Code chapter 502, the Iowa Uniform Securities Act (Blue Sky Law).

“*Administrator*” means the commissioner of insurance or the deputy administrator appointed under Iowa Code section 502.601.

“*CCH NASAA Reports*” means the official statements of policy of the North American Securities Administrators Association, Inc., printed by Commerce Clearing House, the official reporter for NASAA.

“*CRD*” means the Central Registration Depository.

“*CSRU*” means the Iowa child support recovery unit.

“*FDIC*” means the Federal Deposit Insurance Corporation.

“*FINRA*” means the Financial Industry Regulatory Authority.

“*Form ADV*” means Uniform Application for Investment Adviser Registration.

“*Form ADV-E*” means the Certificate of Accounting of Client Securities and Funds in the Possession or Custody of an Investment Adviser.

“*Form ADV-H*” means Notice of Hardship Application for Investment Adviser Registration.

“*Form ADV-W*” means Notice of Withdrawal from Registration as Investment Adviser.

“*Form BD*” means Uniform Application for Broker-Dealer Registration.

“*Form BDW*” means Uniform Request for Broker-Dealer Withdrawal.

“*Form ICP*” means Agricultural Cooperative Notice of Sales of Notes or Evidences of Indebtedness.

“*Form F-7*” means Registration Statement Under the Securities Act of 1933, for registration of securities of certain Canadian issuers offered for cash upon the exercise of rights granted to existing security holders.

“*Form F-8*” means Registration Statement Under the Securities Act of 1933, for registration of securities of certain Canadian issuers to be issued in exchange offers or a business combination.

“*Form F-9*” means Registration Statement Under the Securities Act of 1933, for registration of certain investment grade debt or investment grade preferred securities of certain Canadian issuers.

“*Form F-10*” means Registration Statement Under the Securities Act of 1933, for registration of securities of certain Canadian issuers.

“*Form NF*” means Uniform Investment Company Notice Filing.

“*Form S-1*” means Registration Statement Under the Securities Act of 1933, for registration of securities for which no other form is authorized or prescribed.

“*Form SB-2*” means Registration Statement Under the Securities Act of 1933, for registration of securities to be sold to the public by small business issuers.

“*Form U-1*” means Uniform Application to Register Securities.

“*Form U-2*” means Uniform Consent to Service of Process.

“*Form U-2A*” means Uniform Corporate Resolution.

“*Form U-4*” means Uniform Application for Securities Industry Registration or Transfer.

“*Form U-5*” means Uniform Termination Notice for Securities Industry Registration.

“*Form U-6*” means Uniform Disciplinary Action Reporting Form.

“*Form U-7*” means Small Corporate Offering Registration Form.

“*Form USR-1*” means Investment Company Report of Sales.

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

“IARD” means the Investment Advisory Registration Depository.

“Immediate family” includes 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” includes any other person who is supported, directly or indirectly, to a material extent by an agent.

“Investment contract” as used in Iowa Code section 502.102(28) includes:

1. Any investment in a common enterprise with the expectation of profit to be derived through the essential managerial efforts of someone other than the investor.

(1) “Common enterprise” in this definition means an enterprise in which the fortunes of the investor are tied to the efficacy of the efforts and successes of those seeking the investment or of a third party.

(2) “Profit” in this definition includes income or a return on the investment, including a fixed rate of return, dividends, other periodic payments, or the increased value of the investment; or

2. Any investment by which an offeree furnishes initial value to an offerer, and a portion of this initial value is subjected to the risks of the enterprise, and the furnishing of the initial value is induced by the offerer’s promises or representations which give rise to a reasonable understanding that a valuable benefit of some kind over and above the initial value will accrue to the offeree as a result of the operation of the enterprise, and the offeree does not exercise practical and actual control over the managerial decisions of the enterprise.

“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.

“NASAA” means the North American Securities Administrators Association, Inc.

“NASDAQ” means the NASDAQ Stock Market.

“NCUA” means the National Credit Union Association.

“NSMIA” means the National Securities Markets Improvement Act of 1996, Public Law 104-290.

“NYSE” means the New York Stock Exchange.

“OTC” means over the counter.

“PCAOB” means the Public Company Accounting Oversight Board.

“SAI” means Statement of Additional Information.

“SEC” means the United States Securities and Exchange Commission as established pursuant to 15 U.S.C. Section 78(d).

“SOIF” means Solicitation of Interest Form.

This rule is intended to implement Iowa Code section 502.605(1).

[**ARC 916B**, IAB 10/20/10, effective 11/24/10; **ARC 1076C**, IAB 10/2/13, effective 11/6/13; **ARC 2175C**, IAB 9/30/15, effective 11/4/15]

191—50.2(502) Cost of audit or inspection.

50.2(1) The administrator may assess the broker-dealer or investment adviser for reasonable charges of travel, lodging, and other expenses incurred by division staff or independent persons conducting an audit or inspection and directly attributable to an audit or inspection made pursuant to Iowa Code section 502.411(4). The assessment of costs of meals, lodging, transportation, and other actual and necessary travel expenses, if any, incurred by persons conducting an audit or inspection shall be determined in accordance with one of the following, as agreed by the administrator and the persons conducting an audit or inspection:

a. The department of administrative services (DAS) state accounting enterprise Accounting Policy and Procedures Manual guidelines for employee travel (<https://das.iowa.gov/state-accounting/sae-policies-procedures-manual>) and the DAS form Travel Section Policy and Procedures (<https://das.iowa.gov/state-accounting/travel-relocation>) in effect at the time of the audit or inspection.

b. The department of administrative services state accounting enterprise Accounting Policy and Procedures Manual guidelines for travel for in-state board, commission, advisory council, and task force member expenses.

c. The United States General Services Administration Continental United States ("CONUS") per diem travel allowances for lodging, meals and incidental expenses.

d. A reimbursement schedule as agreed by the administrator and the persons conducting the audit or inspection.

50.2(2) If costs are assessed under subrule 50.2(1), the administrator may, upon completion of the examination, or at such regular intervals prior to completion as the administrator determines, prepare an account of the costs incurred in performing and preparing the report of the examination which shall be charged to and paid by the broker-dealer or investment adviser examined.

50.2(3) The administrator shall notify the broker-dealer or investment adviser of the expenses attributable to the audit or inspection as soon as practicable.

50.2(4) Assessments collected pursuant to this rule shall be paid by the broker-dealer or investment adviser as directed by the administrator either to the administrator or to the persons conducting the audit or inspection. The persons conducting the audit or inspection shall be reimbursed only for the actual and necessary costs incurred in conducting the audit or inspection.

This rule is intended to implement Iowa Code section 502.411(4).

[ARC 1076C, IAB 10/2/13, effective 11/6/13; ARC 2175C, IAB 9/30/15, effective 11/4/15]

191—50.3(502) Interpretative opinions or no-action letters. Interested persons may request the administrator to issue an interpretative opinion pursuant to Iowa Code section 502.605(4). These requests will be answered by means of a no-action letter. Requests for confirmation of the availability of an exemption shall be answered in the same manner. The following procedure is recommended for the submission of such requests:

50.3(1) The request should be in writing and include the factual situation involved, a citation to the applicable part of the rule or statute, and the question sought to be answered. Any disclosure or informational materials which pertain to the issue should also be filed.

50.3(2) The administrator, or any person delegated under Iowa Code section 502.601(1), may respond to the request by determining to take or not to take a no-action position or by declining to reach a determination due to insufficient facts, conflicting case or administrative law or such other reasons as the administrator's discretionary power allows.

50.3(3) All no-action determinations shall be based upon the representations made by the requesting party in the letter and information filed, since any different facts or conditions might require a different conclusion. The no-action letter shall express the division's position on enforcement action only and shall not purport to express any legal conclusion on the questions presented. No determination shall take a position on whether or not any disclosure materials satisfactorily comply with the antifraud and civil liability sections of the Act.

50.3(4) A no-action determination issued under this rule may be provided to interested persons for a filing fee of \$100.

This rule is intended to implement Iowa Code section 502.605(4).

191—50.4 to 50.9 Reserved.

DIVISION II
REGISTRATION OF BROKER-DEALERS AND AGENTS

191—50.10(502) Broker-dealer registrations, renewals, amendments, succession, and withdrawals.

50.10(1) An applicant for an initial registration to conduct business as a broker-dealer must:

a. File a current Form BD. If the applicant is a member of FINRA, Form BD shall be filed with CRD. If the applicant is not a member of FINRA, Form BD shall be signed and notarized and filed with the administrator; and

b. Pay a \$200 filing fee. If the applicant is a member of FINRA, the fee shall be remitted to the CRD. If the applicant is not a member of FINRA, the fee shall be remitted to the administrator.

50.10(2) No application for initial registration will be deemed complete for purposes of Iowa Code section 502.406(3) until the applicant has been approved as a member of FINRA.

50.10(3) An applicant that is a member of FINRA and that seeks renewal of a broker-dealer registration shall comply with the renewal time frames established by FINRA for renewal on the CRD system and shall:

- a. File with CRD an updated Form BD;
- b. Pay to the CRD a \$200 renewal filing fee.

50.10(4) An applicant that is not a member of FINRA and that seeks renewal of a broker-dealer registration shall by November 30 of each year:

- a. File with the administrator an updated Form BD, manually signed and notarized;
- b. File with the administrator the renewal applicant's most recent audited financial statements if they were not previously submitted to the administrator pursuant to subrule 50.10(1);
- c. Pay a \$200 renewal filing fee, which shall be remitted to the administrator.

50.10(5) Failure to comply with the requirements of subrule 50.10(3) or 50.10(4) shall be deemed a request for withdrawal of the broker-dealer registration, and the registration will be terminated as of December 31 of the renewal year.

50.10(6) A registered broker-dealer that is a FINRA member shall submit a withdrawal request by filing an accurate and complete Form BDW with CRD. A registered broker-dealer that is not a FINRA member shall submit a withdrawal request by filing an accurate and complete Form BDW with the administrator.

50.10(7) For purposes of Iowa Code section 502.406(2), a correcting amendment to the information or a record contained in either an initial or renewal application shall be considered to be filed "promptly" with the administrator if filed within 30 days of the event necessitating the correcting amendment.

50.10(8) Succession and change in registration.

a. In the case of an organizational change, including a change in the state of incorporation or form of organization, not involving a material change in financial condition or management, a broker-dealer shall file all applicable amendments to Form BD.

b. In the case of an organizational change, including a change in the state of incorporation or form of organization, involving a material change in financial condition or management, a broker-dealer shall file a new application for registration pursuant to subrule 50.10(1). The filing must include the fee pursuant to paragraph 50.10(1) "c" and registration fees for all Iowa-registered agents.

c. In the case of a change in name, a broker-dealer shall file all applicable amendments to Form BD.

50.10(9) Upon the administrator's oral or written request, a broker-dealer shall provide to the administrator the broker-dealer's most recent financial reports, audited or unaudited, within two business days of the request. A broker-dealer may utilize express mail delivery or transmission via electronic means to comply with a request pursuant to this subrule. Financial reports not received by the filing deadline are subject to a late fee of \$50 per day beyond the filing deadline, not to exceed an aggregate penalty of \$500. Imposition of the late fee is not a reportable event. In the event of the broker-dealer's continued noncompliance, the administrator may also pursue sanctions authorized by Iowa Code section 502.412.

This rule is intended to implement Iowa Code section 502.411(2).

[ARC 9169B, IAB 10/20/10, effective 11/24/10]

191—50.11(502) Principals. Every registered broker-dealer shall have at least two officers or partners registered with FINRA as principals, appropriate to the function(s) to be performed.

This rule is intended to implement Iowa Code section 502.406.

[ARC 9169B, IAB 10/20/10, effective 11/24/10]

191—50.12(502) Agent and issuer registrations, renewals and amendments.

50.12(1) Agent registration. Every applicant for registration as an agent of a broker-dealer shall:

a. Pass the Uniform Securities Agent State Law Examination (Series 63) or the Uniform Combined State Law Examination (Series 66);

b. Pass the appropriate qualifying examination administered by the Financial Industry National Regulatory Authority (FINRA). In the event that an applicant for registration as an agent has received a waiver by FINRA of a FINRA examination otherwise required by this paragraph, the FINRA waiver will be accepted in lieu of the examination requirement;

c. File an accurate and complete Form U-4 with CRD; and

d. Pay a \$40 filing fee to FINRA if applying for registration as an agent of a FINRA member broker-dealer, or to the administrator if applying for registration as an agent of a non-FINRA member broker-dealer.

50.12(2) Any individual who is out of the business of effecting transactions in securities for less than two years from the date of filing an application and who has previously passed an examination required in subrule 50.12(1) shall not be required to retake the examination to be eligible to be relicensed upon application.

50.12(3) Renewals, amendments, and withdrawal requests.

a. A registered agent of a FINRA member broker-dealer shall submit all renewals, renewal fees, amendments to Form U-4, and withdrawal requests to CRD. A withdrawal request shall be made by filing an accurate and complete Form U-5 with CRD.

b. A registered agent of a non-FINRA member broker-dealer shall submit all renewals, renewal fees, amendments to Form U-4, and withdrawal requests to the administrator. A withdrawal request shall be made by filing an accurate and complete Form U-5 with the administrator.

50.12(4) An issuer seeking to employ persons as agents of the issuer within the meaning of Iowa Code section 502.102(2) must apply in writing to the administrator for such authority. The application shall include:

a. A statement of the issuer's intent to employ agents for the sale of its securities;

b. The name, address, social security number, and proof of satisfaction of subrule 50.12(1) for each agent;

c. A complete description of the subject securities;

d. A complete and accurate Form U-4; and

e. A \$40 filing fee.

This rule is intended to implement Iowa Code section 502.406.

[ARC 9169B, IAB 10/20/10, effective 11/24/10; ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.13(502) Agent continuing education requirements. Every registered agent shall comply with all applicable continuing education requirements adopted by FINRA, NYSE, or any other self-regulatory agency. Failure to comply with any such requirements may be a basis for discipline pursuant to Iowa Code section 502.412(4) "n."

This rule is intended to implement Iowa Code section 502.411(8).

[ARC 9169B, IAB 10/20/10, effective 11/24/10]

191—50.14(502) Broker-dealer record-keeping requirements.

50.14(1) Unless otherwise provided by an SEC order, each broker-dealer registered or required to be registered under the Act shall make, maintain and preserve books and records in compliance with SEC Rules 17a-3 (17 CFR 240.17a-3), 17a-4 (17 CFR 240.17a-4), 15c2-6 (17 CFR 240.15c2-6) and 15c2-11 (17 CFR 240.15c2-11).

50.14(2) To the extent that the SEC amends the above-referenced rules, broker-dealers complying with such rules as amended shall not be subject to enforcement action by the administrator for violating this rule to the extent that the violation results solely from the broker-dealer's compliance with the amended rule.

This rule is intended to implement Iowa Code section 502.411(3).

191—50.15(502) Broker-dealer minimum financial requirements and financial reporting requirements.

50.15(1) Each broker-dealer registered or required to be registered under the Act shall comply with SEC Rules 15c3-1 (17 CFR 240.15c3-1), 15c3-2 (17 CFR 240.15c3-2), and 15c3-3 (17 CFR 240.15c3-3).

50.15(2) Each broker-dealer registered or required to be registered under the Act shall comply with SEC Rule 17a-11 (17 CFR 240.17a-11) and shall file with the administrator copies of notices of financial deficiencies, as required under SEC Rule 17a-11 (17 CFR 240.17a-11).

50.15(3) To the extent that the SEC amends the above-referenced rules, broker-dealers complying with such rules as amended shall not be subject to enforcement action by the administrator for violations resulting solely from the broker-dealer's compliance with the amended rules.

This rule is intended to implement Iowa Code section 502.411(2).

191—50.16(502) Dishonest or unethical practices in the securities business.

50.16(1) Dishonest or unethical business practices by any person in the securities business, other than an agent, investment adviser, investment adviser representative, or federal covered investment adviser, as prohibited pursuant to Iowa Code section 502.412(4) "m" include, but are not limited to, the following:

a. Engaging in any unreasonable and unjustifiable delay in delivering securities purchased by any customers or paying, upon request, free credit balances reflecting completed transactions of any customers;

b. Inducing in a customer's account trading which is excessive in size or frequency relative to the financial resources and character of the account;

c. Suitability:

(1) Failing to use reasonable diligence, in regard to the opening and maintenance of every account, to know and retain the essential facts concerning every customer and concerning the authority of each person acting on behalf of such customer;

(2) Recommending a transaction or investment strategy involving a security or securities without a reasonable basis to believe that the transaction or investment strategy is suitable for the customer, based on the information obtained through the reasonable diligence of the member or associated person to ascertain the customer's investment profile. A customer's investment profile includes, but is not limited to, the customer's age, other investments, financial situation and needs, tax status, investment objectives, investment experience, investment time horizon, liquidity needs, risk tolerance, and any other information the customer may disclose to the broker-dealer or agent in connection with such recommendation;

d. Executing a transaction on behalf of a customer without authorization;

e. Exercising any discretionary power in effecting a transaction for a customer's account without first obtaining written discretionary authority from the customer, unless the discretionary power relates solely to the time or price for executing the orders;

f. Executing any transaction in a margin account without securing from the customer a properly executed written margin agreement prior to the initial transaction in the account;

g. Failing to segregate customers' free securities or securities held in safekeeping;

h. Hypothecating a customer's securities without having a lien on them unless the broker-dealer secures from the customer a properly executed written consent promptly after the initial transaction, except as otherwise permitted by SEC rules;

i. Entering into a transaction with or for a customer at a price not reasonably related to the current market price of the security or receiving an unreasonable commission or profit;

j. Failing to furnish on or before the transaction confirmation date a final prospectus, or, if a final prospectus is not available, a preliminary prospectus together with additional documents which include all information that would be set forth in the final prospectus, to a customer purchasing securities in an offering registered pursuant to Iowa Code section 502.303 or 502.304 or that is subject to a notice filing made pursuant to Iowa Code section 502.302. If the offering is not registered, the broker-dealer shall furnish those disclosure documents that are customarily available;

k. Charging unreasonable and inequitable fees for services performed, including miscellaneous services such as collecting moneys due for principal, dividends or interest, exchange or transfer of securities, appraisals, safekeeping, custody of securities or other services regarding the securities business;

l. Offering to buy from or sell to any person any security at a stated price unless the broker-dealer is prepared to purchase or sell the security at the stated price and under the conditions as stated at the time of the offer to buy or sell the security;

m. Representing that a security is being offered to a customer "at the market" or a price relevant to the market price unless the broker-dealer knows or has reasonable grounds to believe that a market for the security exists other than that made, created or controlled by the broker-dealer, or by any person for whom the broker-dealer is acting or with whom the broker-dealer is associated in the distribution, or any person controlled by, controlling or under common control with such broker-dealer;

n. Effecting any transaction in, or inducing the purchase or sale of, any security by any manipulative, deceptive or fraudulent device, practice, plan, program, design or contrivance, including but not limited to:

(1) Effecting any transaction in a security involving no change in the beneficial ownership thereof;

(2) Entertaining an order for the purchase or sale of any security knowing that an order or orders of substantially the same size have been or will be entered by or for the same or different parties at substantially the same time and price for the purpose of creating a false or misleading appearance of active trading in the security or a false or misleading appearance regarding the market for the security. Nothing in this subparagraph shall prohibit a broker-dealer from entering bona fide agency cross transactions for the broker-dealer's customers;

(3) Effecting, alone or with one or more persons, a series of transactions in any security which creates actual or apparent active trading in a security or raising or depressing the price of the security for the purpose of inducing the purchase or sale of the security by others;

o. Guaranteeing a customer against loss in any securities account of the customer carried by the broker-dealer or in any securities transaction effected by the broker-dealer with or for the customer;

p. Publishing or circulating, or causing to be published or circulated, any notice, circular, advertisement, newspaper article, investment service, or communication of any kind purporting to report any transaction as a purchase or sale of any security unless the broker-dealer believes that the transaction was a bona fide purchase or sale of such security, or purporting to quote the bid price or asked price for any security unless the broker-dealer believes that the quotation represents a bona fide bid for or offer of such security;

q. Using any advertising or sales presentation in a deceptive or misleading fashion including but not limited to a distribution of any nonfactual data, material or presentation based on conjecture, unfounded or unrealistic claims or assertions in any brochure or flyer, or display by words, pictures, graphs or other medium designed to supplement, detract from, supersede or defeat the purpose or effect of any prospectus or disclosure;

r. Failing to disclose that the broker-dealer is controlled by, controlling, affiliated with or under common control of the issuer of any security before entering into any contract with or for a customer for the purchase or sale of the security. The existence of any control or affiliation shall be disclosed to the customer in writing prior to completion of the transaction;

s. Failing to make a bona fide public offering of all of the securities allotted to a broker-dealer for distribution, whether the securities were acquired by the broker-dealer as an underwriter, as a selling group member, or from a member participating in the distribution as an underwriter or selling group member;

t. Failing or refusing to furnish a customer, upon reasonable request, information to which the customer is entitled or to respond to a formal written request or complaint from the customer;

u. Failing or refusing to provide information requested in writing by the administrator within 14 days or a later time as prescribed by the administrator;

v. Extending credit to a customer in violation of the Securities Exchange Act of 1934 or the regulations of the Federal Reserve Board;

- w. Engaging in acts or practices enumerated in rule 191—50.100(502);
 - x. Failing in the solicitation of a sale or purchase of an OTC non-NASDAQ security to promptly provide, upon the customer's request, the most current prospectus, the most recent periodic report filed pursuant to Section 13 of the Securities Exchange Act of 1934, or any other available research reports;
 - y. Marking any order tickets or confirmations as unsolicited when the transaction is solicited;
 - z. Failing to provide each customer, on no greater than a quarterly basis, a statement of account that, for all OTC non-NASDAQ equity securities in the account for which the firm has been a market maker during the reportable period, contains a value for each security based on the closing market bid on a date certain for any month in which activity has occurred in a customer's account;
 - aa. Failing to comply with any applicable provision of the FINRA Conduct Rules or any applicable fair practice or ethical standard promulgated by the SEC or by a self-regulatory organization approved by the SEC; and
 - bb. Engaging in or aiding in "boiler-room" operations or high-pressure tactics in connection with the promotion of speculative offerings or "hot issues" by means of an intensive telephone campaign or unsolicited calls to persons not known by, nor having an account with, the agent or broker-dealer represented by the agent, where the prospective purchaser is encouraged to make a hasty decision to buy, irrespective of the purchaser's investment needs and objectives.
- 50.16(2)** Dishonest or unethical practices by an agent in the securities business as prohibited pursuant to Iowa Code section 502.412(4) "m" include, but are not limited to, the following:
- a. Lending money or securities to or borrowing money or securities from a customer or acting as a custodian for money, securities, or an executed stock power of a customer unless the customer is a member of the agent's immediate family and the act or practice is approved in advance by the agent's supervisory personnel;
 - b. Effecting securities transactions not recorded on the regular books or records of the broker-dealer the agent represents unless the transactions are authorized in writing by the broker-dealer prior to executing the transaction;
 - c. Establishing or maintaining an account containing fictitious information for the purpose of executing transactions otherwise prohibited;
 - d. Sharing, directly or indirectly, in profits or losses in any customer account without the written authorization of the customer and the broker-dealer the agent represents;
 - e. Dividing or otherwise splitting the agent's commissions, profits, or other compensation from the purchase or sale of securities with any person who is not registered as an agent for the same broker-dealer or for a broker-dealer under direct or indirect common control;
 - f. Soliciting or accepting a gift, directly or indirectly, from an unrelated customer that in the aggregate exceeds \$250 in a calendar year. A gift accepted by an immediate family member from an unrelated customer shall be included in the aggregate limit. An agent shall not solicit or accept from a customer a gift transferred through a relative or third party to the agent's benefit that would have the effect of evading this paragraph;
 - g. Soliciting or accepting being named as a beneficiary, executor, or trustee in a will or trust of an unrelated customer;
 - h. Evading or otherwise negating the requirements of paragraph 50.16(2) "a," "f" or "g" by terminating the customer relationship for the purpose of soliciting or accepting a loan or gift or being named as a beneficiary, executor or trustee in a will or trust that the agent is otherwise not permitted to solicit or accept. An agent is not in violation of this paragraph if the agent has made a bona fide termination of the customer relationship and conducted no securities-related business or other business for a period of three years with the customer;
 - i. Engaging in conduct specified in subrule 50.16(1), paragraphs "b" to "f," "i," "j," "n" to "q," "u," and "w" to "aa";
 - j. Engaging in conduct deemed dishonest or unethical in rule 191—50.55(502); and

k. Employing any method or tactic which uses undue pressure, force, fright, or threat, whether explicit or implied, to solicit the purchase or sale of securities, or committing any act which shows that the agent has exerted undue influence over a person.

This rule is intended to implement Iowa Code section 502.412(4) "m."
[ARC 9169B, IAB 10/20/10, effective 11/24/10; ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.17(502) Rules of conduct.

50.17(1) Each broker-dealer, after executing and before completing each transaction with its customer, shall give or send the customer a written confirmation. A broker-dealer not registered pursuant to the Securities Exchange Act of 1934 shall provide a written confirmation including, at a minimum:

a. A description of the security purchased or sold, the date of the transaction, the price at which the security was purchased or sold and any commission charged;

b. A statement as to whether the broker-dealer was acting for its own account, as the agent for the customer, as the agent for some other person, or as the agent for both the customer and some other person;

c. When the broker-dealer is acting as an agent for the customer, the name of the person from whom the security was purchased or to whom it was sold or the fact that such information will be furnished upon the customer's request.

50.17(2) A broker-dealer registered pursuant to the Securities Exchange Act of 1934 shall comply with all requirements of the Securities Exchange Act of 1934 and its implementing rules regarding written confirmations.

50.17(3) Each broker-dealer shall establish written supervisory procedures and a system for applying those procedures which may reasonably be expected to prevent and detect any violations of Iowa Code chapter 502, its implementing rules, and any orders issued pursuant to it. Each broker-dealer shall designate and qualify a number of supervisory employees reasonable in relation to the number of its registered agents, offices, and transactions in Iowa.

50.17(4) Each broker-dealer whose principal office is located in Iowa shall have at least one partner, officer or registered agent employed on a full-time basis at its principal office.

This rule is intended to implement Iowa Code sections 502.411(3) and 502.412(4) "i."

191—50.18(502) Limited registration of Canadian broker-dealers and agents.

50.18(1) A Canadian broker-dealer may register under this rule if the broker-dealer:

a. Files with the administrator an application in the form required by the jurisdiction in which the broker-dealer has its principal office;

b. Files with the administrator a consent to service of process on Form U-2;

c. Is registered as a broker-dealer and is in good standing in the jurisdiction from which the broker-dealer is effecting transactions into Iowa and files with the administrator satisfactory evidence thereof;

d. Is a member of a self-regulatory organization or stock exchange in Canada; and

e. Pays a \$200 filing fee.

50.18(2) An agent representing a Canadian broker-dealer registered under this rule in effecting transactions in securities in Iowa may register under this rule if the agent:

a. Files with the administrator an application in the form required by the jurisdiction in which the broker-dealer has its principal office;

b. Files with the administrator a consent to service of process;

c. Is registered and is in good standing in the jurisdiction from which the agent is effecting transactions into Iowa and files with the administrator satisfactory evidence thereof; and

d. Pays a \$40 filing fee.

50.18(3) A Canadian broker-dealer that is resident in Canada and has no office or other physical presence in Iowa may, provided that the broker-dealer is registered under this rule, effect transactions in Iowa:

a. With or for a person from Canada temporarily residing in Iowa with whom the Canadian broker-dealer had a bona fide broker-dealer-client relationship before the person entered the United States;

b. With or for a person from Canada currently residing in Iowa whose transactions are in a self-directed, tax-advantaged retirement plan in Canada of which the person is the holder or contributor; or

c. With or through:

(1) The issuers of the securities involved in the transactions;

(2) Other registered broker-dealers;

(3) Banks, savings institutions, trust companies, insurance companies, or investment companies as the term is defined in the Investment Company Act of 1940;

(4) Pension or profit-sharing trusts; or

(5) Other financial institutions or institutional investors, whether acting on their own behalf or as trustees.

50.18(4) An agent registered pursuant to subrule 50.18(2) representing a Canadian broker-dealer registered pursuant to subrule 50.18(1) may effect all securities transactions that the broker-dealer is authorized by subrule 50.18(3) to effect.

50.18(5) If no denial order is in effect and no proceeding is pending pursuant to Iowa Code section 502.304, a registration filed pursuant to this rule becomes effective on the forty-fifth day after an application is filed, unless otherwise provided by order of the administrator.

50.18(6) A Canadian broker-dealer registered under this rule shall:

a. Maintain provincial or territorial registration and membership in a self-regulatory organization or stock exchange and remain in good standing in each;

b. Provide, upon the administrator's request, all books and records relating to its business in Iowa as a broker-dealer;

c. Promptly inform the administrator of any criminal action taken against the broker-dealer or of any finding or sanction imposed on the broker-dealer as a result of a self-regulatory or other regulatory action involving fraud, theft, deceit, misrepresentation, or like conduct; and

d. Disclose in writing to each of the broker-dealer's clients in Iowa that the broker-dealer and its agents are not subject to the full regulatory requirements of the Act.

50.18(7) An agent of a Canadian broker-dealer registered under this rule shall:

a. Maintain the agent's provincial or territorial registration and remain in good standing; and

b. Promptly inform the administrator of any criminal action taken against the agent or of any finding or sanction imposed on the agent as a result of a self-regulatory or other regulatory action involving fraud, theft, deceit, misrepresentation, or like conduct.

50.18(8) Renewal applications for Canadian broker-dealers and agents under this rule must be filed before December 1 each year and may be made by filing with the administrator the most recent renewal application, if any, filed in the jurisdiction in which the broker-dealer has its principal office or, if no such renewal application is required, the most recent application filed pursuant to paragraph 50.18(1)"a" or 50.18(2)"a."

50.18(9) Every applicant for registration or renewal registration pursuant to this rule shall pay the applicable fee for broker-dealers and agents as set forth in Iowa Code section 502.410.

50.18(10) A Canadian broker-dealer or agent registered under this rule and in compliance with paragraph 50.18(3)"c" is exempt from all the requirements of the Act, except for the antifraud sections and the requirements set out in this rule.

50.18(11) All transactions in securities effected between Canadian broker-dealers or agents registered under this rule and Canadian persons meeting the requirements of paragraph 50.18(3)"a" or "b" are exempt from Iowa Code sections 502.301 and 502.504.

This rule is intended to implement Iowa Code section 502.401(4).

[ARC 9169B, IAB 10/20/10, effective 11/24/10]

191—50.19(502) Brokerage services by national and state banks.

50.19(1) A bank may, without registering as a broker-dealer, effect:

- a. Transactions pursuant to Iowa Code section 502.102(4) "c", or
- b. Transactions permitted by order of the administrator.

50.19(2) A bank that has entered into a contract with an Iowa-registered broker-dealer may provide the following ministerial securities services without registering as a broker-dealer:

a. Provide bank customers and the public with a telephone number of the broker-dealer and provide telephone facilities on bank premises for customers and members of the public to use in contacting the broker-dealer;

b. Distribute literature to bank customers and members of the public about particular services provided by the broker-dealer, subject to the requirements of subrule 50.19(4);

c. Provide broker-dealer account applications to bank customers and members of the public and provide assistance in completing the forms. The disclosures required pursuant to subrule 50.19(4), in the form prescribed by subrule 50.19(5), shall be included on either the account application or an attachment to the application. If the disclosures are provided on an attachment to the application, both the application and attachment must be signed by the applicant. The bank may mail the completed account applications to a broker-dealer;

d. Assist bank customers wishing to transfer funds into and out of their bank accounts for securities transactions; and

e. Provide mailers to bank customers and members of the public and assist them in transmitting securities and securities documents to the broker-dealer.

50.19(3) A bank that has entered into a contract with an Iowa-registered broker-dealer may attempt to effect and effect securities transactions without registering as a broker-dealer if all of the following requirements are met:

a. Any bank employee who attempts to effect and effects securities transactions is a registered agent of the broker-dealer and:

- (1) Has passed an acceptable subject matter examination pursuant to paragraph 50.12(1) "a";
- (2) Has passed the FINRA Series 63 or Series 66 examination;
- (3) Is registered with FINRA; and
- (4) Is registered as an agent of the broker-dealer pursuant to rule 191—50.12(502).

b. If the broker-dealer provides securities services in an area of public access on the bank premises in which banking services are not provided, the bank requires that the broker-dealer clearly distinguish the area in which securities services are provided. If securities services and banking services are provided in the same public area on the bank premises, there shall be a sign clearly identifying the broker-dealer providing the securities services.

c. The bank receives only the following types of compensation from the broker-dealer:

(1) Transaction-related compensation, subject to the restrictions provided by paragraph 50.19(7) "b";

- (2) An administrative fee;
- (3) Payments for compensation of employees jointly employed by the bank and the broker-dealer; and
- (4) Lease payments.

50.19(4) A bank attempting to effect and effecting securities transactions pursuant to a contract with an Iowa-registered broker-dealer may distribute advertisements or promotional materials without registering as a broker-dealer if the advertisements or promotional materials clearly and prominently:

a. Identify the broker-dealer;

b. State in bold typeface that securities transactions and related earnings or profits are not insured by the FDIC;

c. State that the securities offered by the broker-dealer are not guaranteed by, nor are they obligations of, the bank; and

d. State that the bank and the broker-dealer are separate organizations.

50.19(5) The following or a similar statement printed in bold typeface and capital letters shall satisfy the disclosure requirements of subrule 50.19(4): [NAME OF BROKER-DEALER] IS NOT A BANK, AND SECURITIES OFFERED BY [NAME OF BROKER-DEALER] ARE NOT BACKED OR GUARANTEED BY ANY BANK NOR ARE THEY INSURED BY THE FDIC.

50.19(6) The disclosure requirements of subrule 50.19(4) shall not apply to radio or television advertisements not exceeding 30 seconds in length.

50.19(7) A bank shall not engage in the following securities activities:

a. Distribute prospectuses to bank customers or to members of the public regarding securities unless done so:

(1) In the exercise of trust functions permitted to banks;

(2) Pursuant to registration as a broker-dealer; or

(3) In the performance of securities activities as permitted by subrule 50.19(1), 50.19(2), or 50.19(3);

b. Allow registered joint bank and broker-dealer employees to split commissions or other transaction-related remuneration received from customers with unregistered bank employees;

c. Transmit account statements, confirmations, or other broker-dealer communications to bank customers or members of the public unless the communications contain a disclosure statement as required by subrule 50.19(4);

d. Permit bank employees who are not registered securities agents of the broker-dealer to receive or transmit orders to the broker-dealer from customers or the public, except as permitted by subrule 50.19(1); and

e. Permit bank employees who are not registered agents of the broker-dealer to perform securities functions directly involving customer contact, except as provided in subrules 50.19(1) and 50.19(2).

This rule is intended to implement Iowa Code sections 502.102(4) "c" and 502.401.

[ARC 9169B, IAB 10/20/10, effective 11/24/10]

191—50.20(502) Broker-dealers having contracts with national and state banks.

50.20(1) A broker-dealer engaging in securities activities with banks as permitted by subrules 50.19(2) and 50.19(3) shall maintain for three years and make available to the administrator upon request the following records:

a. Copies of all advertisements and promotional literature disseminated by the bank and broker-dealer regarding securities services and products offered by the broker-dealer to bank customers and the public;

b. Copies of each contract executed between the bank and the broker-dealer which propose to sell securities to bank customers or the public;

c. Copies of new account forms to be completed by bank customers or members of the public who open an account with the broker-dealer;

d. A list of every bank employee who is a registered securities agent of the broker-dealer and the employee's social security number and CRD number; and

e. Copies of compliance and procedures manuals regarding the securities activities of the bank.

50.20(2) In addition to any responsibilities assumed pursuant to subrule 50.69(5), a broker-dealer engaging in securities transactions pursuant to a contract with a bank as permitted by subrules 50.19(2) and 50.19(3) shall not allow a person who is not an Iowa-registered securities agent of the broker-dealer to use the broker-dealer name, logo, or trademark on business cards or letterheads.

This rule is intended to implement Iowa Code sections 502.102(4) "c" and 502.401.

191—50.21(502) Brokerage services by credit unions, savings banks, and savings and loan institutions.

50.21(1) A credit union, savings bank, or savings and loan institution may, without registering as a broker-dealer, effect:

a. Transactions pursuant to Iowa Code section 502.102(4) "c"; and

b. Transactions permitted by order of the administrator.

50.21(2) A credit union, savings bank, or savings and loan institution that has entered into a contract with an Iowa-registered broker-dealer may provide the following ministerial securities services without registering as a broker-dealer:

a. Provide customers and the public with a telephone number of the broker-dealer and provide telephone facilities on its premises for customers and members of the public to use in contacting the broker-dealer;

b. Distribute literature to its customers and members of the public about particular services provided by the broker-dealer, subject to the requirements of subrule 50.21(4);

c. Provide broker-dealer account applications to its customers and members of the public and provide assistance in completing the forms. The disclosures required pursuant to subrule 50.21(4) shall be included on either the account application or an attachment to the application. If the disclosures are provided on an attachment to the application, both the application and attachment must be signed by the applicant. The credit union, savings bank, or savings and loan institution may mail the completed account applications to a broker-dealer;

d. Assist its customers wishing to transfer funds into and out of their accounts for securities transactions; and

e. Provide mailers to its customers and members of the public and assist them in transmitting securities and securities documents to the broker-dealer.

50.21(3) A credit union, savings bank, or savings and loan institution that has entered into a contract with an Iowa-registered broker-dealer may attempt to effect and effect securities transactions without registering as a broker-dealer if all of the following requirements are met:

a. Any credit union, savings bank, or savings and loan institution employee who attempts to effect and effects securities transactions is a registered agent of the broker-dealer and:

(1) Has passed an acceptable subject matter examination pursuant to paragraph 50.12(1) "a";

(2) Has passed the FINRA Series 63 or Series 66 examination;

(3) Is registered with FINRA; and

(4) Is registered as an agent of the broker-dealer pursuant to rule 191—50.12(502).

b. If the broker-dealer provides securities services in an area of public access on the credit union, savings bank, or savings and loan institution premises in which credit union, savings bank, or savings and loan institution services are not provided, the credit union, savings bank, or savings and loan institution requires that the broker-dealer clearly distinguish the area in which securities services are provided. If securities services and credit union, savings bank, or savings and loan institution services are provided in the same public area on the bank premises, there shall be a sign clearly identifying the broker-dealer providing the securities services.

c. The credit union, savings bank, or savings and loan institution receives only the following types of compensation from the broker-dealer:

(1) Transaction-related compensation, subject to the restrictions provided by paragraph 50.19(7) "b";

(2) An administrative fee;

(3) Payments for compensation of employees jointly employed by the credit union, savings bank, or savings and loan institution and the broker-dealer; and

(4) Lease payments.

50.21(4) Credit unions, savings banks, and savings and loan institutions attempting to effect and effecting securities transactions under contracts with Iowa-registered broker-dealers may distribute advertisements or promotional materials without registering as broker-dealers if the advertisements or promotional materials clearly and prominently:

a. Identify the broker-dealer.

b. Disclose in bold print that securities transactions and related earnings or profits are not insured by:

(1) The FDIC, in the case of savings banks and savings and loan institutions, or

(2) The NCUA, in the case of credit unions.

c. Disclose that securities offered by the broker-dealer are not guaranteed by, nor are they obligations of, the credit union, savings bank, or savings and loan institution.

d. Disclose that the credit union, savings bank, or savings and loan institution and the broker-dealer are separate organizations.

50.21(5) The following or a similar statement in bold print and capital letters will satisfy the disclosure requirements of subrule 50.21(4): [NAME OF BROKER-DEALER] IS NOT A [SAVINGS BANK, SAVINGS AND LOAN INSTITUTION, OR CREDIT UNION], AND SECURITIES OFFERED BY [NAME OF BROKER-DEALER] ARE NOT BACKED OR GUARANTEED BY ANY [SAVINGS BANK, SAVINGS AND LOAN INSTITUTION, OR CREDIT UNION] NOR ARE THEY INSURED BY THE [FDIC OR NCUA].

50.21(6) The disclosure requirements of subrule 50.21(4) shall not apply to radio or television advertisements not exceeding 30 seconds in length.

50.21(7) Credit unions, savings banks, and savings and loan institutions shall not:

a. Distribute prospectuses for securities to customers or to members of the public except:

(1) In the exercise of trust functions permitted to them;

(2) Pursuant to registration as a broker-dealer; or

(3) In the performance of securities activities as permitted by subrules 50.21(1) to 50.21(3); or

b. Engage in any of the activities proscribed if performed by an unregistered bank by paragraphs 50.19(7) "b" to "e."

This rule is intended to implement Iowa Code sections 502.102(4) "c" and 502.401.

[ARC 9169B, IAB 10/20/10, effective 11/24/10]

191—50.22(502) Broker-dealers having contracts with credit unions, savings banks, and savings and loan institutions.

50.22(1) A broker-dealer engaging in securities activities with credit unions, savings banks, or savings and loan institutions as permitted by subrules 50.21(2) and 50.21(3) shall maintain for three years and make available to the administrator upon request the following records:

a. Copies of all advertisements and promotional literature disseminated by the credit union, savings bank, or savings and loan institution and the broker-dealer regarding securities services and products offered by the broker-dealer to credit union, savings bank, or savings and loan institution customers and the public;

b. Copies of each contract executed between the credit union, savings bank, or savings and loan institution and the broker-dealer which proposes to sell securities to credit union, savings bank, or savings and loan institution customers or the public;

c. Copies of new account forms to be completed by credit union, savings bank, or savings and loan institution customers or members of the public who open an account with the broker-dealer;

d. A list of every credit union, savings bank, or savings and loan institution employee who is a registered securities agent of the broker-dealer and the employee's social security number and CRD number; and

e. Copies of compliance and procedures manuals regarding the securities activities of the credit union, savings bank, or savings and loan institution.

50.22(2) In addition to any responsibilities assumed pursuant to subrule 50.69(5), a broker-dealer engaging in securities transactions pursuant to a contract with a credit union, savings bank, or savings and loan institution as permitted by subrules 50.21(2) and 50.21(3) shall not allow a person who is not an Iowa-registered securities agent of the broker-dealer to use the broker-dealer name, logo, or trademark on business cards or letterheads.

This rule is intended to implement Iowa Code sections 502.102(4) "c" and 502.401.

191—50.23 to 50.29 Reserved.

DIVISION III
REGISTRATION OF INVESTMENT ADVISERS,
INVESTMENT ADVISER REPRESENTATIVES,
AND FEDERAL COVERED INVESTMENT ADVISERS

191—50.30(502) Electronic filing with designated entity.

50.30(1) *Designation.* Pursuant to Iowa Code sections 502.406 and 502.608(3)“a,” the administrator designates the IARD operated by FINRA to receive and store filings and collect related fees from investment advisers on behalf of the administrator.

50.30(2) *Use of IARD.* Unless otherwise provided, all investment adviser applications, amendments, reports, notices, related filings and fees required to be filed with the administrator pursuant to the rules promulgated under the Act shall be filed electronically with and transmitted to IARD. The following additional conditions relate to such electronic filings:

a. *Electronic signature.* When a signature or signatures are required by the particular instructions of any filing to be made through IARD, a duly authorized signatory of the applicant, as required, shall affix the duly authorized signatory’s electronic signature to the filing by typing the duly authorized signatory’s name in the appropriate fields and submitting the filing to IARD. Submission of a filing in this manner shall constitute irrefutable evidence of legal signature by any individuals whose names are typed on the filing.

b. *When filed.* Solely for purposes of a filing made through IARD, a document is considered filed with the administrator when all fees are received and the filing is accepted by IARD on behalf of the state.

This rule is intended to implement Iowa Code sections 502.102(8), 502.406 and 502.608(3)“a.”
[ARC 9169B, IAB 10/20/10, effective 11/24/10]

191—50.31(502) Investment adviser applications and renewals.

50.31(1) *Investment adviser applications—required filings.* The application for initial registration as an investment adviser shall be made by:

- a. Filing Form ADV Parts 1 and 2 with IARD; and
- b. Remitting the \$100 filing fee to IARD pursuant to Iowa Code section 502.410(3).

50.31(2) *Investment adviser applications—discretionary filings.* The administrator may require that an application for initial registration also include the following:

- a. Financial statements as set forth in paragraph 50.42(1)“f” including, but not limited to, a copy of the balance sheet for the last fiscal year and, if the balance sheet is prepared as of a date more than 45 days from the date of the filing of the application, an unaudited balance sheet prepared in accordance with subrule 50.40(7);
- b. A copy of the surety bond required pursuant to rule 191—50.41(502), if any; and
- c. Any other information necessary for determining whether registration is appropriate.

50.31(3) *Investment adviser renewals—required filings.* Annual renewals by investment advisers shall be made by:

- a. Filing an annual renewal registration with IARD; and
- b. Remitting the \$100 filing fee to IARD as required pursuant to Iowa Code section 502.410(3).

50.31(4) *Investment adviser renewals—discretionary filings.* The administrator may require the filing of a copy of the surety bond, if any, required pursuant to rule 191—50.41(502).

50.31(5) *Completion of filing.* An application for initial or renewal registration is considered filed for the purposes of Iowa Code section 502.406 when the required fee and all required submissions have been received by IARD and the administrator.

50.31(6) *Updates and amendments.* The investment adviser is under a continuing obligation to update information provided on Form ADV as follows:

a. An updated Form ADV must be filed with IARD within 90 days of the end of the investment adviser’s fiscal year; and

b. Any amendment to Form ADV must be filed with IARD within 30 days of the event causing the required amendment.

50.31(7) Succession and change in registration.

a. In the case of an organizational change, including a change in the state of incorporation or form of organization, not involving a material change in financial condition or management, an investment adviser shall file all applicable amendments to Form ADV.

b. In the case of an organizational change, including a change in the state of incorporation or form of organization, involving a material change in financial condition or management, an investment adviser must file a new application for registration pursuant to subrule 50.31(1). The filing must include the fee pursuant to paragraph 50.31(1) "b" and registration fees for all Iowa-registered investment adviser representatives.

c. In the case of a change in name, an investment adviser shall file all applicable amendments to Form ADV.

This rule is intended to implement Iowa Code sections 502.102(8) and 502.406.
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.32(502) Application for investment adviser representative registration.

50.32(1) Designation. Pursuant to Iowa Code sections 502.406 and 502.608(3) "a," the administrator designates the CRD operated by FINRA to receive and store filings and collect related fees from investment adviser representatives on behalf of the administrator.

50.32(2) Initial application. The application for initial registration as an investment adviser representative made pursuant to Iowa Code section 502.406(1) shall be made by filing Form U-4 with the CRD. The following shall be submitted to the CRD with the application:

a. Proof of compliance by the investment adviser representative with the examination requirements of rule 191—50.33(502); and

b. If applicable, the \$30 fee required pursuant to Iowa Code section 502.410(4).

50.32(3) Annual renewal. Annual renewals by investment adviser representatives shall be made by:

a. Filing an annual renewal registration with CRD; and

b. If applicable, remitting the \$30 filing fee to CRD as required pursuant to Iowa Code section 502.410(4).

50.32(4) Completion of filing. An application for initial or renewal registration is considered filed for the purposes of Iowa Code section 502.406 when the required fee and all required submissions have been received by the CRD.

50.32(5) Updates, amendments, withdrawals and terminations. The investment adviser representative is under a continuing obligation to update information provided on Form U-4 as follows:

a. Any amendment to information provided on Form U-4 must be filed with CRD within 30 days of the event causing the required amendment; and

b. A withdrawal request or termination must be filed with CRD within 30 days of the event causing the necessity of a withdrawal request or termination. A withdrawal request shall be made by filing an accurate and complete Form U-5 with CRD.

This rule is intended to implement Iowa Code sections 502.102(8) and 502.406.
[ARC 9169B, IAB 10/20/10, effective 11/24/10]

191—50.33(502) Examination requirements.

50.33(1) Except as exempted by subrule 50.33(2), a person applying to be registered as an investment adviser representative shall provide the administrator with proof that the person has obtained a passing score on one of the following examinations:

a. The Series 65 examination as implemented January 1, 2000; or

b. The Series 7 examination and Series 66 examination as implemented January 1, 2000. In the event that an applicant for registration as an investment adviser representative has received a waiver by FINRA of the Series 7 examination otherwise required by this paragraph, the FINRA waiver will be accepted in lieu of the examination requirement.

50.33(2) Unless otherwise ordered by the administrator in connection with a violation of the Act, the following individuals shall be exempt from the examination requirements of subrule 50.33(1):

a. Any individual who is registered as an investment adviser or investment adviser representative in any jurisdiction in the United States on or before January 19, 2000.

b. Any individual who is registered as an investment adviser or investment adviser representative in any jurisdiction in the United States after November 1, 2001, provided that the jurisdiction in which the investment adviser or investment adviser representative is registered requires the passage of the examinations in subrule 50.33(1).

c. Any individual who has not been registered as an investment adviser or investment adviser representative in any jurisdiction for a period of two years shall be required to comply with the examination requirements of this rule.

d. Any individual who currently holds one of the following professional designations:

(1) Certified Financial Planner or CFP designation awarded by the Certified Financial Planner Board of Standards, Inc.;

(2) Chartered Financial Consultant (ChFC) designation awarded by The American College, Bryn Mawr, Pennsylvania;

(3) Personal Financial Specialist (PFS) designation administered by the American Institute of Certified Public Accountants;

(4) Chartered Financial Analyst (CFA) designation granted by the Association for Investment Management and Research;

(5) Chartered Investment Counselor (CIC) designation granted by the Investment Counsel Association of America; or

(6) Any other professional designation recognized by order of the administrator.

This rule is intended to implement Iowa Code section 502.412(5).

[ARC 9169B, IAB 10/20/10, effective 11/24/10]

191—50.34(502) Notice filing requirements for federal covered investment advisers.

50.34(1) Notice filing. The notice filing for a federal covered investment adviser pursuant to Iowa Code section 502.405 shall be filed with IARD on an executed Form ADV. A notice filing of a federal covered investment adviser shall be deemed filed for purposes of this subrule when Form ADV and the fee of \$100 required pursuant to Iowa Code section 502.410(5) are received by IARD.

50.34(2) Form ADV Part 2. The administrator may:

a. Accept a copy of Part 2 of Form ADV as filed electronically with IARD; or

b. Deem Part 2 of Form ADV filed if a federal covered investment adviser provides, within five days of a request, Part 2 of Form ADV to the administrator. Because the administrator deems Part 2 of Form ADV to be filed, a federal covered investment adviser is not required to submit Part 2 of Form ADV to the administrator unless specifically requested to do so.

50.34(3) Renewal. The annual renewal of the notice filing for a federal covered investment adviser pursuant to Iowa Code section 502.405 shall be filed with IARD. The renewal of the notice filing shall be deemed filed for purposes of this subrule when the \$100 fee required pursuant to Iowa Code section 502.410(5) is accepted by IARD.

50.34(4) Updates and amendments. A federal covered investment adviser must file with IARD any amendments to the federal covered investment adviser's Form ADV.

This rule is intended to implement Iowa Code section 502.405.

[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.35(502) Withdrawal of investment adviser registration. The application for withdrawal of registration as an investment adviser pursuant to Iowa Code section 502.409 shall be completed on Form ADV-W and filed with IARD.

This rule is intended to implement Iowa Code section 502.409.

191—50.36(502) Investment adviser brochure.**50.36(1) General requirements.**

a. Unless otherwise provided in this rule, an investment adviser registered or required to be registered pursuant to Section 403 of the Act shall furnish each advisory client and prospective advisory client with:

- (1) A brochure which may be a copy of Part 2A of its Form ADV or written documents containing the information required by Part 2A of Form ADV;
 - (2) A copy of its Part 2B brochure supplement for each individual:
 1. Providing investment advice and having direct contact with clients in this state; or
 2. Exercising discretion over assets of clients in this state, even if no direct contact is involved;
 - (3) A copy of its Part 2A Appendix 1 wrap fee brochure if the investment adviser sponsors or participates in a wrap fee account;
 - (4) A summary of material changes, which may be included in Form ADV Part 2 or given as a separate document; and
 - (5) Such other information as the administrator may require.
- b. The brochure must comply with the language, organizational format and filing requirements specified in the Instructions to Form ADV Part 2.
- c. Notwithstanding the SEC's Instructions for Part 2A of Form ADV, fee changes constitute material changes requiring an update to all parts of Form ADV.

50.36(2) Delivery.

a. *Initial delivery.* An investment adviser, except as provided in paragraph 50.36(2) "c," shall deliver the Part 2A brochure and any brochure supplements required by rule 191—50.36(502) to a prospective advisory client:

- (1) Not less than 48 hours before an investment adviser enters into any advisory contract with such client or prospective client; or
- (2) At the time an advisory client enters into any such contract, if the advisory client has a right to terminate the contract without penalty within five business days after entering into the contract.

b. *Annual delivery.* An investment adviser, except as provided in paragraph 50.36(2) "c," must:

- (1) Deliver within 120 days of the end of its fiscal year a free, updated brochure and related brochure supplements which include or are accompanied by a summary of material changes; or
- (2) Deliver a summary of material changes that includes an offer to provide a copy of the updated brochures and supplements and information on how the client may obtain a copy of the brochures and supplements, provided that advisers are not required to deliver a summary of material changes if no material changes have taken place since the last summary and brochure delivery.

c. *Exceptions to delivery.* Delivery of the brochure and related brochure supplements required by paragraphs 50.36(2) "a" and "b" need not be made to:

- (1) Clients who receive only impersonal advice and who pay less than \$500 in fees per year; or
- (2) An investment company registered under the Investment Company Act of 1940; or
- (3) A business development company as defined in the Investment Company Act of 1940 and whose advisory contract meets the requirements of Section 15c of that Act.

d. *Electronic delivery.* Delivery of the brochure and related supplements may be made electronically if the investment adviser:

- (1) In the case of an initial delivery to a potential client, obtains verification that readable copies of the brochure and supplements were received by the client;
- (2) In the case of other than initial deliveries, obtains each client's prior consent to provide the brochure and supplements electronically;
- (3) Prepares the electronically delivered brochure and supplements in the format prescribed in subrule 50.36(1) and Instructions to Form ADV Part 2;
- (4) Delivers the brochure and supplements in a format that can be retained by the client in either electronic or paper form; or
- (5) Establishes procedures to supervise personnel transmitting the brochure and supplements and to prevent violations of this rule.

50.36(3) Other disclosures. Nothing in this rule shall relieve any investment adviser from any obligation pursuant to any provision of the Act or the rules thereunder or other federal or state law to disclose any information to its advisory clients or prospective advisory clients not specifically required by this rule.

50.36(4) Definitions. For the purpose of this rule:

a. “Contract for impersonal advisory services” means any contract relating solely to the provision of investment advisory services:

(1) By means of written material or oral statements which do not purport to meet the objectives or needs of specific individuals or accounts;

(2) Through the issuance of statistical information containing no expression of opinion as to the investment merits of a particular security; or

(3) Any combination of the foregoing services.

b. “Entering into,” in reference to an advisory contract, does not include an extension or renewal without material change of any such contract which is in effect immediately prior to such extension or renewal.

This rule is intended to implement Iowa Code section 502.411(7).

[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.37(502) Cash solicitation.

50.37(1) Payment of a cash fee, directly or indirectly, by an investment adviser to a solicitor for solicitation activities shall constitute an act, practice, or course of conduct operating as a fraud or deceit upon a person, pursuant to Iowa Code section 502.502(2), if:

a. The solicitor:

(1) Is subject to an order issued by the administrator pursuant to Iowa Code section 502.412(4);

(2) Has been convicted of a felony or within the previous ten years has been convicted of a misdemeanor involving conduct described in Iowa Code section 502.412(4) “c”; or

(3) Is found by the administrator to have engaged or has been convicted of engaging in any of the conduct specified in Iowa Code section 502.505, 502.412(4) “b” or 502.412(4) “i”; has materially aided in violating Iowa Code section 502.412(4) “d”; or is subject to an order, judgment, or decree pursuant to Iowa Code section 502.412(4) “d” to “f.”

b. The cash fee is not paid pursuant to a written agreement to which the investment adviser is a party. If the cash fee is paid pursuant to a written agreement, the written agreement must:

(1) Describe the solicitation activities to be engaged in by the solicitor on behalf of the investment adviser and the compensation to be received for the solicitation activities;

(2) Contain an undertaking by the solicitor to perform the solicitor’s duties under the agreement in a manner consistent with the instructions of the investment adviser and the provisions of the Act and its implementing rules, as applicable; and

(3) Require that the solicitor, at the time of any solicitation activities for which compensation is paid or is to be paid by the investment adviser, provide the client with a current copy of the investment adviser’s written disclosure statement required by subparagraph 50.36(2) “a”(2) or SEC Rule 204-3, if applicable, and a separate written disclosure statement as described in subrule 50.37(2). Prior to or upon entering into a written or oral investment advisory contract with a client, the investment adviser shall obtain a signed and dated acknowledgment of receipt by the client of the investment adviser’s and solicitor’s written disclosure statements. Additionally, the investment adviser shall make a bona fide effort to ascertain whether the solicitor has complied in all aspects with the written agreement, and shall have a reasonable basis for believing that the solicitor has complied.

c. The cash fee is paid to a solicitor:

(1) For solicitation activities regarding anything other than impersonal advisory services; or

(2) Who is a partner, officer, director, or employee of the investment adviser or is a partner, officer, director, or employee of a person who controls, is controlled by, or is under common control with the investment adviser without disclosure of the status of the solicitor as a partner, officer, director, or

employee of the investment adviser or other person and of any affiliation between the investment adviser and the solicitor to the client at the time of solicitation or referral.

50.37(2) The separate written disclosure statement required to be furnished pursuant to subparagraph 50.37(1) "b"(3) shall contain the following information:

- a. The name of the solicitor;
- b. The name of the investment adviser;
- c. The nature of the relationship, including any affiliation, between the solicitor and the investment adviser;
- d. A statement that the solicitor will be compensated for the solicitor's solicitation services by the investment adviser;
- e. The terms of such compensation arrangement, including a description of the compensation paid or to be paid to the solicitor; and
- f. The amount, if any, the client will be charged for the cost of obtaining the client's account in addition to the advisory fee, and the differential, if any, in advisory fees charged by the investment adviser if the differential is the result of the investment adviser's agreement to compensate the solicitor for soliciting or referring clients.

50.37(3) Nothing in this rule relieves any person of any fiduciary duty or other obligation to which the person may be subject pursuant to contract or law.

50.37(4) For the purpose of this rule:

"*Client*" includes any prospective client.

"*Impersonal advisory services*" means investment advisory services provided solely through written materials or oral statements not purporting to meet the objectives or needs of the specific client, statistical information containing no expressions of opinion as to the investment merits of particular securities, or any combination of the foregoing.

"*Principal place of business*" of an investment adviser means the executive office of the investment adviser from which the officers, partners, or managers of the investment adviser direct, control, and coordinate the activities of the investment adviser.

"*Solicitor*" means any person who, directly or indirectly, solicits any client for or refers any client to an investment adviser.

50.37(5) An investment adviser shall retain a copy of each written agreement, acknowledgment and solicitor disclosure statement required by this rule in accordance with Iowa Code section 502.411(3) and paragraph 50.42(1) "o." However, an investment adviser registered in Iowa whose principal place of business is located outside Iowa shall not be subject to the record maintenance requirements of this subrule and the applicable provisions of paragraph 50.42(1) "o" if:

- a. The investment adviser is registered or licensed as an investment adviser in the state in which the investment adviser maintains the investment adviser's principal place of business;
- b. The investment adviser complies with the applicable books and records requirements of the state in which the investment adviser maintains the investment adviser's principal place of business; and
- c. The provisions of this rule would require the investment adviser to maintain books or records in addition to those required by the laws of the state in which the investment adviser maintains the investment adviser's principal place of business.

This rule is intended to implement Iowa Code section 502.502(2).

191—50.38(502) Prohibited conduct in providing investment advice.

50.38(1) An investment adviser, an investment adviser representative, or a federal covered investment adviser is a fiduciary and has a duty to act primarily for the benefit of its clients. Rule 191—50.38(502) applies to federal covered investment advisers to the extent that the alleged conduct is fraudulent, deceptive, or as otherwise permitted by the NSMIA. While the extent and nature of this duty varies according to the nature of the relationship between an investment adviser, an investment adviser representative, or a federal covered investment adviser and its clients and the circumstances of each case, an investment adviser, an investment adviser representative, or a federal covered investment

adviser shall not engage in prohibited fraudulent, deceptive, or manipulative conduct including, but not limited to:

- a. Recommending to a client to whom investment advisory services are provided the purchase, sale, or exchange of any security without reasonable grounds to believe that the recommendation is suitable for the client on the basis of information furnished by the client after reasonable inquiry concerning the client's investment objectives, financial situation and needs, and any other information known by the investment adviser, investment adviser representative, or federal covered investment adviser;
- b. Exercising any discretionary authority in placing an order for the purchase or sale of securities for a client without obtaining written discretionary authority from the client within ten business days after the date of the first transaction placed pursuant to discretionary authority, unless the discretionary authority relates solely to the price at which, or the time when, an order for a definite amount of a specified security shall be executed, or both;
- c. Inducing trading in a client's account that is excessive in size or frequency compared to the financial resources, investment objectives, and character of the account;
- d. Placing an order to purchase or sell a security for a client account without authority to do so;
- e. Placing an order to purchase or sell a security for a client account upon instruction of a third party without first obtaining a written third-party trading authorization from the client;
- f. Borrowing money or securities from a client unless the client is a broker-dealer, an affiliate of the investment adviser, or a financial institution engaged in the business of loaning funds;
- g. Loaning money or securities to a client unless the investment adviser is a financial institution engaged in the business of loaning funds or the client is an affiliate of the investment adviser;
- h. Misrepresenting to any client, or prospective client, the qualifications of the investment adviser, investment adviser representative, or federal covered investment adviser or any employee, or affiliated persons, or misrepresenting the nature of the advisory services being offered or fees to be charged for such service, or omitting to state a material fact necessary to make the statements made regarding qualifications, services or fees, in light of the circumstances under which they are made, not misleading;
- i. Providing a report or recommendation to any advisory client prepared by someone other than the investment adviser, investment adviser representative, or federal covered investment adviser without disclosing that fact. This prohibition does not apply when the investment adviser, investment adviser representative, or federal covered investment adviser uses published research reports or statistical analyses to render advice or when an investment adviser, investment adviser representative, or federal covered investment adviser orders such a report in the normal course of providing service;
- j. Charging a client an unreasonable fee;
- k. Failing to disclose to clients in writing before any advice is rendered any material conflict of interest regarding the investment adviser, investment adviser representative, or federal covered investment adviser or any of its employees, or affiliated persons which could reasonably be expected to impair the rendering of unbiased and objective advice including, but not limited to:
 - (1) Compensation arrangements connected with investment advisory services to clients which are in addition to compensation from such clients for such services; and
 - (2) Charging a client an investment advisory fee for rendering advice when compensation for effecting securities transactions pursuant to such advice will be received by the investment adviser, investment adviser representative, or federal covered investment adviser or its employees or affiliated persons;
- l. Knowingly selling any security to or purchasing any security from a client while acting as principal for an advisory account of the investment adviser, investment adviser representative, or federal covered investment adviser, or knowingly effecting any sale or purchase of any security for the account of the client while acting as broker-dealer for a person other than the client, without disclosing to the client in writing before the completion of the transaction the capacity in which the investment adviser, investment adviser representative, or federal covered investment adviser is acting and without obtaining the written consent of the client to the transaction.

- (1) The prohibitions of paragraph 50.38(1) "l" shall not apply to any transaction with a customer of a broker-dealer if the broker-dealer is not acting as an investment adviser in relation to the transaction.
- (2) The prohibitions of paragraph 50.38(1) "l" shall not apply to any transaction with a customer of a broker-dealer if the broker-dealer acts solely as an investment adviser:
 1. By means of publicly distributed written materials or publicly made oral statements;
 2. By means of written materials or oral statements not purporting to meet the objectives or needs of specific individuals or accounts;
 3. Through the issuance of statistical information containing no expressions of opinion as to the investment merits of a particular security; or
 4. Any combination of the foregoing services.
- (3) Publicly distributed written materials or publicly made oral statements shall disclose that, if the purchaser of the advisory communication uses the investment adviser's services in connection with the sale or purchase of a security which is a subject of the communication, the investment adviser may act as principal for its own account or as agent for another person. Compliance by the investment adviser with the foregoing disclosure requirement shall not relieve the investment adviser of any other disclosure obligations under the Act.
- (4) Definitions for purposes of rule 191—50.38(502):
 1. "*Publicly distributed written materials*" means written materials which are distributed to 35 or more persons who pay for those materials.
 2. "*Publicly made oral statements*" means oral statements made simultaneously to 35 or more persons who pay for access to those statements.
 - m. Guaranteeing a client that a specific result will be achieved with advice rendered;
 - n. Making, in the solicitation of clients, any untrue statement of a material fact, or omitting to state a material fact necessary in order to make the statement made, in light of the circumstances under which they are made, not misleading;
 - o. Disclosing the identity, affairs, or investments of any client unless required by law to do so, or unless disclosed with the client's consent;
 - p. Taking any action, directly or indirectly, regarding securities or funds in which any client has any beneficial interest when the investment adviser has custody or possession of such securities or funds and when the action of the investment adviser or investment adviser representative is subject to and in violation of the custody requirements provided by rule 191—50.39(502);
 - q. Failing to establish, maintain, and enforce written policies and procedures reasonably designed to prevent the misuse of material nonpublic information in violation of Section 204A of the Investment Advisers Act of 1940;
 - r. Engaging in any act, practice, or course of business which is fraudulent, deceptive, manipulative, or unethical;
 - s. Engaging in conduct or any act, indirectly or through or by any other person, which is unlawful for such person to do directly under the provisions of this Act, its implementing rules, or order of the administrator;
 - t. Failing to disclose or providing incomplete disclosure to a client regarding any securities-related activities, or engaging in deceptive practices;
 - u. Soliciting or accepting a gift, directly or indirectly, from an unrelated customer that in the aggregate exceeds \$250 in a calendar year. A gift accepted by an immediate family member from an unrelated client shall be included in the aggregate limit. An investment adviser shall not solicit or accept from a client a gift transferred through a relative or third party to the investment adviser's benefit that would have the effect of evading this paragraph;
 - v. Soliciting or accepting being named as a beneficiary, executor, or trustee in a will or trust of an unrelated customer;
 - w. Evading or otherwise negating the requirements of paragraph 50.38(1) "f," "g," "u" or "v," by terminating the customer relationship for the purpose of soliciting or accepting a loan or gift or being named as a beneficiary, executor or trustee in a will or trust that the agent is otherwise not permitted to solicit or accept. An investment adviser or investment adviser representative will not be in violation of

this rule if the investment adviser or investment adviser representative has made a bona fide termination of the client relationship and conducted no securities-related business or other business for a period of three years with the client;

x. Engaging in conduct deemed dishonest or unethical in rule 191—50.55(502); and

y. Employing any method or tactic which uses undue pressure, force, fright, or threat, whether explicit or implied, in connection with providing investment advice, or committing any act which shows that an investment adviser or investment adviser representative has exerted undue influence over a client.

50.38(2) An investment adviser, investment adviser representative, or federal covered investment adviser shall not, directly or indirectly, publish, circulate, or distribute any advertisement that does any one of the following:

a. Refers to any testimonial of any kind concerning the investment adviser, investment adviser representative, or federal covered investment adviser or concerning any advice, analysis, report, or other service rendered by such investment adviser, investment adviser representative, or federal covered investment adviser.

b. Refers to past specific recommendations of the investment adviser, investment adviser representative, or federal covered investment adviser that were or would have been profitable to any person, except that an investment adviser, investment adviser representative, or federal covered investment adviser may furnish or offer to furnish a list of all recommendations made by the investment adviser, investment adviser representative, or federal covered investment adviser within the immediately preceding period of not less than one year if the advertisement or list also includes both of the following:

(1) The name of each security recommended, the date and nature of each recommendation, the market price at that time, the price at which the recommendation was to be acted upon, and the most recently available market price of each such security.

(2) A legend on the first page in prominent print or type that states that the reader should not assume that recommendations made in the future will be profitable or will equal the performance of the securities in the list.

c. Represents that any graph, chart, formula, or other device being offered can in and of itself be used to determine which securities to buy or sell, or when to buy or sell them; or which represents, directly or indirectly, that any graph, chart, formula, or other device being offered will assist any person in making that person's own decisions as to which securities to buy or sell, or when to buy or sell them, without prominently disclosing in such advertisement the limitations thereof and the difficulties with respect to the use of any graph, chart, formula or device.

d. Represents that any report, analysis, or other service will be furnished for free or without charge, unless such report, analysis, or other service actually is or will be furnished entirely free and without any direct or indirect condition or obligation.

e. Represents that the administrator has approved any advertisement.

f. Contains any untrue statement of a material fact, or any statement that is otherwise false or misleading.

50.38(3) With respect to federal covered investment advisers, the provisions of subrule 50.38(2) apply only to the extent permitted by Section 203A of the Investment Advisers Act of 1940.

50.38(4) For the purposes of subrule 50.38(2), the term "advertisement" shall include any notice, circular, letter, or other written communication addressed to more than one person, or any notice or other announcement in any electronic or paper publication, by radio or television, or by any medium, that offers any one of the following:

a. Any analysis, report, or publication concerning securities.

b. Any analysis, report, or publication that is to be used in making any determination as to when to buy or sell any security, or which security to buy or sell.

c. Any graph, chart, formula, or other device to be used in making any determination as to when to buy or sell any security, or which security to buy or sell.

d. Any other investment advisory service with regard to securities.

50.38(5) The prohibitions of rule 191—50.38(502) shall not apply to an investment adviser effecting an agency cross transaction for an advisory client provided the following conditions are met:

a. The advisory client executes a written consent prospectively authorizing the investment adviser to effect agency cross transactions for such client;

b. Before obtaining such written consent from the client, the investment adviser makes full written disclosure to the client that, with respect to agency cross transactions, the investment adviser will act as broker-dealer for, receive commissions from, and have a potentially conflicting division of loyalties and responsibilities regarding both parties to the transactions;

c. At or before the completion of each agency cross transaction, the investment adviser or any other person relying on subrule 50.38(5) sends the client a written confirmation. The written confirmation shall include:

(1) A statement of the nature of the transaction;

(2) The date the transaction took place;

(3) An offer to furnish, upon request, the time when the transaction took place; and

(4) The source and amount of any other remuneration the investment adviser received or will receive in connection with the transaction. In the case of a purchase, if the investment adviser was not participating in a distribution, or, in the case of a sale, if the investment adviser was not participating in a tender offer, the written confirmation may state whether the investment adviser has been receiving or will receive any other remuneration and that the investment adviser will furnish the source and amount of such remuneration to the client upon the client's written request;

d. At least annually, and with or as part of any written statement or summary of the account from the investment adviser, the investment adviser or any other person relying on subrule 50.38(5) sends each client a written disclosure statement identifying:

(1) The total number of agency cross transactions for the client during the period since the date of the last such statement or summary; and

(2) The total amount of all commissions or other remuneration the investment adviser received or will receive in connection with agency cross transactions for the client during the period;

e. Each written disclosure and confirmation required by subrule 50.38(5) must include a conspicuous statement indicating that the client may revoke the written consent required under paragraph 50.38(5) "a" at any time by providing written notice to the investment adviser;

f. No agency cross transaction may be effected in which the same investment adviser recommended the transaction to both any seller and any purchaser;

g. "*Agency cross transaction for an advisory client*," for purposes of subrule 50.38(5), means a transaction in which a person acts as an investment adviser in relation to a transaction in which the investment adviser, or any person controlling, controlled by, or under common control with such investment adviser, including an investment adviser representative, acts as a broker-dealer for both the advisory client and for another client on the other side of the transaction. When acting in such capacity, such person acting as an investment adviser, or any person controlling, controlled by, or under common control with such investment adviser, including an investment adviser representative, is required to be registered as a broker-dealer in this state unless excluded from the definition of investment adviser;

h. Nothing in subrule 50.38(5) shall be construed to relieve an investment adviser or investment adviser representative from acting in the best interests of the client, including fulfilling the duty with respect to the best price and execution for the particular transaction for the client, nor shall subrule 50.38(5) relieve any investment adviser or investment adviser representative of any other disclosure obligations imposed by the Act.

This rule is intended to implement Iowa Code section 502.502(2).
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.39(502) Custody of client funds or securities by investment advisers.

50.39(1) Safekeeping required. It is unlawful and deemed to be a fraudulent, deceptive, or manipulative act, practice, or course of business for an investment adviser, registered or required to be registered, to have custody of client funds or securities unless the following conditions are met:

a. *Notice to administrator.* The investment adviser notifies the administrator promptly in writing that the investment adviser has or may have custody. Such notification is required to be given on Form ADV.

b. *Qualified custodian.* A qualified custodian maintains those funds and securities:

(1) In a separate account for each client under that client's name; or

(2) In accounts that contain only the investment adviser's clients' funds and securities, under the investment adviser's name as agent or trustee for the clients, or, in the case of a pooled investment vehicle that the investment adviser manages, in the name of the pooled investment vehicle.

c. *Notice to clients.* If an investment adviser opens an account with a qualified custodian on its client's behalf, under the client's name, under the name of the investment adviser as agent, or under the name of a pooled investment vehicle, the investment adviser must notify the client in writing of the qualified custodian's name and address and the manner in which the funds or securities are maintained, promptly when the account is opened and following any changes to this information. If the investment adviser sends account statements to a client to whom the investment adviser is required to provide this notice, the investment adviser must include in the notification provided to that client and in any subsequent account statement the investment adviser sends that client a statement urging the client to compare the account statements from the custodian with those from the investment adviser.

d. *Account statements.* The investment adviser has a reasonable basis, after due inquiry, for believing that the qualified custodian sends an account statement, at least quarterly, to each client for which the qualified custodian maintains funds or securities, identifying the amount of funds and of each security in the account at the end of the period and setting forth all transactions in the account during that period.

e. *Special rule for limited partnerships and limited liability companies.* If the investment adviser or a related person is a general partner of a limited partnership (or managing member of a limited liability company, or holds a comparable position for another type of pooled investment vehicle):

(1) The account statements required under paragraph 50.39(1)"d" must be sent to each limited partner (or member or other beneficial owner); and

(2) The investment adviser must:

1. Enter into a written agreement with an independent party who is obliged to act in the best interest of the limited partners, members, or other beneficial owners to review all fees, expenses and capital withdrawals from the pooled accounts; and

2. Send all invoices or receipts to the independent party, detailing the amount of the fee, expenses or capital withdrawal and the method of calculation such that the independent party can:

• Determine that the payment is in accordance with the pooled investment vehicle standards (generally the partnership agreement or membership agreement); and

• Forward, to the qualified custodian, approval for payment of the invoice with a copy to the investment adviser.

f. *Independent verification.* The client funds and securities of which the investment adviser has custody are verified by actual examination at least once during each calendar year, by an independent certified public accountant (CPA), pursuant to a written agreement between the investment adviser and the independent CPA, at a time that is chosen by the independent CPA without prior notice or announcement to the investment adviser and that is irregular from year to year. The written agreement must provide for the first examination to occur within six months of execution of the written agreement, except that, if the investment adviser maintains client funds or securities pursuant to rule 191—50.38(502) as a qualified custodian, the agreement must provide for the first examination to occur no later than six months after the investment adviser obtains the internal control report. The written agreement must require the independent CPA to:

(1) File a certificate on Form ADV-E with the administrator within 120 days of the time chosen by the independent CPA in paragraph 50.39(1)"f," stating that the independent CPA has examined the funds and securities and describing the nature and extent of the examination;

(2) Notify the administrator within one business day of the finding of any material discrepancies during the course of the examination, by means of a facsimile transmission or electronic mail, followed by first-class mail, directed to the attention of the administrator; and

(3) File within four business days of the resignation or dismissal from, or other termination of, the engagement, or removing itself or being removed from consideration for being reappointed, Form ADV-E accompanied by a statement that includes:

1. The date of such resignation, dismissal, removal, or other termination, and the name, address, and contact information of the independent CPA; and

2. An explanation of any problems relating to examination scope or procedure that contributed to such resignation, dismissal, removal, or other termination.

g. *Investment advisers acting as qualified custodians.* If the investment adviser maintains, or if the investment adviser has custody because a related person maintains, client funds or securities pursuant to rule 191—50.39(502) as a qualified custodian in connection with advisory services the investment adviser provides to clients:

(1) The independent CPA that the investment adviser retains to perform the independent verification required by paragraph 50.39(1) “f” must be registered with, and subject to regular inspection as of the commencement of the professional engagement period, and as of each calendar year-end, by, the Public Company Accounting Oversight Board in accordance with its rules; and

(2) The investment adviser must obtain, or receive from its related person, within six months of execution of the written agreement and thereafter no less frequently than once each calendar year a written internal control report prepared by an independent CPA.

1. The internal control report must include an opinion of an independent CPA as to whether controls have been placed in operation as of a specific date, and are suitably designed and are operating effectively to meet control objectives relating to custodial services, including the safeguarding of funds and securities held by either the investment adviser or a related person on behalf of the investment adviser’s clients, during the year;

2. The independent CPA must verify that the funds and securities are reconciled to a custodian other than the investment adviser or the investment adviser’s related person; and

3. The independent CPA must be registered with, and subject to regular inspection as of the commencement of the professional engagement period, and as of each calendar year-end, by, the Public Company Accounting Oversight Board in accordance with its rules.

h. *Independent representatives.* A client may designate an independent representative to receive, on the client’s behalf, notices and account statements as required under paragraphs 50.39(1) “c” and “d.”

50.39(2) Exceptions.

a. *Shares of mutual funds.* With respect to shares of an open-end company as defined in Section 5(a)(1) of the Investment Company Act of 1940 (“mutual fund”), the investment adviser may use the mutual fund transfer agent in lieu of a qualified custodian for purposes of complying with subrule 50.39(1).

b. *Certain privately offered securities.*

(1) The investment adviser is not required to comply with paragraph 50.39(1) “b” with respect to securities that are:

1. Acquired from the issuer in a transaction or chain of transactions not involving any public offering;

2. Uncertificated and ownership thereof is recorded only on the books of the issuer or its transfer agent in the name of the client; and

3. Transferable only with prior consent of the issuer or holders of the outstanding securities of the issuer.

(2) Notwithstanding subparagraph 50.39(2) “b”(1), the provisions of paragraph 50.39(2) “b” are available with respect to securities held for the account of a limited partnership (or limited liability company, or other type of pooled investment vehicle) only if the limited partnership is audited, and the audited financial statements are distributed, as described in paragraph 50.39(2) “d,” and the investment adviser notifies the administrator in writing that the investment adviser intends to provide audited

financial statements, as described in this subparagraph. Such notification is required to be provided on Form ADV.

c. *Fee deduction.* Notwithstanding paragraph 50.39(1) "f," an investment adviser is not required to obtain an independent verification of client funds and securities maintained by a qualified custodian if all of the following conditions are met:

- (1) The investment adviser has custody of the funds and securities solely as a consequence of its authority to make withdrawals from client accounts to pay its advisory fee;
- (2) The investment adviser has written authorization from the client to deduct advisory fees from the account held with the qualified custodian;
- (3) Each time a fee is directly deducted from a client account, the investment adviser concurrently:
 1. Sends the independent party designated pursuant to subparagraph 50.39(1) "e"(2) an invoice or statement of the amount of the fee to be deducted from the client's account; and
 2. Sends the client an invoice or statement itemizing the fee. Itemization includes the formula used to calculate the fee, the amount of assets under management on which the fee is based, and the time period covered by the fee; and
- (4) The investment adviser notifies the administrator in writing that the investment adviser intends to use the safeguards provided in paragraph 50.39(2) "c." Such notification is required to be given on Form ADV.

d. *Limited partnerships subject to annual audit.* An investment adviser is not required to comply with paragraphs 50.39(1) "c" and "d" and shall be deemed to have complied with paragraph 50.39(1) "f" with respect to the account of a limited partnership (or limited liability company, or another type of pooled investment vehicle) if each of the following conditions is met:

- (1) The adviser sends to all limited partners (or members or other beneficial owners), at least quarterly, a statement showing:
 1. The total amount of all additions to and withdrawals from the fund as a whole as well as the opening and closing value of the fund at the end of the quarter based on the custodian's records;
 2. A listing of all long and short positions on the closing date of the statement in accordance with the Financial Accounting Standards Board, Rule ASC 946-210-50; and
 3. The total amount of additions to and withdrawals from the fund by the investor as well as the total value of the investor's interest in the fund at the end of the quarter;
- (2) At least annually the fund is subject to an audit and distributes the fund's audited financial statements prepared in accordance with generally accepted accounting principles to all limited partners (or members or other beneficial owners) and the administrator within 120 days of the end of the fund's fiscal year;
- (3) The audit is performed by an independent CPA that is registered with, and subject to regular inspection as of the commencement of the professional engagement period, and as of each calendar year-end, by, the Public Company Accounting Oversight Board in accordance with its rules;
- (4) Upon liquidation, the adviser distributes the fund's final audited financial statements prepared in accordance with generally accepted accounting principles to all limited partners (or members or other beneficial owners) and the administrator promptly after the completion of such audit;
- (5) The written agreement with the independent CPA must require the independent CPA, upon resignation or dismissal from, or other termination of, the engagement, or upon removing itself or being removed from consideration for being reappointed, to notify the administrator within four business days accompanied by a statement that includes:
 1. The date of such resignation, dismissal, removal, or other termination, and the name, address, and contact information of the independent CPA; and
 2. An explanation of any problems relating to audit scope or procedure that contributed to such resignation, dismissal, removal, or other termination;
- (6) The investment adviser must also notify the administrator in writing that the investment adviser intends to employ the use of the statement delivery and audit safeguards described in paragraph 50.39(2) "d." Such notification is required to be given on Form ADV.

e. *Registered investment companies.* The investment adviser is not required to comply with rule 191—50.39(502) with respect to the account of an investment company registered under the Investment Company Act of 1940.

50.39(3) Delivery to related persons. Sending an account statement under paragraph 50.39(1) "e" or distributing audited financial statements under paragraph 50.39(2) "d" shall not satisfy the requirements of rule 191—50.39(502) if such account statements or financial statements are sent solely to limited partners (or members or other beneficial owners) that themselves are limited partnerships (or limited liability companies, or another type of pooled investment vehicle) and are related persons of the investment adviser.

50.39(4) Definitions. For the purposes of this rule:

a. "*Control*" means the power, directly or indirectly, to direct the management or policies of a person whether through ownership of securities, by contract, or otherwise. "*Control*" includes the following:

(1) Each of the investment adviser's officers, partners, or directors exercising executive responsibility (or persons having similar status or functions) is presumed to control the investment adviser;

(2) A person is presumed to control a corporation if the person:

1. Directly or indirectly has the right to vote 25 percent or more of a class of the corporation's voting securities; or

2. Has the power to sell or direct the sale of 25 percent or more of a class of the corporation's voting securities;

(3) A person is presumed to control a partnership if the person has the right to receive upon dissolution, or has contributed, 25 percent or more of the capital of the partnership;

(4) A person is presumed to control a limited liability company if the person:

1. Directly or indirectly has the right to vote 25 percent or more of a class of the interests of the limited liability company;

2. Has the right to receive upon dissolution, or has contributed, 25 percent or more of the capital of the limited liability company; or

3. Is an elected manager of the limited liability company; or

(5) A person is presumed to control a trust if the person is a trustee or managing agent of the trust.

b. "*Custody*" means holding, directly or indirectly, client funds or securities, having any authority to obtain possession of client funds or securities, or having the ability to appropriate client funds or securities. The investment adviser has custody if a related person holds, directly or indirectly, client funds or securities, or has any authority to obtain possession of them, in connection with advisory services the investment adviser provides to clients.

(1) "*Custody*" includes:

1. Possession of client funds or securities unless received inadvertently and returned to the sender within three business days of receiving them and the investment adviser maintains the records required under paragraph 50.42(1) "v";

2. Any arrangement including, but not limited to, a general power of attorney pursuant to which the investment adviser is authorized or permitted to withdraw client funds or securities maintained with a custodian upon the investment adviser's instruction; and

3. Any capacity including, but not limited to, general partner of a limited partnership, managing member of a limited liability company, a comparable position for another type of pooled investment vehicle, or trustee of a trust that gives the investment adviser or a person supervised by the investment adviser legal ownership of or access to client funds or securities.

(2) Receipt of checks drawn by clients and made payable to third parties will not meet the definition of custody if forwarded to the third party within three business days of receipt and the investment adviser maintains the records required under paragraph 50.42(1) "v."

c. "*Independent certified public accountant*" means a certified public accountant that meets the standards of independence described in Rule 2-01(b) and (c) of Regulation S-X (17 CFR 210.2-01(b) and (c)).

d. “*Independent representative*” means a person who:

- (1) Acts as agent for an advisory client including, in the case of a pooled investment vehicle, limited partners of a limited partnership, members of a limited liability company, or other beneficial owners of another type of pooled investment vehicle, and who is by law or contract required to act in the best interest of the advisory client or the limited partners or members, or other beneficial owners;
- (2) Does not control, is not controlled by, and is not under common control with the investment adviser; and
- (3) Does not have and has not had within the past two years a material business relationship with the investment adviser.

e. “*Qualified custodian*” means the following independent institutions or entities that are not affiliated with the investment adviser by any direct or indirect common control and have not had a material business relationship with the investment adviser in the previous two years:

- (1) A bank or savings association that has deposits insured by the Federal Deposit Insurance Corporation under the Federal Deposit Insurance Act;
- (2) A broker-dealer registered in Iowa and with the SEC holding client assets in customer accounts;
- (3) A registered futures commission merchant registered pursuant to Section 4(f)(a) of the Commodity Exchange Act that is holding client funds and security futures or other securities incidental to transactions in contracts for the purchase or sale of a commodity for future delivery and options thereon in customer accounts; and
- (4) A foreign financial institution that customarily holds financial assets for its customers, provided that the foreign financial institution keeps the advisory clients’ assets in customer accounts segregated from its proprietary assets.

f. “*Related person*” means any person, directly or indirectly, controlling or controlled by the investment adviser, and any person that is under common control with the investment adviser.

This rule is intended to implement Iowa Code section 502.411(5).
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.40(502) Minimum financial requirements for investment advisers.

50.40(1) An investment adviser registered or required to be registered under the Act that has custody of client funds or securities shall maintain at all times a minimum net worth of \$35,000 except:

a. An investment adviser that has custody solely due to direct fee deduction and that is also in compliance with the applicable safekeeping requirements of paragraph 50.39(2)“c” and the record-keeping requirements of rule 191—50.42(502) is not required to comply with the net worth requirements of this rule; and

b. An investment adviser having custody solely due to advising pooled investment vehicles and that is in compliance with the applicable safekeeping requirements of paragraph 50.39(1)“e” or 50.39(2)“d” and the record-keeping requirements of rule 191—50.42(502) is not required to comply with the net worth requirements of this rule.

50.40(2) An investment adviser registered or required to be registered pursuant to the Act that has discretionary authority over client funds or securities but does not have custody of client funds or securities shall maintain a minimum net worth of \$10,000 at all times.

50.40(3) An investment adviser registered or required to be registered pursuant to the Act shall maintain a positive net worth at all times.

50.40(4) Unless otherwise exempted, an investment adviser registered or required to be registered pursuant to the Act shall notify the administrator if the investment adviser’s net worth is less than the minimum required. Notice must be filed in a report to the administrator no later than the close of business on the next business day following the decrease in net worth. Additionally, an investment adviser shall file by the close of business on the next business day a report with the administrator of the investment adviser’s financial condition including, at a minimum, the following:

- a. A trial balance of all ledger accounts;
- b. A list of all client funds or securities which are not segregated;
- c. A computation of the aggregate amount of client ledger debit balances; and

d. The total number of client accounts managed by the investment adviser.

50.40(5) The administrator may require the submission of a current appraisal for the purpose of establishing the worth of any asset.

50.40(6) An investment adviser that has its principal place of business in a state other than this state is not required to maintain the minimum capital required by this rule provided that the investment adviser is registered as an investment adviser in the state in which the investment adviser has its principal place of business and is in compliance with that state's laws regarding minimum capital requirements.

50.40(7) For purposes of this rule:

a. "Net worth" means an excess of assets over liabilities calculated in accordance with generally accepted accounting principles. The calculation of assets shall not include the following: prepaid expenses (except those prepaid expenses classified as assets under generally accepted accounting principles); deferred charges, goodwill, franchise rights, organizational expenses, patents, copyrights, marketing rights, unamortized debt discount and expense, and all other assets of intangible nature; in the case of an individual, home(s), home furnishings, automobile(s), or any other personal items not readily marketable; in the case of a corporation, advances or loans to stockholders or officers; and in the case of a partnership, advances or loans to partners.

b. "Custody" means the same as defined in paragraph 50.39(4) "b."

c. An investment adviser shall not be deemed to be exercising discretion when the investment adviser places trade orders with a broker-dealer pursuant to a third-party trading agreement if:

(1) The investment adviser has executed a separate investment adviser contract exclusively with the investment adviser's client which acknowledges that a third-party trading agreement will be executed to allow the investment adviser to effect securities transactions for the client in the client's broker-dealer account;

(2) The investment adviser contract specifically states that the client does not grant discretionary authority to the investment adviser and the investment adviser in fact does not exercise discretion with respect to the account; and

(3) A third-party trading agreement is executed between the client and a broker-dealer which specifically limits the investment adviser's authority in the client's broker-dealer account to the placement of trade orders and deduction of investment adviser fees.

This rule is intended to implement Iowa Code section 502.411(1).

[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.41(502) Bonding requirements for investment advisers.

50.41(1) Every investment adviser registered or required to be registered under the Act:

a. Having custody of or discretionary authority over client funds or securities shall be bonded in an amount determined by the administrator based upon the number of clients and the total assets under management of the investment adviser; and

b. Having custody of or discretionary authority over client funds or securities when the investment adviser does not meet the minimum net worth standard provisions of subrules 50.40(1) and 50.40(2) must be bonded in the amount of the net worth deficiency rounded up to the nearest \$5,000.

50.41(2) A bond required by this rule shall be issued by a company qualified to do business in this state in the form determined by the administrator and shall be subject to the claims of clients of the investment adviser regardless of the client's state of residence.

50.41(3) An investment adviser that has a principal place of business in a state other than Iowa is exempt from this rule provided that the investment adviser is registered as an investment adviser in the state in which the investment adviser has its principal place of business and is in compliance with that state's laws regarding bonding requirements.

50.41(4) For purposes of this rule, "custody" means the same as defined in paragraph 50.39(4) "b."

This rule is intended to implement Iowa Code section 502.411(5).

[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.42(502) Record-keeping requirements for investment advisers.

50.42(1) An investment adviser registered or required to be registered pursuant to the Act shall make and keep true, accurate and current the following books, ledgers and records:

a. A journal or journals, including cash receipts and disbursements records, and any other records of original entry forming the basis of any ledger entries.

b. General and auxiliary ledgers (or other comparable records) reflecting asset, liability, reserve, capital, income, and expense accounts.

c. A memorandum of each order given by the investment adviser for the purchase or sale of any security, of any instruction received by the investment adviser from the client concerning the purchase, sale, receipt or delivery of a particular security, and of any modification or cancellation of any such order or instruction. The memorandum shall describe the terms and conditions of the order, instruction, modification or cancellation; identify the person connected with the investment adviser who recommended the transaction to the client and the person who placed the order; indicate whether discretionary power was exercised; and indicate the account for which entered, the date of entry, and, where applicable, the bank or broker-dealer by or through whom executed.

d. All checkbooks, bank statements, canceled checks and cash reconciliations of the investment adviser.

e. All invoices, bills, or statements, or copies of those documents, relating to the investment adviser's business as an investment adviser regardless of whether the expense or debt is paid or unpaid.

f. All trial balances, financial statements, and internal audit working papers relating to the investment adviser's business as an investment adviser. For the purposes of this paragraph, "financial statements" means a balance sheet prepared in accordance with generally accepted accounting principles, an income statement, a cash flow statement, and a net worth computation, if applicable, as required by subrule 50.40(7).

g. Originals of all written communications received by and copies of all written communications sent by the investment adviser relating to:

(1) Any recommendation made or proposed to be made and any advice given or proposed to be given;

(2) Any receipt, disbursement, or delivery of funds or securities; or

(3) The placing or execution of any order to purchase or sell any security, except:

1. The investment adviser shall not be required to keep any unsolicited market letters and other similar communications of general public distribution not prepared by or for the investment adviser; and

2. The investment adviser is not required to keep a record of the names and addresses of persons to whom a notice, circular, or other advertisement offering any report, analysis, publication or other investment advisory service is sent if sent to more than ten persons; however, if the notice, circular, or other advertisement is distributed to persons named on any list, the investment adviser must retain with the copy of the notice, circular, or advertisement a memorandum describing the list and its source.

h. A list or other record of all accounts identifying the accounts in which the investment adviser is vested with any discretionary power with respect to the funds, securities or transactions of any client.

i. Copies of all powers of attorney and other documents granting discretionary authority by any client to the investment adviser.

j. Copies of each agreement entered into by the investment adviser with any client, and all other written agreements otherwise relating to the investment adviser's business as an investment adviser.

k. A file containing copies of each notice, circular, advertisement, newspaper article, investment letter, bulletin, or other communication including electronic media that the investment adviser circulates or distributes, directly or indirectly, to two or more persons not affiliated with the investment adviser and, if the notice, circular, advertisement, newspaper article, investment letter, bulletin, or other communication including one in electronic media format recommends the purchase or sale of a specific security and does not state the reasons for the recommendation, a memorandum indicating the investment adviser's reasons for the recommendation.

l. Transactions involving beneficial ownership.

(1) A record of every transaction in a security in which the investment adviser or any advisory representative of the investment adviser has or by reason of any transaction acquires a direct or indirect beneficial ownership, except the following:

1. Transactions effected in any account over which neither the investment adviser nor any advisory representative of the investment adviser has any direct or indirect influence or control; and

2. Transactions in securities which are direct obligations of the United States.

(2) The required record shall state, at a minimum, the title and amount of the security involved, the date and nature of the transaction (i.e., purchase, sale or other acquisition or disposition), the price at which the transaction was effected, and the name of the bank or broker-dealer with or through which the transaction was effected. The record may also contain a statement declaring that the reporting or recording of any transaction shall not be construed as an admission that the investment adviser or advisory representative has any direct or indirect beneficial ownership in the security. A transaction must be recorded no later than ten days after the end of the calendar quarter in which the transaction was effected. An investment adviser shall not be in violation of this paragraph because of a failure to record securities transactions of an advisory representative if the investment adviser establishes that the investment adviser instituted adequate procedures and used reasonable diligence to promptly obtain reports of all transactions required by this paragraph to be recorded.

m. Notwithstanding the provisions of paragraph 50.42(1) "l," when the investment adviser is primarily engaged in a business or businesses other than advising investment advisory clients, a record must be maintained of every transaction in a security in which the investment adviser or any advisory representative of the investment adviser has, or by reason of any transaction acquires, any direct or indirect beneficial ownership, except:

(1) Transactions effected in any account over which neither the investment adviser nor any advisory representative of the investment adviser has any direct or indirect influence or control; or

(2) Transactions in securities which are direct obligations of the United States.

The record shall state the title and amount of the security involved, the date and nature of the transaction (i.e., purchase, sale, or other acquisition or disposition), the price at which it was effected, and the name of the broker-dealer or bank with or through which the transaction was effected. The record may also contain a statement declaring that the reporting or recording of any transaction shall not be construed as an admission that the investment adviser or advisory representative has any direct or indirect beneficial ownership in the security. A transaction shall be recorded not later than ten days after the end of the calendar quarter in which the transaction was effected. An investment adviser shall not be deemed to have violated the provisions of this subparagraph because of a failure to record securities transactions of an advisory representative if the investment adviser establishes that the investment adviser instituted adequate procedures and used reasonable diligence to promptly obtain reports of all transactions required to be recorded.

n. A copy of each written statement and each amendment or revision, given or sent to any client or prospective client of the investment adviser in accordance with rule 191—50.36(502), and a record of the dates on which each written statement, amendment and revision was given or offered to be given to any client or any prospective client who subsequently becomes a client.

o. For each client that was obtained by the investment adviser by means of a solicitor to whom a cash fee was paid by the investment adviser:

(1) A copy of any written agreement relating to the payment of a cash fee to which the investment adviser is a party;

(2) A signed and dated acknowledgment of receipt from the client evidencing the client's receipt of the investment adviser's disclosure statement and a written disclosure statement of the solicitor; and

(3) A copy of the solicitor's written disclosure statement.

The written agreement, acknowledgment and solicitor disclosure statement will be deemed to be in compliance if such documents comply with Rule 275.206(4)-3 of the Investment Advisers Act of 1940.

p. All accounts, books, internal working papers, and any other records or documents that are necessary to form the basis for or demonstrate the calculation of the performance or rate of return of all managed accounts or securities recommendations provided in any notice, circular, advertisement,

newspaper article, investment letter, bulletin, or other communication, including electronic media, that is directly or indirectly circulated or distributed by the investment adviser to two or more persons (other than persons connected with the investment adviser). However, with respect to the performance of managed accounts only, the retention of all account statements reflecting all debits, credits, and other transactions in a client's account for the period of the statement, and the retention of all worksheets necessary to demonstrate the calculation of the performance or rate of return of the managed account shall satisfy the requirements of this paragraph.

q. A file containing copies of all written communications received or sent regarding any litigation or customer or client complaints involving the investment adviser or any investment adviser representative or employee.

r. The basis, in writing, for any recommendation or investment advice provided to an investment advisory client.

s. Copies of all written procedures regarding the supervision of the employees and investment adviser representatives that are reasonably designed to achieve compliance with securities laws and regulations.

t. A file containing a copy of each document (other than any notices of general dissemination) that was filed with or received from any state or federal agency or self-regulatory organization pertaining to the investment adviser or its investment adviser representatives, as defined by subrule 50.42(11), including but not limited to all applications, amendments, renewal filings, and correspondence.

u. Original copies signed by the lawful signatory of the investment adviser and the investment adviser representative of each initial Form U-4 and each U-4 Amendment to Disclosure Reporting Pages (DRPs).

v. For each transaction in which the investment adviser inadvertently held or obtained the client's securities or funds and returned them to the client within three business days of receipt or forwarded a check drawn by a client and made payable to a third party within three business days of receipt, a ledger or list of all funds or securities held or obtained with the following information:

- (1) Issuer;
- (2) Type of security and series;
- (3) Date of issue;
- (4) For debt instruments, the denomination, interest rate and maturity date;
- (5) Certificate number, including alphabetical prefix or suffix;
- (6) Name in which registered;
- (7) Date submitted to the investment adviser;
- (8) Date sent to client or sender;
- (9) Form of delivery to client or sender, or copy of the form of delivery to client or sender; and
- (10) Mail confirmation number, if applicable, or confirmation by client or sender of the return of the security or fund.

w. If an investment adviser obtains possession of securities that are acquired from the issuer in a transaction or chain of transactions not involving a public offering that comply with the exception from custody in paragraph 50.39(2) "b," the adviser shall keep:

(1) A record showing the issuer's or current transfer agent's name, address, telephone number, and other applicable contact information pertaining to the party responsible for recording the client's interests in the securities; and

(2) A copy of any legend, shareholder agreement, or other agreement providing that the securities are transferable only with prior consent of the issuer or holders of the outstanding securities of the issuer.

50.42(2) In addition to the retention requirements of subrule 50.42(1), an investment adviser having custody of client funds or securities, as defined by paragraph 50.39(3) "b," shall retain the following records:

a. Copies of all documents executed by each client, including but not limited to a limited power of attorney, pursuant to which the investment adviser is authorized or permitted to withdraw a client's funds or securities maintained with a custodian upon the adviser's instruction to the custodian;

b. A journal or other record for all accounts reflecting all purchases, sales, receipts, and deliveries of securities, including but not limited to certificate numbers, and all other debits and credits to the accounts;

c. A separate ledger account for each client showing all purchases, sales, receipts and deliveries of securities, the date and price of each purchase or sale, and all debits and credits;

d. Copies of confirmations of all transactions effected by or for the account of any client;

e. A record for each security in which any client has a position showing, at a minimum, the name of each client having an interest in the security, the amount of interest of each client in the security, and the location of each security;

f. A copy of each client's quarterly account statements as generated and delivered by the qualified custodian. Additionally, if the investment adviser generates a statement that is delivered to the client, the investment adviser shall retain copies of those statements along with information indicating the dates on which the statements were provided to the client;

g. If applicable, a copy of the special examination report, financial statements, and letter verifying the completion of and describing the nature and extent of an examination by an independent certified public accountant and documentation describing the nature and extent of the examination and a record regarding any findings of any material discrepancies found during the examination; and

h. If applicable, evidence of the client's designation of an independent representative.

50.42(3) An investment adviser deemed to have custody of client securities or funds because the investment adviser advises a pooled investment vehicle shall, in addition to any other applicable record retention requirements, keep the following records:

a. True, accurate, and current account statements;

b. If utilizing the exception provided by paragraph 50.39(2) "c," the date(s) of the audit, a copy of the audited financial statements, and evidence of the mailing of the audited financial statements to all limited partners, members, or other beneficial owners within 120 days of the end of the fiscal year;

c. If subject to paragraph 50.39(1) "e," a copy of the written agreement with the independent party reviewing all fees and expenses and describing the responsibilities of the independent third party, and copies of all invoices and receipts showing approval by the independent third party for payment through the qualified custodian.

50.42(4) Each investment adviser subject to subrule 50.42(1) that renders investment supervisory or management services to any client shall, with respect to the portfolio being supervised or managed and to the extent that the information is reasonably available to or obtainable by the investment adviser, retain the following records:

a. For each client, detailed information regarding the securities purchased and sold including, but not limited to, the date of the purchase or sale, the total dollar amount of the purchase or sale, and the price at which the security was purchased or sold.

b. For each security in which any client has a current position, the name of each client and current amount or interest of the client.

50.42(5) Records required to be retained pursuant to rule 191—50.42(502) shall be kept as follows:

a. Except as provided in paragraphs 50.42(1) "k" and "p," all records required to be made under subrules 50.42(1) to 50.42(3) and paragraph 50.42(4) "a" shall be maintained and preserved in a readily accessible location for a period of not less than five years from the end of the fiscal year during which the last entry was made on record, with no less than the first two years being kept in the principal office of the investment adviser.

b. Partnership articles and any amendments, articles of incorporation, charters, minute books, and stock certificate books of the investment adviser and of any predecessor shall be maintained in the principal office of the investment adviser and preserved until at least three years after termination of the enterprise.

c. Books and records required to be retained pursuant to paragraphs 50.42(1) "k" and 50.42(1) "p" shall be maintained and preserved in a readily accessible location for a period of not less than five years from the end of the fiscal year during which the investment adviser last published or otherwise disseminated, directly or indirectly, the notice, circular, advertisement, newspaper article, investment

letter, bulletin, or other communication including by electronic media, with no less than the first two years being kept in the principal office of the investment adviser.

d. Books and records required to be retained pursuant to paragraphs 50.42(1) "q" to "v" shall be maintained and preserved in a readily accessible location for a period of not less than five years from the end of the fiscal year during which the last entry was made on such record, with no less than the first two years being kept in the principal office of the investment adviser, or the time period during which the investment adviser is registered or required to be registered in this state, whichever is less.

e. Notwithstanding other record preservation requirements of rule 191—50.42(502), an investment adviser that has rendered or renders investment advisory services shall maintain at all times the following records at the investment adviser's business location from which the customer or client is being provided or has been provided investment advisory services during the applicable retention period:

(1) All records required to be preserved pursuant to paragraphs 50.42(1) "c," "g" to "j," "n," "o," and "q" to "s" and subrules 50.42(2) to 50.42(4); and

(2) All records required pursuant to paragraphs 50.42(1) "k" to "p" identifying the name of the investment adviser representative providing investment advice from that business location, or identifying the physical address, mailing address, electronic mailing address, or telephone number of the business location. The records will be maintained for the period described in paragraph 50.42(5) "a."

50.42(6) An investment adviser subject to subrule 50.42(1) that ceases to conduct or discontinues business as an investment adviser shall arrange for and be responsible for the retention of the records required to be retained pursuant to this rule for the applicable retention period. The investment adviser shall notify the administrator in writing prior to ceasing to conduct or discontinuing business as an investment adviser of the exact address where the books and records will be maintained during the retention period.

50.42(7) An investment adviser required to retain records pursuant to this rule may maintain the records in such manner that the identity of any client to whom the investment adviser renders investment supervisory services is indicated by numerical code, alphabetical code, or similar designation.

50.42(8) Record maintenance.

a. Pursuant to subrule 50.42(4), the records required to be maintained and preserved may be immediately produced or reproduced, and maintained and preserved for the required time, by an investment adviser in:

(1) Paper or hard-copy form, as those records are kept in their original form; or

(2) Micrographic media, including microfilm, microfiche, or any similar medium; or

(3) Electronic storage media, including any digital storage medium or system, that meet the terms of this subrule.

b. The investment adviser must:

(1) Arrange and index the records in a way that permits easy location, access, and retrieval of any particular record;

(2) Provide promptly any of the following that the administrator may request:

1. A legible, true, and complete copy of the record in the medium and format in which it is stored;
2. A legible, true, and complete printout of the record; and

3. Means to access, view, and print the records; and

(3) Separately store, for the time required for preservation of the original record, a duplicate copy of the record in any medium allowed by this subrule.

c. In the case of records created or maintained in electronic storage media, the investment adviser must establish and maintain procedures:

(1) To maintain and preserve the records, so as to reasonably safeguard them from loss, alteration, or destruction;

(2) To limit access to the records to properly authorized personnel and the administrator; and

(3) To reasonably ensure that any reproduction of a nonelectronic original record in electronic storage media is complete, true, and legible when retrieved.

50.42(9) Compliance with any substantially similar record-keeping requirements of Rules 17a-3 [17 CFR 240.17a-3] and 17a-4 [17 CFR 240.17a-4] of the Securities Exchange Act of 1934 shall be deemed to be in compliance with this rule.

50.42(10) Every investment adviser that is registered or required to be registered in this state and that has its principal place of business in a state other than this state shall be exempt from the requirements of this rule, provided the investment adviser is properly registered in that state and is in compliance with that state's record-keeping requirements.

50.42(11) For purposes of this rule:

"Advisory representative" means any partner, officer or director of the investment adviser; any employee who participates in any way in the determination of which recommendations shall be made; any employee who, in connection with the employee's duties, obtains any information concerning which securities are being recommended prior to the effective dissemination of the recommendations; and any of the following persons who obtain information concerning securities recommendations being made by the investment adviser prior to the effective dissemination of the recommendations:

1. Any person in a relationship of control with the investment adviser;
2. Any person affiliated with a controlling person; and
3. Any person affiliated with an affiliated person.

"Control" means the power to exercise a controlling influence over the management or policies of a company, unless that power results solely from an official position with the company. Any person who owns beneficially, either directly or through one or more controlled companies, more than 25 percent of the voting securities of a company shall be presumed to control the company.

An investment adviser shall not be deemed to be exercising a discretionary power as to the price at which or the time when a transaction is effected or is to be effected if, before the order is given by the investment adviser, the client has directed or approved the purchase or sale of a definite amount of the particular security.

"Investment adviser primarily engaged in a business or businesses other than advising investment advisory clients" means an investment adviser that for each of the most recent three fiscal years or for the period of time since organization, whichever is less, derives on an unconsolidated basis more than 50 percent of total sales and revenues and income (or loss) before income taxes and extraordinary items from business activities other than advising investment advisory clients.

"Investment supervisory services" means continuous advice regarding investment of funds provided to each client on the basis of the individual needs of the client.

"Solicitor" means any person or entity that for compensation acts as an agent of an investment adviser in referring potential clients.

This rule is intended to implement Iowa Code section 502.411(3).

[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.43(502) Financial reporting requirements for investment advisers.

50.43(1) Every registered investment adviser that has custody of client funds or securities or requires payment of advisory fees six months or more in advance and in excess of \$500 per client shall file with the administrator an audited balance sheet as of the end of the investment adviser's fiscal year. Each balance sheet filed pursuant to this rule must be:

- a. Examined in accordance with generally accepted auditing standards and prepared in conformity with generally accepted accounting principles;
- b. Audited by an independent certified public accountant; and
- c. Accompanied by an opinion of the accountant as to the report of financial position, and by a note stating the principles used to prepare the opinion, the basis of included securities, and any other explanations required for clarity.

50.43(2) Every registered investment adviser that has discretionary authority over, but not custody of, client funds or securities shall file with the administrator a balance sheet, which need not be audited, but which must be prepared in accordance with generally accepted accounting principles or such other basis of accounting acceptable to the administrator and represented by the investment adviser or the

person who prepared the statement as true and accurate, as of the end of the investment adviser's fiscal year.

50.43(3) The financial statements required by this rule shall be filed with the administrator within 90 days following the end of the investment adviser's fiscal year.

50.43(4) Every investment adviser that has its principal place of business in a state other than this state shall file only such reports as required by the state in which the investment adviser maintains its principal place of business, provided the investment adviser is licensed in such state and is in compliance with such state's financial reporting requirements.

This rule is intended to implement Iowa Code section 502.411(2).
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.44(502) Solely incidental services by certain professionals.

50.44(1) General approach.

a. Certain professionals may rely on an exclusion from the definition of "investment adviser" contained in Iowa Code section 502.102(15)"b" for lawyers, accountants, engineers or teachers whose performance of investment advice is solely incidental to the practice of the person's profession. Whether the exclusion from the definition of "investment adviser" is available to a lawyer, accountant, engineer or teacher providing investment advisory services within the meaning of Iowa Code section 502.102(15)"b" depends upon the relevant facts and circumstances.

b. In general, the administrator will determine whether the investment advisory services provided and the fees charged are solely incidental to the total services provided to the individual client by comparing whether the aggregate of such fees and services is solely incidental to the aggregate of services provided to all clients. In addition, the administrator will take other relevant factors into consideration in determining the applicability of the exclusion including, but not limited to, whether the firm establishes a separate subsidiary, division, or other business entity to perform advisory services or maintains an investment adviser registration with the U.S. Securities and Exchange Commission under the Investment Advisers Act of 1940. In this context, the administrator would refer to U.S. Securities and Exchange Commission Release IA-1092 relating to the analogous exclusion in the Investment Advisers Act of 1940 which states that ". . . the exclusion . . . is not available . . . to a lawyer or accountant who holds himself out to the public as providing financial planning, pension consulting, or other financial advisory services. In such a case it would appear that the performance of investment advisory services by the person would not be solely incidental to his practice as a lawyer or accountant."

50.44(2) General versus specific advice. A lawyer, accountant, engineer or teacher, whether or not holding oneself out to the public as providing financial planning or other financial advisory services, who does not render advice with respect to investing in specific securities, types of securities, or categories of securities need not register as an investment adviser. Registration is not required when the securities advice provided to clients in this state is limited to a general recommendation that the client should be more aggressive or more conservative in securities investments, a general recommendation as to the percentage of the client's assets that should be in securities, or a general recommendation that the client pursue an income-producing or growth-oriented investment strategy, provided the recommendation does not identify specific securities, types of securities, or categories of securities. For the purpose of this subrule, the phrase "types of securities" means classes of securities in which the issuer is not specifically identified, such as common stock, preferred stock, options, warrants, bonds, and mutual funds, and the phrase "categories of securities" means general areas of securities investments where neither the issuer nor the types of securities are identified such as cyclical securities, automotive industry securities, international securities, and NYSE securities. Asset allocation recommendations, however, generally do include advice on types of securities.

EXAMPLE: An accountant provides clients accounting and financial planning services. No advice with respect to specific securities, types of securities, or categories of securities is provided. The accountant need not register as an investment adviser.

50.44(3) Professional does not hold self out as a financial planner. When the securities advice is provided by a lawyer, accountant, engineer, or teacher who does not hold oneself out to the public as

providing financial planning or other financial advisory services, the availability of the exclusion from the definition of "investment adviser" contained in Iowa Code section 502.102(15) "b" for securities advice rendered solely incidental to the profession will depend on those factors set forth in paragraph 50.44(1) "b."

EXAMPLE A: An accountant who does not hold oneself out to the public as providing financial planning or other financial advisory services provides the client both accounting and financial planning services. The services involve advice with respect to specific securities, types of securities, or categories of securities. Whether the accountant is excluded from the definition of investment adviser depends on those factors set forth in paragraph 50.44(1) "b," including a comparison of the extent of the securities advisory services provided to any client as contrasted with the accounting services provided to that client. The comparison is measured by the compensation paid for each service.

EXAMPLE B: An accountant provides a client financial planning services only. The financial planning services involve advice with respect to specific securities, types of securities, or categories of securities. The accountant is not excluded from the definition of investment adviser and therefore must register as an investment adviser.

50.44(4) Professional holds self out as a financial planner.

a. If the investment advice provided by a lawyer, accountant, engineer, or teacher who holds oneself out to the public as providing financial planning or other financial advisory services is part of the financial plan being provided to a financial planning client, the professional cannot rely on the exclusion from the definition of "investment adviser" contained in Iowa Code section 502.102(15) "b" for investment advice rendered incidentally to the practice of the profession.

EXAMPLE: An accountant who holds oneself out to the public as providing financial planning or other financial advisory services provides the client both accounting and financial planning services. The financial planning services involve advice with respect to specific securities, types of securities, or categories of securities. The accountant is not excluded from the definition of investment adviser no matter how insignificantly the securities advice compares to the other financial planning advice or accounting services rendered.

b. When a lawyer, accountant, engineer, or teacher holding oneself out to the public as providing financial planning or other financial advisory services does not provide advice on specific securities, types of securities, or categories of securities as part of financial planning services but provides such advice in connection with the practice of the profession, in most instances the exclusion from the definition of investment adviser would be unavailable because the professional is holding oneself out as a financial planner or financial adviser. If, however, securities advice is not part of financial planning services and is both limited and isolated, the exclusion may still be available.

EXAMPLE: An accountant who holds oneself out to the public as providing financial planning or other financial advisory services provides clients both accounting and financial planning services. No securities advice is rendered as part of the financial planning services. Clients, on a few occasions, request the accountant's advice on investing in certain limited partnerships. The fees charged to such a client for the advice total only a small percentage of the fees charged to that client for accounting services provided. The accountant is excluded from the definition of investment adviser. The example presented is intentionally narrow in order to illustrate that once the accountant holds oneself out as a financial planner or financial adviser, even if the only securities advice provided for compensation is not part of the financial planning or advisory activities, only limited and isolated securities advice may be provided without registration as an investment adviser.

This rule is intended to implement Iowa Code section 502.102(15) "b."

191—50.45(502) Registration exemption for investment advisers to private funds.

50.45(1) Definitions. For purposes of this rule, the following definitions shall apply:

"3(c)(1) fund" means a qualifying private fund that is eligible for the exclusion from the definition of an investment company under Section 3(c)(1) of the Investment Company Act of 1940, 15 U.S.C. 80a-3(c)(1).

“Private fund adviser” means an investment adviser who provides advice solely to one or more qualifying private funds.

“Qualifying private fund” means a private fund that meets the definition of a qualifying private fund in SEC Rule 203(m)-1, 17 CFR § 275.203(m)-1.

“Value of primary residence” means the fair market value of a person’s primary residence, less the amount of debt secured by the property up to its fair market value.

“Venture capital fund” means a private fund that meets the definition of a venture capital fund in SEC Rule 203(l)-1, 17 CFR § 275.203(l)-1.

50.45(2) Exemption for private fund advisers. Subject to the additional requirements of subrule 50.45(3), a private fund adviser shall be exempt from the registration requirements of Iowa Code section 502.403 if the private fund adviser satisfies each of the following conditions:

a. Neither the private fund adviser nor any of its advisory affiliates are subject to a disqualification as described in Rule 262 of SEC Regulation A, 17 CFR § 230.262;

b. The private fund adviser files with the state each report and amendment thereto that an exempt reporting adviser is required to file with the SEC pursuant to SEC Rule 204-4, 17 CFR § 275.204-4;

c. The private fund adviser pays any applicable fees.

50.45(3) Additional requirements for private fund advisers to certain 3(c)(1) funds. In order to qualify for the exemption described in subrule 50.45(2), a private fund adviser who advises at least one 3(c)(1) fund that is not a venture capital fund shall, in addition to satisfying each of the conditions specified in paragraph 50.45(3) “b,” comply with the following requirements:

a. The private fund adviser shall advise only those 3(c)(1) funds (other than venture capital funds) whose outstanding securities (other than short-term paper) are beneficially owned entirely by persons who, after deducting the value of the primary residence from the person’s net worth, would each meet the definition of a qualified client in SEC Rule 205-3, 17 CFR § 275.205-3, at the time the securities are purchased from the issuer.

b. At the time of purchase, the private fund adviser shall disclose the following in writing to each beneficial owner of a 3(c)(1) fund that is not a venture capital fund:

(1) All services, if any, to be provided to individual beneficial owners;

(2) All duties, if any, the private fund adviser owes to the beneficial owners; and

(3) Any other material information affecting the rights or responsibilities of the beneficial owners.

c. The private fund adviser shall obtain on an annual basis audited financial statements of each 3(c)(1) fund that is not a venture capital fund and shall deliver a copy of such audited financial statements to each beneficial owner of the fund.

50.45(4) Federal covered investment advisers. If a private fund adviser is registered with the SEC, the adviser shall not be eligible for this exemption and shall comply with the state notice filing requirements applicable to federal covered investment advisers.

50.45(5) Investment adviser representatives. A person is exempt from the registration requirements if the person is employed by or associated with an investment adviser that is exempt from registration in this state pursuant to rule 191—50.45(502) and does not otherwise act as an investment adviser representative.

50.45(6) Electronic filing. The report filings described in paragraph 50.45(2) “b” shall be made electronically through the IARD. A report shall be deemed filed when the report and the fee required are filed and accepted by the IARD on the state’s behalf.

50.45(7) Transition. An investment adviser that becomes ineligible for the exemption provided by rule 191—50.45(502) must comply with all applicable laws and rules requiring registration or notice filing within 90 days from the date the investment adviser’s eligibility for this exemption ceases.

50.45(8) Grandfathering for investment advisers to 3(c)(1) funds with nonqualified clients. An investment adviser to a 3(c)(1) fund (other than a venture capital fund) that has one or more beneficial owners who are not qualified clients as described in paragraph 50.45(3) “a” is eligible for the exemption contained in subrule 50.45(2) if the following conditions are satisfied:

a. The subject fund existed prior to November 6, 2013;

b. As of November 6, 2013, the subject fund ceases to accept beneficial owners who are not qualified clients, as described in paragraph 50.45(3) "a";

c. The investment adviser discloses in writing the information described in paragraph 50.45(3) "b" to all beneficial owners of the fund; and

d. As of November 6, 2013, the investment adviser delivers audited financial statements as required by paragraph 50.43(3) "c."

This rule is intended to implement Iowa Code section 502.403.

[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.46(502) Contents of investment advisory contract. The provisions of this rule shall apply to federal covered investment advisers to the extent that the conduct alleged is fraudulent, deceptive, or as otherwise permitted by the National Securities Markets Improvement Act of 1996.

50.46(1) It is unlawful for any investment adviser, investment adviser representative, or federal covered investment adviser to enter into, extend, or renew any investment advisory contract unless it provides in writing:

a. The services to be provided, the term of the contract, the investment advisory fee, the formula for computing the fee, the amount of prepaid fee to be returned in the event of termination or nonperformance of the contract, and any grant of discretionary power to the investment adviser, investment adviser representative, or federal covered investment adviser;

b. That no direct or indirect assignment or transfer of the contract may be made by the investment adviser, investment adviser representative, or federal covered investment adviser without the consent of the client or other party to the contract;

c. That the investment adviser, investment adviser representative, or federal covered investment adviser shall not be compensated on the basis of a share of capital gains upon or capital appreciation of the funds or any portion of the funds of the client;

d. That the investment adviser, investment adviser representative, or federal covered investment adviser, if a partnership, shall notify the client or other party to the investment contract of any change in the membership of the partnership within a reasonable time after the change.

50.46(2) It is unlawful for any investment adviser, investment adviser representative, or federal covered investment adviser to:

a. Include in an advisory contract any condition, stipulation, or provisions binding any person to waive compliance with any provision of this Act or of the Investment Advisers Act of 1940, or any other practice contrary to the provisions of Section 215 of the Investment Advisers Act of 1940; or

b. Enter into, extend or renew any advisory contract contrary to the provisions of Section 205 of the Investment Advisers Act of 1940. This provision shall apply to all advisers and investment adviser representatives registered or required to be registered under this Act, notwithstanding whether such adviser or representative would be exempt from federal registration pursuant to Section 203(b) of the Investment Advisers Act of 1940.

50.46(3) Notwithstanding paragraph 50.46(1) "c," an investment adviser may enter into, extend or renew an investment advisory contract which provides for compensation to the investment adviser on the basis of a share of capital gains upon or capital appreciation of the funds, or any portion of the funds, of the client if the conditions in paragraphs 50.46(3) "a" to "d" are met.

a. The client entering into the contract must be:

(1) A natural person or a company that, immediately after entering into the contract, has at least \$750,000 under the management of the investment adviser; or

(2) A person that the investment adviser and its investment adviser representatives reasonably believe, immediately before entering into the contract, is a natural person or a company whose net worth, at the time the contract is entered into, exceeds \$1,500,000. The net worth of a natural person may include assets held jointly with that person's spouse.

b. The compensation paid to the investment adviser with respect to the performance of any securities over a given period must be based on a formula with the following characteristics:

(1) In the case of securities for which market quotations are readily available within the meaning of Rule 2a-4(a)(1) under the Investment Company Act of 1940 (definition of "current net asset value" for use in computing periodically the current price of redeemable security), the formula must include the realized capital losses and unrealized capital depreciation of the securities over the period;

(2) In the case of securities for which market quotations are not readily available within the meaning of Rule 2a-4(a)(1) under the Investment Company Act of 1940, the formula must include:

1. The realized capital losses of securities over the period; and

2. If the unrealized capital appreciation of the securities over the period is included, the unrealized capital depreciation of the securities over the period; and

(3) The formula must provide that any compensation paid to the investment adviser under paragraph 50.46(3) "b" is based on the gains less the losses (computed in accordance with subparagraphs 50.46(3) "b"(1) and (2)) in the client's account for a period of not less than one year.

c. Before entering into the advisory contract and in addition to the requirements of Form ADV, the investment adviser must disclose in writing to the client or the client's independent agent all material information concerning the proposed advisory arrangement, including the following:

(1) That the fee arrangement may create an incentive for the investment adviser to make investments that are riskier or more speculative than would be the case in the absence of a performance fee;

(2) Where relevant, that the investment adviser may receive increased compensation with regard to unrealized appreciation as well as realized gains in the client's account;

(3) The periods which will be used to measure investment performance throughout the contract and their significance in the computation of the fee;

(4) The nature of any index which will be used as a comparative measure of investment performance, the significance of the index, and the reason the investment adviser believes that the index is appropriate; and

(5) When the investment adviser's compensation is based in part on the unrealized appreciation of securities for which market quotations are not readily available within the meaning of Rule 2a-4(a)(1) under the Investment Company Act of 1940, how the securities will be valued and the extent to which the valuation will be independently determined.

d. The investment adviser (and any investment adviser representative) that enters into the contract must reasonably believe, immediately before entering into the contract, that the contract represents an arm's length arrangement between the parties and that the client (or in the case of a client which is a company as defined in paragraph 50.46(6) "d," the person representing the company), alone or together with the client's independent agent, understands the proposed method of compensation and its risks. The representative of a company may be a partner, director, officer or an employee of the company or of the trustee, where the company is a trust, or any other person designated by the company or trustee, but must satisfy the definition of client's independent agent set forth in paragraph 50.46(6) "c."

50.46(4) Any person entering into or performing an investment advisory contract under rule 191—50.46(502) is not relieved of any obligations under rule 191—50.38(502) or any other applicable provision of the Act or any rule or order thereunder.

50.46(5) Nothing in rule 191—50.46(502) shall relieve a client's independent agent from any obligation to the client under applicable law.

50.46(6) The following definitions apply for purposes of rule 191—50.46(502):

a. "*Affiliate*" shall have the same definition as in Section 2(a)(3) of the Investment Company Act of 1940.

b. "*Assignment*," as used in paragraph 50.46(1) "b," includes, but is not limited to, any transaction or event that results in any change to the individuals or entities with the power, directly or indirectly, to direct the management or policies of, or to vote more than 50 percent of any class of voting securities of, the investment adviser or federal covered investment adviser as compared to the individuals or entities that had such power as of the date when the contract was first entered into, extended or renewed.

c. "*Client's independent agent*" means any person who agrees to act as an investment advisory client's agent in connection with the contract. "*Client's independent agent*" does not include:

- (1) The investment adviser relying on rule 191—50.46(502);
- (2) An affiliated person of the investment adviser or an affiliated person of an affiliated person of the investment adviser including an investment adviser representative;
- (3) An interested person of the investment adviser;
- (4) A person who receives, directly or indirectly, any compensation in connection with the contract from the investment adviser, an affiliated person of the investment adviser, an affiliated person of an affiliated person of the investment adviser or an interested person of the investment adviser; or
- (5) A person with any material relationship between the person (or an affiliated person of that person) and the investment adviser (or an affiliated person of the investment adviser) that exists, or has existed at any time during the past two years.
 - d. "*Company*" means a corporation, partnership, association, joint stock company, trust, or any organized group of persons, whether incorporated or not; or any receiver, trustee in a case under Title 11 of the United States Code, or similar official or any liquidating agent for any of the foregoing, in the liquidating agent's capacity as such. "*Company*" shall not include:
 - (1) A company required to be registered under the Investment Company Act of 1940 but which is not so registered;
 - (2) A private investment company is an entity which would be defined as an investment company under Section 3(a) of the Investment Company Act of 1940 but for the exception from that definition provided by Section 3(c)(1) of that Act;
 - (3) An investment company registered under the Investment Company Act of 1940; or
 - (4) A business development company as defined in Section 202(a)(22) of the Investment Advisers Act of 1940, unless each of the equity owners of any such company, other than the investment adviser entering into the contract, is a natural person or a company within the meaning of "company."
 - e. "*Interested person*" means:
 - (1) Any member of the immediate family of any natural person who is an affiliated person of the investment adviser;
 - (2) Any person who knowingly has any direct or indirect beneficial interest in, or who is designated as trustee, executor, or guardian of any legal interest in, any security issued by the investment adviser or by a controlling person of the investment adviser if that beneficial or legal interest exceeds:
 1. One-tenth of one percent of any class of outstanding securities of the investment adviser or a controlling person of the investment adviser; or
 2. Five percent of the total assets of the person seeking to act as the client's independent agent; or
 - (3) Any person or partner or employee of any person who has acted as legal counsel for the investment adviser within the past two years.

[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.47 to 50.49 Reserved.

DIVISION IV
RULES COVERING ALL REGISTERED PERSONS

191—50.50(502) Internet advertising by broker-dealers, investment advisers, broker-dealer agents, investment adviser representatives, and federal covered investment advisers.

50.50(1) Broker-dealers, investment advisers, broker-dealer agents, investment adviser representatives, and federal covered investment advisers who use the Internet, the World Wide Web, or similar proprietary or common carrier electronic systems (collectively described as the "Internet") to disseminate information regarding products and services through communications directed generally to anyone having access to the Internet and transmitted through posting on bulletin boards, displays on home pages or similar methods (hereinafter "Internet communications") will not be considered to be transacting business in Iowa pursuant to Iowa Code section 502.401, 502.402, 502.403, 502.404, or 502.405 based solely on that communication, if:

- a. The Internet communication contains a legend clearly stating that:

(1) The broker-dealer, investment adviser, broker-dealer agent, investment adviser representative, or federal covered investment adviser may only transact business in a state if first registered pursuant to or excluded or exempt from the state broker-dealer, investment adviser, broker-dealer agent, or investment adviser representative registration requirements, or federal covered investment adviser notice requirement; and

(2) The broker-dealer, investment adviser, broker-dealer agent, investment adviser representative, or federal covered investment adviser will not effect or attempt to effect transactions in securities or render personalized investment advice for compensation absent compliance with applicable state broker-dealer, investment adviser, broker-dealer agent, or investment adviser representative registration requirements, or federal covered investment adviser notice requirement or applicable exemption or exclusion;

b. The Internet communication contains a mechanism, including but not limited to technical firewalls or other policies and procedures, to ensure that, prior to effecting or attempting to effect transactions with customers in Iowa or prior to direct communication with prospective customers or clients in Iowa, the broker-dealer, investment adviser, broker-dealer agent, or investment adviser representative is first registered in Iowa or, in the case of a federal covered investment adviser, has made a notice filing, or qualifies for an exemption or exclusion from registration requirements;

c. The Internet communication is limited to general information regarding products and services, and the broker-dealer, investment adviser, broker-dealer agent, investment adviser representative, or federal covered investment adviser does not effect or attempt to effect transactions in securities in Iowa or provide personalized investment advice for compensation; and

d. In the case of a broker-dealer agent or investment adviser representative:

(1) The agent's broker-dealer, investment adviser, or federal covered investment adviser affiliation is prominently disclosed within the Internet communication;

(2) The broker-dealer, investment adviser, or federal covered investment adviser with whom the agent or representative is affiliated reviews and approves the content of any Internet communication by the broker-dealer agent or investment adviser representative;

(3) The broker-dealer, investment adviser, or federal covered investment adviser with whom the agent or representative is associated first authorizes the dissemination of information on the particular products and services through the Internet communication; and

(4) The broker-dealer agent or investment adviser representative acts within the scope of the authority granted by the broker-dealer, investment adviser, or federal covered investment adviser in the dissemination of information through the Internet communication.

50.50(2) Nothing in this rule shall excuse broker-dealer, investment adviser, broker-dealer agent, investment adviser representative, and federal covered investment adviser compliance with applicable securities registration, notice filing, antifraud or related provisions.

50.50(3) Nothing in this rule shall be construed to affect the activities of any broker-dealer, investment adviser, broker-dealer agent, investment adviser representative, or federal covered investment adviser engaged in business in Iowa that is not subject to the jurisdiction of the administrator as a result of NSMIA.

This rule is intended to implement Iowa Code sections 502.401 to 502.405.

191—50.51(502) Consent to service.

50.51(1) Every consent appointing the administrator or successor to be an attorney to receive service of any lawful process as required by Iowa Code section 502.611 shall be properly notarized and shall contain, at a minimum, the following information:

- a. Name of the applicant;
- b. Address of the applicant;
- c. A statement that the consent is irrevocable;
- d. A statement that the consent is valid as to any noncriminal suit, action or proceeding against the applicant or the successor, executor or administrator of the applicant which arises out of the Act; and

e. A statement that the applicant stipulates and agrees that service upon the administrator shall have the same validity as if served personally upon the applicant.

50.51(2) A form of consent to service of process provided by the administrator, a Form U-2, or a consent to service of process contained in any other form authorized or required to be filed by these rules shall satisfy subrule 50.51(1).

50.51(3) A broker-dealer, investment adviser, agent, investment adviser representative, federal covered investment adviser, or issuer may incorporate by reference any consent to service of process required to be filed pursuant to Iowa Code sections 502.302(1) "a," 502.302(3), 502.303(2), 502.304(2), 502.406(1) and 502.611, or the administrative rules implementing these sections.

This rule is intended to implement Iowa Code section 502.611.

191—50.52(252J) Denial, suspension or revocation of agent or investment adviser representative registration for failure to pay child support.

50.52(1) Upon receipt of a certificate of noncompliance from the CSRU for default on debts owed to or collected by the CSRU, the administrator shall issue a notice to a securities agent or investment adviser representative applicant or registrant that any pending application for registration will be denied or any current registration will be suspended or revoked 30 days after the date of the notice. The notice shall be served by restricted certified mail, return receipt requested, or by personal service as provided by the Iowa Rules of Civil Procedure, unless the applicant or registrant accepts service personally or through authorized counsel.

50.52(2) The administrator shall provide the applicant or registrant with a copy of the certificate of noncompliance and shall provide a notice advising the applicant that:

a. The administrator intends to deny an application or to suspend or revoke a registration due to receipt of a certificate of noncompliance from the CSRU;

b. The applicant or registrant must contact the CSRU to schedule a conference or to otherwise obtain a withdrawal of a certificate of noncompliance;

c. Unless the CSRU furnishes a withdrawal of a certificate of noncompliance to the administrator within 30 days of issuance of the notice, the application shall be denied or the registration shall be suspended or revoked;

d. The applicant or registrant does not have a right to a hearing before the administrator, but may, pursuant to Iowa Code section 252J.9, request a court hearing within 30 days of provision of notice by the administrator; and

e. The filing of an application for hearing with the district court will stay the proceedings of the division.

50.52(3) The filing of an application for hearing with the district court under Iowa Code section 252J.9 automatically stays action of the administrator until the administrator is notified of the resolution of the application.

50.52(4) If the administrator does not receive a withdrawal of the certificate of noncompliance from the CSRU or a notice that an application for district court hearing has been filed, the administrator shall deny, suspend or revoke the application or registration 30 days after the notice prescribed in subrule 50.52(2) is issued.

50.52(5) Upon receiving a withdrawal of the certificate of noncompliance from the CSRU, the administrator shall immediately halt action to deny an application or suspend or revoke a registration. The applicant or registrant shall be notified that action has been halted. If the application has already been denied or if a registration has already been suspended or revoked, the applicant or former registrant shall reapply for registration. The application shall be granted if the individual is otherwise in compliance with applicable laws, rules, regulations and orders.

50.52(6) All application fees must be paid by the applicant before a registration will be issued after the administrator has denied, suspended, or revoked a registration pursuant to Iowa Code chapter 252J.

50.52(7) Notwithstanding any statutory confidentiality provision, the administrator may share information with the CSRU for the sole purpose of identifying applicants or registrants subject to enforcement pursuant to Iowa Code chapter 252J.

This rule is intended to implement Iowa Code chapter 252J.

191—50.53(261) Denial, suspension or revocation of agent or investment adviser representative registration for failure to pay debts owed to or collected by the college student aid commission.

50.53(1) Upon receipt of a certificate of noncompliance from the college student aid commission for defaults on debts owed to or collected by the commission, the administrator shall issue a notice to a securities agent or investment adviser representative applicant or registrant that any pending application for registration or any current registration will be denied, suspended or revoked 30 days after the date of the notice. The notice shall be served by restricted certified mail, return receipt requested, or by personal service as provided by the Iowa Rules of Civil Procedure, unless the applicant or registrant accepts service personally or through authorized counsel.

50.53(2) The administrator shall provide the applicant or registrant with a copy of the certificate of noncompliance and shall provide a notice advising the applicant or registrant that:

- a. The administrator intends to deny an application or suspend or revoke a registration due to receipt of a certificate of noncompliance from the college student aid commission;
- b. The applicant or registrant must contact the college student aid commission to schedule a conference or to otherwise obtain a withdrawal of a certificate of noncompliance;
- c. Unless the college student aid commission furnishes a withdrawal of a certificate of noncompliance to the administrator within 30 days of issuance of the notice, the application shall be denied or the registration shall be suspended or revoked;
- d. The applicant or registrant does not have a right to a hearing before the administrator but may, pursuant to Iowa Code section 261.126, request a district court hearing within 30 days of provision of notice by the administrator; and
- e. The filing of an application for hearing with the district court will stay the proceedings of the division.

50.53(3) The filing of an application for hearing with the district court under Iowa Code section 261.127 automatically stays action of the administrator until the administrator is notified of the resolution of the application.

50.53(4) If the administrator does not receive a withdrawal of the certificate of noncompliance from the college student aid commission or a notice that an application for district court hearing has been filed, the administrator shall deny the application or suspend or revoke the registration 30 days after the notice prescribed in subrule 50.53(2) is issued.

50.53(5) If the administrator receives a withdrawal of the certificate of noncompliance from the college student aid commission, the administrator shall immediately halt action to deny, suspend or revoke an application or registration. The applicant or registrant shall be notified that action has been halted. If the application or registration has already been denied, suspended or revoked, the applicant or former registrant shall reapply for registration. The application shall be granted if the individual is otherwise in compliance with applicable laws, rules, regulations and orders.

50.53(6) All application fees must be paid by the applicant before a registration will be issued after the administrator has denied, suspended, or revoked a registration pursuant to Iowa Code section 261.126.

50.53(7) Notwithstanding any statutory confidentiality provision, the administrator may share information with the college student aid commission for the sole purpose of identifying applicants or registrants subject to enforcement pursuant to Iowa Code section 261.126.

This rule is intended to implement Iowa Code section 261.126.

[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.54(272D) Denial, suspension or revocation of agent or investment adviser representative registration for failure to pay state debt.

50.54(1) Upon receipt of a certificate of noncompliance from the centralized collection unit of the department of revenue (CCU), the administrator shall issue a notice to a securities agent or investment adviser representative applicant or registrant that any pending application for registration will be denied or any current registration will be suspended or revoked 60 days after the date of the notice. The notice shall be served by restricted certified mail, return receipt requested, or by personal service as provided by the Iowa Rules of Civil Procedure, unless the applicant or registrant accepts service personally or through authorized counsel.

50.54(2) The administrator shall provide the applicant or registrant with a copy of the certificate of noncompliance and shall provide a notice advising the applicant that:

a. The administrator intends to deny an application or to suspend or revoke a registration due to receipt of a certificate of noncompliance from the CCU;

b. The applicant or registrant must contact the CCU to schedule a conference or to otherwise obtain a withdrawal of a certificate of noncompliance;

c. Unless the CCU furnishes a withdrawal of a certificate of noncompliance to the administrator within 60 days of issuance of the notice, the application shall be denied or the registration shall be suspended or revoked;

d. The applicant or registrant does not have a right to a hearing before the administrator, but may file an application for hearing in district court pursuant to Iowa Code section 272D.9; and

e. The filing of an application for hearing with the district court will stay the proceedings of the division.

50.54(3) The filing of an application for hearing with the district court under Iowa Code section 272D.9 automatically stays action of the administrator until the administrator is notified of the resolution of the application.

50.54(4) If the administrator does not receive a withdrawal of the certificate of noncompliance from the CCU or a notice that an application for district court hearing has been filed, the administrator shall deny, suspend or revoke the application or registration 60 days after the notice prescribed in subrule 50.54(2) is issued.

50.54(5) Upon receiving a withdrawal of the certificate of noncompliance from the CCU, the administrator shall immediately halt action to deny an application or suspend or revoke a registration. The applicant or registrant shall be notified that action has been halted. If the application has already been denied or if a registration has already been suspended or revoked, the applicant or former registrant shall reapply for registration. The application shall be granted if the individual is otherwise in compliance with applicable laws, rules, regulations and orders.

50.54(6) All application fees must be paid by the applicant before a registration will be issued after the administrator has denied, suspended, or revoked a registration pursuant to Iowa Code chapter 272D.

50.54(7) Notwithstanding any statutory confidentiality provision, the administrator may share information with the CCU for the sole purpose of identifying applicants or registrants subject to enforcement pursuant to Iowa Code chapter 272D.

This rule is intended to implement Iowa Code chapter 272D.
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.55(502) Use of senior-specific certifications and professional designations.

50.55(1) The use of a senior-specific certification or designation by any person in connection with the offer, sale, or purchase of securities or the provision of advice as to the value of or the advisability of investing in, purchasing, or selling securities, either directly or indirectly or through publications or writings, or by issuing or promulgating analyses or reports relating to securities, that indicate or imply that the user has special certification or training in advising or servicing senior citizens or retirees in such a way as to mislead any person shall be a dishonest and unethical practice in the securities, commodities, investment, franchise, banking, finance, or insurance business within the meaning of Iowa Code section

502.412(4) "m." The prohibited use of such certifications or professional designation includes, but is not limited to, the following:

- a. Use of a certification or professional designation by a person who has not actually earned or is otherwise ineligible to use such certification or designation;
- b. Use of a nonexistent or self-conferred certification or professional designation;
- c. Use of a certification or professional designation that indicates or implies a level of occupational qualifications obtained through education, training, or experience that the person using the certification or professional designation does not have; and
- d. Use of a certification or professional designation that was obtained from a designating or certifying organization that:
 - (1) Is primarily engaged in the business of instruction in sales or marketing;
 - (2) Does not have reasonable standards or procedures for ensuring the competency of its designees or certificants;
 - (3) Does not have reasonable standards or procedures for monitoring and disciplining its designees or certificants for improper or unethical conduct; or
 - (4) Does not have reasonable continuing education requirements for its designees or certificants in order to maintain the designation or certificate.

50.55(2) There is a rebuttable presumption that a designating or certifying organization is not disqualified solely for purposes of 50.55(1) "d" when the organization has been accredited by:

- a. The American National Standards Institute;
- b. The National Commission for Certifying Agencies; or
- c. An organization that is on the United States Department of Education's list entitled "Accrediting Agencies Recognized for Title IV Purposes" and the designation or credential issued therefrom does not primarily apply to sales or marketing.

50.55(3) In determining whether a combination of words or an acronym standing for a combination of words constitutes a certification or professional designation indicating or implying that a person has special certification or training in advising or servicing senior citizens or retirees, the administrator shall consider the following factors:

- a. Use of one or more words such as "senior," "retirement," "elder," or similar words combined with one or more words such as "certified," "registered," "chartered," "adviser," "specialist," "consultant," "planner," or similar words in the name of the certification or professional designation; and
- b. The manner in which those words are combined.

50.55(4) For purposes of this rule, a certification or professional designation does not include a job title within an organization that is licensed or registered by a state or federal financial services regulatory agency, when that job title:

- a. Indicates seniority or standing within the organization; or
- b. Specifies an individual's area of specialization within the organization.

For purposes of this subrule, financial services regulatory agency includes, but is not limited to, an agency that regulates broker-dealers, investment advisers, or investment companies as defined under the Investment Company Act of 1940.

50.55(5) Nothing in this rule shall limit the administrator's authority to enforce existing provisions of law.

This rule is intended to implement Iowa Code section 502.605(1).
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

DIVISION V
REGISTRATION OF SECURITIES

191—50.60(502) Notice filings for investment company securities offerings.

50.60(1) Except as provided in subrule 50.60(5), no investment company that is registered under the Investment Company Act of 1940 or that has a currently filed registration statement under the Securities Act of 1933 is required to file with the administrator, either prior to the initial offer or after the initial offer in Iowa of a security which is a covered security under Section 18(b)(2) of the Securities Act of 1933, a copy of any document which is part of a federal registration statement filed with the SEC or is part of an amendment to such federal registration statement.

50.60(2) Prior to the initial offer of a federal covered security in Iowa, an investment company that is registered under the Investment Company Act of 1940 or that has filed a registration statement under the Securities Act of 1933 shall file with the administrator:

- a. A notice of filing on Form NF;
- b. A filing fee; and
- c. A consent to service of process.

50.60(3) A notice of filing may be renewed prior to expiration by filing the following with the administrator:

- a. A notice of filing on Form NF; and
- b. Payment of the applicable fee under Iowa Code section 502.302(1) "a" as amended by 2015 Iowa Acts, House File 632.

50.60(4) Amendments to notice filings are made on Form NF and are effective upon receipt by the administrator. Withdrawal or termination of a notice filing is made by filing Form NF or providing the administrator with notice of the withdrawal or termination in a similar format. An amendment, withdrawal, or termination is effective upon receipt by the administrator of the required notice and all fees required by Iowa Code section 502.302(1) "a" as amended by 2015 Iowa Acts, House File 632.

This subrule is intended to implement Iowa Code section 502.302 and 2015 Iowa Acts, House File 632.

50.60(5) An investment company that is registered under the Investment Company Act of 1940 or that has filed a registration statement under the Securities Act of 1933 shall file, upon written request of the administrator and within the time period set forth in the request, a copy of any document identified in the request that is part of the federal registration statement filed with the SEC or part of an amendment to such federal registration statement.

50.60(6) An investment company that makes a notice filing under subrule 50.60(2) and that pays an initial \$400 filing fee under Iowa Code section 502.302(1) "a" as amended by 2015 Iowa Acts, House File 632, shall pay a \$400 renewal fee prior to the notice filing's annual renewal date. Notice filings that are not renewed by the annual renewal date shall expire.

This subrule is intended to implement Iowa Code section 502.302 and 2015 Iowa Acts, House File 632.

This rule is intended to implement Iowa Code section 502.302(1).
[ARC 2175C, IAB 9/30/15, effective 11/4/15]

191—50.61(502) Registration of small corporate offerings.

50.61(1) Form U-7 may be obtained from the NASAA Web site at www.nasaa.org. Form U-7 has been developed under the Small Business Investment Incentive Act of 1980 which prescribes state and federal cooperation in furthering the policies of the Act: diminishing the burden of raising investment capital and minimizing interference with the business of capital formation.

50.61(2) To be eligible to use Form U-7, the issuer shall comply with each of the following requirements:

- a. The issuer shall:
 - (1) Be a corporation or limited liability company organized under the laws of the United States or Canada, or any state, province, or territory or possession thereof, or the District of Columbia and have its principal place of business in one of the foregoing;

- (2) Not be subject to the reporting requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934;
- (3) Not be an investment company registered or required to be registered under the Investment Company Act of 1940;
- (4) Not be engaged in or propose to be engaged in petroleum exploration and production, mining, or other extractive industries;
- (5) Not be a development stage company that either has no specific business plan or purpose or has indicated that its business plan is to engage in a merger or acquisition with an unidentified company or companies or other entity or person; and
- (6) Not be disqualified under subrule 50.61(3).

b. The offering price for common stock or common ownership interests (hereinafter, collectively referred to as "common stock"), the exercise price for options, warrants, or rights to common stock, or the conversion price for securities convertible into common stock must be greater than or equal to U.S. \$1 per share or unit of interest. The issuer must agree with the administrator that the issuer will not split its common stock, or declare a stock dividend for two years after the effective date of the registration if such action has the effect of lowering the price below U.S. \$1.

c. Commissions, fees or other remuneration for soliciting any prospective purchaser in connection with the offering in the state are only paid to persons who, if required to be registered or licensed, the issuer believes, and has reason to believe, are appropriately registered or licensed in the state.

d. Financial statements shall be prepared in accordance with either U.S. or Canadian generally accepted accounting principles. If appropriate, a reconciliation note should be provided. If the company has not conducted significant operations, statements of receipts and disbursements shall be included in lieu of statements of income. Interim financial statements may be unaudited. All other financial statements shall be audited by independent certified public accountants, provided, however, that if each of the following four conditions are met, such financial statements in lieu of being audited may be reviewed by independent certified public accountants in accordance with the Accounting and Review Service Standards promulgated by the American Institute of Certified Public Accountants or the Canadian equivalent:

(1) The company shall not have previously sold securities through an offering involving the general solicitation of prospective investors by means of advertising, mass mailings, public meetings, "cold call" telephone solicitation, or any other method directed toward the public;

(2) The company has not been previously required under federal, state, provincial or territorial securities laws to provide audited financial statements in connection with any sale of its securities;

(3) The aggregate amount of all previous sales of securities by the company (exclusive of debt financing with banks and similar commercial lenders) shall not exceed U.S. \$1 million; and

(4) If the offering is a Rule 504 offering, the amount of the present offering does not exceed U.S. \$1 million.

e. The offering shall be made in compliance with Rule 504 of Regulation D, Regulation A, or Section 3(a)(11) of the Securities Act of 1933.

f. The issuer shall comply with the General Instructions to SCOR in Part I of the NASAA SCOR Issuer's Manual.

50.61(3) Disqualifications.

a. Unless the administrator determines that it is not necessary under the circumstances that the disqualification under this subrule be applied, application for registration referred to in subrule 50.61(2) shall be denied if the issuer, any of its officers, directors, stockholders who own 10 percent or greater of the issuer, promoters, or selling agents, or any officer, director or partner of any selling agent:

(1) Has filed a registration statement which is subject to a currently effective stop order entered pursuant to any state or provincial securities laws within five years prior to the filing of the registration statement;

(2) Has been convicted, within five years prior to the filing of the registration statement, of any felony or misdemeanor in connection with the offer, purchase, or sale of securities, or of any felony

involving fraud or deceit including, but not limited to, forgery, embezzlement, obtaining money under false pretenses, larceny, or conspiracy to defraud;

(3) Is currently subject to any state or provincial administrative enforcement order or judgment entered by that state's or province's securities administrator within five years prior to the filing of the registration statement;

(4) Is subject to any state or provincial administrative enforcement order or judgment in which fraud or deceit including, but not limited to, making untrue statements of material facts and omitting to state material facts, was found, and the order or judgment was entered within five years prior to the filing of the current application for registration;

(5) Is subject to any state or provincial administrative enforcement order or judgment which prohibits, denies, or revokes the use of any exemption from registration in connection with the offer, purchase or sale of securities;

(6) Is currently subject to any order, judgment, or decree of any court of competent jurisdiction that temporarily, preliminarily, or permanently restrains or enjoins such party from engaging in or continuing any conduct or practice in connection with the purchase or sale of any security, or involving the making of any false filing with the state, entered within five years prior to the filing of the registration statement; or

(7) Has violated the law of a foreign jurisdiction governing or regulating any aspect of the business of securities or banking or, within the past five years, has been the subject of an action of a securities regulator of a foreign jurisdiction denying, revoking or suspending the right to engage in the business of securities as a broker-dealer, agent or investment adviser or is the subject of an action of any securities exchange or self-regulatory organization operating under the authority of the securities regulator of a foreign jurisdiction suspending or expelling such person from membership in such exchange or self-regulatory organization.

b. The prohibitions of subparagraphs (1) to (3) and (5) of paragraph 50.61(3) "a" shall not apply if the person subject to the disqualification is duly registered or licensed to conduct securities-related business in the state or province in which the administrative order or judgment was entered against such person, or if the broker-dealer employing such person is registered or licensed in the state and the Form BD filed in the state discloses the order, conviction, judgment or decree relating to such person.

c. No person disqualified shall act in any capacity other than the capacity for which the person is registered or licensed.

d. Disqualification is automatically waived if the jurisdiction which created the basis for disqualification determines upon a showing of good cause that it is not necessary under the circumstances that registration be denied.

This rule is intended to implement Iowa Code section 502.304.

[ARC 2175C, IAB 9/30/15, effective 11/4/15]

191—50.62(502) Streamlined registration for certain equity securities.

50.62(1) An equity security meeting the conditions of this rule may be registered pursuant to Iowa Code section 502.303 if all of the following conditions are satisfied, unless waived by the administrator, and except as provided by subrule 50.62(2):

a. The issuer must be a corporation organized under the laws of one of the states or possessions of the United States;

b. The offering price for common stock, the exercise price if the securities are options, warrants, or rights for common stock, or the conversion price if the securities are convertible into common stock must be equal to or greater than \$5 per share;

c. The issuer of the security has (or will have upon completion of the offering) total assets exceeding \$10 million;

d. The security will be offered under a firm underwriting;

e. The security is the subject of a registration statement filed on Form S-1 or Form SB-2 with the SEC; and

f. The registration statement filed with the administrator contains audited financial statements for each of the two most recently concluded fiscal years of its operations, and the audit for the most recent fiscal year does not include an auditor's report expressing substantial doubt about the issuer's ability to continue as a going concern.

50.62(2) Registration pursuant to this rule is not available if:

a. The issuer is a blind pool or other offering for which the specific business or properties cannot now be described; or

b. The issuer, a principal officer or a principal shareholder thereof, or a broker-dealer offering or selling the securities:

(1) Is subject to statutory disqualification, as defined by subparagraphs (A), (B), (C), or (D) of Section 3(a)(39) of the Securities Exchange Act of 1934;

(2) Has been convicted of any felony under federal or state law regarding the offer, purchase, or sale of any security, or any felony under federal or state law involving fraud or deceit in the ten years prior to the date of the offering;

(3) Is currently named in and subject to any order, judgment, or decree of any court of competent jurisdiction acting under federal or state law temporarily or permanently restraining or enjoining the person from engaging in or continuing any conduct or practice in connection with the offer, purchase, or sale of a security;

(4) Has filed a registration statement which is currently the subject of a stop order entered pursuant to any state's securities law within five years prior to the offering;

(5) Is currently subject to any state administrative enforcement order or judgment entered by that state's securities administrator within five years prior to the offering, or is currently subject to any state's administrative enforcement order or judgment in which fraud or deceit was found within five years prior to the offering; or

(6) Is currently subject to any state's administrative order or judgment prohibiting, denying, or revoking the use of any exemption from registration regarding the offer, sale, or purchase of any security, or involving the making of a false filing with the state within five years of the offering.

50.62(3) The unavailability of streamlined registration pursuant to this rule as a result of the disqualification of a party pursuant to paragraph 50.62(2) "b" may be waived by the administrator if the order, conviction, judgment or decree relating to the party's disqualification was disclosed in writing to the administrator and the administrator determines, based upon good cause shown, that the public interest no longer requires the party to be disqualified.

50.62(4) The administrator shall review a filing made pursuant to this rule within ten business days of receipt. Registration shall be effective upon review, or earlier if the administrator permits a shorter time frame, or comments explaining noncompliance will be promptly sent to the applicant.

50.62(5) The administrator shall not deny the effectiveness of a registration made pursuant to this rule based on subrule 50.66(13) or 50.66(15), or based upon the financial condition of the issuer under Iowa Code section 502.306(1) "h."

50.62(6) The following securities shall be the subject of a lockup with the managing underwriter for no less than 180 days, or a longer period if requested by the managing underwriter of the offering:

a. A security issued to a promoter within three years immediately preceding the offering or to be issued to a promoter for consideration substantially less than the offering price; or

b. A security issued to a promoter for a consideration other than cash, unless the registrant demonstrates that the value of the noncash consideration received in exchange for the security is substantially equal to the offering price for the security. A copy of the lockup agreement shall be filed with the administrator.

50.62(7) For purposes of this rule, a "promoter" is:

a. A person who, acting alone or in concert with one or more other persons, founds or organizes the business or enterprise of the issuer;

b. An officer or director owning securities of the issuer, or a person who owns, beneficially or of record, 10 percent or more of a class of securities of the issuer if the officer, director, or person acquires

any of those securities in a non-arm's-length transaction within the three years prior to the filing of the registration statement pursuant to this rule; or

c. A member of the immediate family of a person described in paragraph "a" or "b" of subrule 50.62(7) if the family member receives securities of the issuer from that person in a non-arm's-length transaction within the three years prior to the filing of the registration statement pursuant to this rule.

This rule is intended to implement Iowa Code section 502.303.

191—50.63(502) Registration of multijurisdictional offerings.

50.63(1) Pursuant to Iowa Code section 502.303(2), offerings filed on SEC Form F-7, Form F-8, Form F-9 or Form F-10 shall become effective the later of three days after filing, or the effective date with the SEC.

50.63(2) Pursuant to Iowa Code section 502.605(3), financial statements and financial information for offerings filed under subrule 50.63(1) shall comply with instructions provided with SEC Form F-7, Form F-8, Form F-9 or Form F-10.

50.63(3) In a Rights Offering, SEC Form F-7 will be accepted in lieu of any state form required to claim an exemption for any transaction pursuant to an offer to existing securities holders.

50.63(4) After the SEC has declared effective an issuer's Form F-8, Form F-9 or Form F-10 registration statement, a nonissuer transaction in any class of the issuer's securities is exempt from registration, whether or not the transaction is effected through a broker-dealer.

This rule is intended to implement Iowa Code sections 502.303(2) and 502.605(3).

191—50.64(502) Form of financial statements.

50.64(1) Except as otherwise provided by this rule, the balance sheet, statement of cash flows, and statement of income required by Iowa Code section 502.304(2) "q" shall be certified by an independent certified public accountant who shall also issue an opinion on the financial statements. The audit and opinion requirements may be waived by the administrator upon written application and for good cause shown.

50.64(2) The balance sheet, statement of cash flows, and statement of income provided for compliance with the four-month requirement of Iowa Code section 502.304(2) "q" need not be certified in accordance with subrule 50.64(1) if such certification was submitted for the last fiscal year prior to the application and the date of the financial statements subject to certification is not more than 12 months prior to the registration date.

This rule is intended to implement Iowa Code section 502.304.

191—50.65(502) Reports contingent to registration by qualification. In the administrator's discretion, a registration by qualification statement filed pursuant to Iowa Code section 502.304 may not become effective until one or both of the following are filed:

1. When the value, after its purchase, of certain property does or will constitute a material portion of the assets of the issuer or any other person whose financial condition is significant to the registration, the report of any appraiser or engineer; and

2. When the ownership of any such property is material to the registration, a signed opinion of legal counsel regarding ownership of any property.

This rule is intended to implement Iowa Code section 502.304(2A).

191—50.66(502) NASAA guidelines and statements of policy.

50.66(1) Overview of national models. In cooperation with the securities administrators of other states and with a view to effectuating a policy to achieve maximum uniformity of regulations regarding the registration of securities, registration and business practices of securities industry and investment advisory registrants, and enforcement of antifraud laws, and in the interest of streamlining the rules contained in Chapter 50, the administrator incorporates by reference the following guidelines and statements of policy promulgated by NASAA. This rule does not include any later amendments or editions of the incorporated matter.

The NASAA Web site allows access to statements of policy, comment letters, model rules, NASAA proposals published for comment, and state rule proposals and may be found at www.nasaa.org, under "regulatory & legal activity."

50.66(2) Registration of oil and gas programs. All oil and gas programs filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Registration of Oil and Gas Programs, which were initially adopted by the NASAA membership on September 22, 1976, as amended on October 12, 1977; October 31, 1979; April 23, 1983; July 1, 1984; September 3, 1987; September 14, 1989; October 24, 1991; May 7, 2007; and May 6, 2012; and published in CCH NASAA Reports at paragraph 2621.

50.66(3) Uniform disclosure guidelines—legend. All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Cover Legends as adopted by the NASAA membership on October 2, 2004, and published in CCH NASAA Reports at paragraph 1351.

50.66(4) Omnibus guidelines. All registrations of limited or general partnerships, joint ventures, unincorporated associations, or similar organizations, other than a corporation formed and operated for the primary purpose of investment in and the operation of or gain from and interest in the assets to be acquired by such entity for which statements of policy have not been adopted by the NASAA membership, filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Omnibus Guidelines as adopted by the NASAA membership on March 29, 1992, as amended on May 7, 2007; and published in CCH NASAA Reports at paragraph 2321.

50.66(5) Registration of commodity pool programs. All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Registration of Commodity Pool Programs as adopted by the NASAA membership on September 21, 1983, effective January 1, 1984, amended August 30, 1990, amended May 7, 2007, amended May 6, 2012, and published in CCH NASAA Reports at paragraph 1201.

50.66(6) Registration of equipment programs. All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Equipment Programs as adopted by the NASAA membership on November 20, 1986, effective January 1, 1987, amended April 22, 1988, October 24, 1991, May 7, 2007, and May 6, 2012, and published in CCH NASAA Reports at paragraph 1601.

50.66(7) Registration of real estate programs. All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Real Estate Programs as adopted by the NASAA membership on September 29, 1993, last revised, May 7, 2007, and published in CCH NASAA Reports at paragraph 3601.

50.66(8) Registration of mortgage programs. All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Mortgage Programs as adopted by the NASAA membership on September 10, 1996, amended May 2007, and published in CCH NASAA Reports, paragraph 701.

50.66(9) Real estate investment trusts. The registration of a real estate investment trust may be disallowed if it does not substantially comply, as determined by the administrator, with the NASAA Statement of Policy Regarding Real Estate Investment Trusts as revised and adopted by the NASAA membership on September 29, 1993, as revised on May 7, 2007, and published in CCH NASAA Reports at paragraph 3401.

50.66(10) Corporate securities definitions. For securities registration purposes, the administrator adopts the various definitions set out in the NASAA Statement of Policy Regarding Corporate Securities Definitions as adopted by the NASAA membership on April 27, 1997, and as amended September 28, 1999, and March 31, 2008, and published in CCH NASAA Reports at paragraph 3812.

50.66(11) Impoundment of proceeds. When an impoundment of proceeds is necessary, it shall substantially comply, as determined by the administrator, with the NASAA Statement of Policy Regarding the Impoundment of Proceeds as adopted by the NASAA membership on April 27, 1997,

and as amended September 28, 1999, and March 31, 2008, and published in CCH NASAA Reports at paragraph 2151.

50.66(12) Loans and other material affiliated transactions. When there have been or will be loans or other material affiliated transactions, the transactions shall substantially comply, as determined by the administrator, with the NASAA Statement of Policy Regarding Loans and Other Material Affiliated Transactions as amended by the NASAA membership on April 27, 1997, and March 31, 2008, and published in CCH NASAA Reports at paragraph 374.

50.66(13) Options and warrants. The issuance of options and warrants may be allowed by the administrator if the issuance is in substantial compliance, as determined by the administrator, with the NASAA Statement of Policy Regarding Options and Warrants as adopted by the NASAA membership on November 17, 1997, and as amended September 28, 1999, and as amended March 31, 2008, and published in CCH NASAA Reports at paragraph 2801.

50.66(14) Preferred stock. A public offering of preferred stock may be allowed by the administrator if the offering substantially complies, as determined by the administrator, with the NASAA Statement of Policy Regarding Preferred Stock as adopted by the NASAA membership on April 27, 1997, and as amended March 31, 2008, and published in CCH NASAA Reports at paragraph 3001.

50.66(15) Promotional shares. The registration of a security may include promotional shares if it substantially complies, as determined by the administrator, with the NASAA Statement of Policy Regarding Promotional Shares as adopted by the NASAA membership on April 27, 1997, and as amended September 28, 1999, and March 31, 2008, and published in CCH NASAA Reports at paragraph 3201.

50.66(16) Risk disclosure. All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Risk Disclosure as adopted by the NASAA membership on September 8, 2001, and published in CCH NASAA Reports at paragraph 1362.

50.66(17) Unsound financial condition. An issuer may be deemed to be in an unsound financial condition if it substantially meets, as determined by the administrator, the conditions provided within the NASAA Statement of Policy Regarding Unsound Financial Condition as adopted by the NASAA membership on April 27, 1997, and as amended September 28, 1999, and March 31, 2008, and published in CCH NASAA Reports at paragraph 3821.

50.66(18) Use of proceeds. The registration of a security may be disallowed if it does not substantially comply, as determined by the administrator, with the NASAA Statement of Policy Regarding Specificity in Use of Proceeds as adopted by the NASAA membership on April 27, 1997, and as amended September 28, 1999, and March 31, 2008, and published in CCH NASAA Reports at paragraph 3831.

50.66(19) Registration of asset-backed securities. All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Registration of Asset-Backed Securities as adopted by the NASAA membership on October 25, 1995, amended May 7, 2007, and May 6, 2012, and published in CCH NASAA Reports at paragraph 501.

This rule is intended to implement Iowa Code sections 502.305(6) and 502.306(1).
[ARC 1076C, IAB 10/2/13, effective 11/6/13; ARC 2175C, IAB 9/30/15, effective 11/4/15]

191—50.67(502) Amendments to registration by qualification. A registration statement registered by qualification pursuant to Iowa Code section 502.304 is presumed to be reasonably current for purposes of Iowa Code section 502.305(9) if:

1. The issuer notifies the administrator in writing of any change in a material fact contained in the registration statement no later than 7 days after the issuer learns of the change; and
2. The issuer notifies the administrator in writing of the results of an annual audit or semiannual report no later than 14 days after receiving such audit results or semiannual report unless the results constitute a change in material fact subject to the provisions of paragraph "1."

This rule is intended to implement Iowa Code section 502.305(9).

191—50.68(502) Delivery of prospectus. As a condition to registration by qualification pursuant to Iowa Code section 502.304, a prospectus containing the information required by Iowa Code section 502.304(2) shall be delivered to each person to which an offer is made, before or concurrently with the earliest of the following events:

1. The first offer made in a record to each person otherwise than by means of a public advertisement, by or for the account of the issuer or any other person on whose behalf the offering is made, or by any underwriter or broker-dealer offering part of an unsold allotment or subscription taken as a participant in the distribution;
 2. The confirmation of any sale made by or for the account of the person;
 3. The payment pursuant to any such sale; or
 4. The delivery of the security pursuant to any such sale.
- This rule is intended to implement Iowa Code section 502.304(5).

191—50.69(502) Advertisements.

50.69(1) The following advertising regarding the offer, sale or purchase of any security in Iowa is exempt from the filing requirements of Iowa Code section 502.504:

- a. A prospectus published or circulated regarding an offering of a security registered pursuant to Iowa Code section 502.303 or 502.304 that is not yet effective, or an offering of a security for which a notice or application for exemption, including the prospectus, has been filed pursuant to Iowa Code section 502.201 or 502.202;
- b. Advertising which provides information regarding only from whom a prospectus may be obtained, a description of the security offered for sale, the price of the security, or the names of broker-dealers having an interest in its sale;
- c. Advertising published by a registered broker-dealer or investment adviser concerning the qualifications or business of the registrant, the general advisability of investing in securities or market quotations or other factual information relating to particular securities or issuers, provided the advertising contains no recommendation concerning the purchase or sale of a particular security;
- d. Unless specifically requested by the administrator, advertising filed with FINRA or that satisfies the requirements of Securities Act of 1933 Rules 230.135a, 230.156, or 230.482; and
- e. Any other advertising the administrator may specify by order.

50.69(2) All advertising required to be filed with the administrator by a registrant shall be filed prior to the date of use. All advertising required to be filed by a person other than a registrant shall be filed at least ten days prior to the date of use, or a shorter period if provided by the administrator. The advertising shall not be used in Iowa until the registrant receives approval from the administrator.

50.69(3) Sales literature of an investment company registered pursuant to the Investment Company Act of 1940 which is materially misleading within the meaning of rules or a statement of policy of the SEC constitutes false or misleading advertising as prohibited by Iowa Code section 502.504(2A).

50.69(4) False or misleading advertisements prohibited by Iowa Code section 502.504(2A) include, but are not limited to, the following:

- a. Comparison charts or graphs showing a distorted, unfair, or unrealistic relationship between the issuer's past performance, progress, or success and that of another company, business, industry, or investment media;
- b. Layout or format omitting information necessary to make the entire advertisement a fair and truthful representation;
- c. Statements or representations without accreditation predicting future profit, success, appreciation, or performance, or otherwise addressing the merit or potential of the securities;
- d. Generalizations, generalized conclusions, opinions, representations, and general statements based upon a particular set of facts and circumstances unless those facts and circumstances are stated and modified or explained by additional facts or circumstances as are necessary to make the entire advertisement a full, fair, and truthful representation;

e. Sales kits or film clips, displays or exposures, which alone or by sequence and progressive compilation present a misleading impression of guaranteed or exaggerated potential, profit, safety, or return;

f. Distribution of any nonfactual or inaccurate data or material by words, pictures, charts, or graphs, or otherwise based upon conjectural, unfounded, extravagant, or flamboyant claims, assertions, or predictions, or upon excessive optimism; and

g. Any package or bonus deal, prize, gimmick, or similar inducement regarding the offer or sale of a security that is combined with or dependent upon the sale of some other product, contract, or service unless the combination has been fully disclosed and specifically described and identified in the advertisement.

50.69(5) Any business card or other advertisement containing the name of an agent shall:

a. Clearly designate the agent as a securities agent or registered representative of the broker-dealer, as applicable, and indicate clearly that the broker-dealer is a broker-dealer;

b. Contain no advertising other than agent name, office address, broker-dealer name, and broker-dealer logo or trademark on the business cards;

c. Provide the office address and telephone number of the location where the agent conducts securities business; and

d. Clearly state the business of that entity and the relationship of the agent to that entity if the name, logo or trademark of any business entity other than that of the broker-dealer appears on the business card or in an advertisement.

50.69(6) A firm employing a sales agent who is offering securities on its behalf is responsible for ensuring that the name of the broker-dealer is displayed on the agent's business cards as prominently as the individual's name.

50.69(7) For the purpose of this rule, "advertisement" means any written or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, or other electronic communications media, published regarding the offer, sale, or purchase of a security.

This rule is intended to implement Iowa Code section 502.504.
[ARC 9169B, IAB 10/20/10, effective 11/24/10]

191—50.70 to 50.79 Reserved.

DIVISION VI
EXEMPTIONS

191—50.80(502) Uniform limited offering exemption.

50.80(1) This rule is the NASAA Uniform Limited Offering Exemption as adopted in September 1983, with amendments adopted through April 29, 1989, without any of the footnotes and may be cited as the "Uniform Limited Offering Exemption."

a. Nothing in this exemption is intended to or should be in any way construed as relieving issuers or persons acting on behalf of issuers from providing disclosure to prospective investors adequate to satisfy the antifraud provisions of Iowa Code chapter 502 and these rules.

b. In view of the objective of this rule and the purposes and policies underlying Iowa Code chapter 502, the exemption is not available to any issuer for any transaction which, although in technical compliance with this rule, is part of a plan or scheme to evade registration or the conditions or limitations explicitly stated in this rule.

c. Nothing in this rule is intended to relieve registered broker-dealers or agents from the due diligence, suitability, "know your customer" standards, or any other requirements of law otherwise applicable to such registered persons.

50.80(2) Under the authority delegated to the administrator to promulgate rules by Iowa Code sections 502.203 and 502.605(1), the following transaction is exempt from the registration provisions of the Act:

a. Any offer or sale of securities offered or sold in compliance with the Securities Act of 1933, Regulation D, Rule 230.505, including any offer or sale made exempt by Rule 508(a), as made effective

in Release No. 33-6389 and as amended by Release Nos. 33-6437, 33-6663, 33-6758, and 33-6825, and which satisfies all of the following:

(1) No commission, fee or other remuneration shall be paid or given, directly or indirectly, to any person for soliciting any prospective purchaser in Iowa unless the person is registered under Iowa Code section 502.406 or is exempt from registration as a broker-dealer by Iowa Code section 502.401(2).

(2) It is a defense to a violation of this subrule if the issuer sustains the burden of proof to establish that the issuer did not know, and in the exercise of reasonable care could not have known, that the person receiving a commission, fee, or other remuneration was not appropriately registered in Iowa.

b. No exemption under this rule is available for the securities of any issuer if any of the parties described in the Securities Act of 1933, Regulation A, Rule 230.262(a), (b), or (c):

(1) Has filed a registration statement subject to a currently effective registration stop order entered under any state's securities law within five years prior to filing the notice required under this exemption;

(2) Has been convicted, within five years prior to filing the notice required under this exemption, of any felony or misdemeanor regarding the offer, purchase or sale of any security or any felony involving fraud or deceit including, but not limited to, forgery, embezzlement, obtaining money under false pretenses, larceny, or conspiracy to defraud;

(3) Is currently subject to any state administrative enforcement order or judgment entered by that state's securities administrator within five years prior to filing the notice required under this exemption, or is currently subject to any state's administrative enforcement order or judgment in which fraud or deceit including, but not limited to, making untrue statements of material facts and omitting to state material facts, was found and the order or judgment was entered within five years prior to filing the notice required under this exemption;

(4) Is currently subject to any state administrative enforcement order or judgment prohibiting, denying, or revoking the use of any exemption from registration regarding the offer, purchase or sale of securities; or

(5) Is currently subject to any order, judgment, or decree of any court of competent jurisdiction temporarily or preliminarily restraining or enjoining, or permanently restraining or enjoining the party from engaging in or continuing any conduct or practice regarding the purchase or sale of any security, or involving the making of any false filing with the state entered within five years prior to filing the notice required under this exemption.

(6) The disqualification of a person under paragraph 50.80(2)"b" may be waived by the administrator if the order, conviction, judgment or decree relating to the person's disqualification has been disclosed in writing to the administrator and the administrator has determined, for good cause shown, that the public interest no longer requires the person to be disqualified.

(7) It is a defense to a violation of this subrule if the issuer sustains the burden of proof to establish that the issuer did not know, and in the exercise of reasonable care could not have known, that a disqualification under this subrule existed.

c. In all sales to nonaccredited investors in Iowa, one of the following conditions must be satisfied or the issuer and any person acting on its behalf shall have reasonable grounds to believe, and after making reasonable inquiry shall believe, that one of the following conditions is satisfied:

(1) The investment is suitable for the purchaser based upon facts, if any, disclosed by the purchaser regarding the purchaser's other security holdings, financial situation and needs. For this condition only, it is presumed that if the investment does not exceed 10 percent of the investor's net worth, it is suitable.

(2) The purchaser, either alone or with a purchaser's representative, has such knowledge and experience in financial and business matters that the purchaser is, or they are, capable of evaluating the merits and risks of the prospective investment.

50.80(3) The failure to comply with a term, condition or requirement of subparagraph 50.80(2)"a"(1), paragraph 50.80(2)"c" or paragraph 50.80(2)"e" will not result in loss of the exemption from the requirements of Iowa Code section 502.301 for any offer or sale to a particular individual or entity if the person relying on the exemption shows:

a. The failure to comply did not pertain to a term, condition or requirement directly intended to protect that particular individual or entity;

b. The failure to comply was insignificant regarding the offering as a whole; and

c. A good-faith and reasonable attempt was made to comply with all applicable terms, conditions, and requirements of subparagraph 50.80(2) "a"(1), paragraph 50.80(2) "c" and paragraph 50.80(2) "e."

50.80(4) Where an exemption is established only through reliance upon subrule 50.80(3), the failure to comply is actionable under Iowa Code sections 502.603 and 502.604.

50.80(5) Transactions exempt under this rule may not be combined with offers and sales exempt under any other rule or provision of the Act. However, nothing in this limitation shall act as an election. Should for any reason the offer and sale fail to comply with all of the conditions for this exemption, the issuer may claim the availability of any other applicable exemption.

50.80(6) The administrator may, by rule or order, increase the number of purchasers or waive any other conditions of this exemption.

This rule is intended to implement Iowa Code section 502.203.

[ARC 2175C, IAB 9/30/15, effective 11/4/15]

191—50.81(502) Notice filings for Rule 506 offerings. Beginning January 1, 2016, an issuer offering a security that is a covered security pursuant to Section 18(b)(4)(D) of the Securities Act of 1933 shall submit no later than 15 days after the first sale of such federal covered security in Iowa an electronic filing and fees through www.efdnasaa.org, under "filers and issuers."

This rule is intended to implement Iowa Code section 502.302(3).

[ARC 2175C, IAB 9/30/15, effective 11/4/15]

191—50.82(502) Notice filings for agricultural cooperative associations.

50.82(1) An agricultural cooperative association issuing notes or other evidence of indebtedness shall notify the administrator in writing 30 days before the security is initially sold. Notification shall include:

a. The name of the issuer, the date of organization of the issuer, and the name of a contact person.

b. A description of the class of persons to whom the offer of securities will be made. If the offering is being made to certain persons or within a specified area, a description of such offerees or area shall be included.

c. A description of the type of security to be offered which includes information regarding interest and interest payment schedules, default, redemption, reinvestment, and other facts regarding the rights of holders that the issuer deems material to the offering.

d. Financial statements of the agricultural cooperative association including a balance sheet as of the end of its most recent fiscal year, prepared under generally accepted accounting principles and accompanied by an independent auditor's report and any other audited financial statements of the association that are available. However, if the filing by the agricultural cooperative association is made within 90 days of the end of its most recent fiscal year and current audited financial statements are not yet available, the filing may consist of an audited balance sheet and other available audited financial statements for the previous fiscal year, prepared under generally accepted accounting principles and accompanied by an independent auditor's report. The agricultural cooperative association shall file an audited balance sheet and any other available audited financial statements for the most recent fiscal year end as soon as they become available, but in no event later than 90 days after the end of its fiscal year.

50.82(2) If, after the anniversary date of its initial notice filing, an agricultural cooperative association continues to issue notes or other evidence of indebtedness under its initial notice filing in order to maintain the exemption, the agricultural cooperative association shall on an annual basis file with the administrator an audited balance sheet and any other audited financial statements within 30 days of the anniversary of its initial notice filing. An agricultural cooperative association making its initial filing based upon a previous year's audited financial statements because of the unavailability of current audited financial statements shall consider its anniversary date to be the date on which the cooperative filed the audited financial statements for the most recent fiscal year. An agricultural cooperative association not issuing notes or other evidence of indebtedness after an anniversary date

of its initial filing is not required to make any further filing of financial information as a condition of qualifying for the exemption from registration.

This rule is intended to implement Iowa Code section 502.201(8B) "b."
[ARC 2175C, IAB 9/30/15, effective 11/4/15]

191—50.83(502) Unsolicited order exemption.

50.83(1) Any unregistered broker-dealer effecting a transaction under an unsolicited order or offer to buy and claiming an exemption from registration based solely upon Iowa Code section 502.202(6) shall obtain acknowledgment from the customer on or before the settlement date of the transaction that the transaction is unsolicited.

50.83(2) The acknowledgment shall take one of the following forms:

a. A confirmation statement, as required pursuant to subrule 50.83(1), displaying in bold print on the face of the statement the words "Unsolicited Order, Notify Immediately if Otherwise"; or

b. A signed statement from the customer acknowledging that the order was unsolicited and containing the name of the customer, the name of the securities involved, the number of securities involved in the transaction, the purchase price of the securities, the transaction date, and the total dollar amount, including commissions paid, of the transaction.

50.83(3) The customer will be presumed to have acknowledged that the transaction was unsolicited if the customer does not indicate otherwise on or before the settlement date.

50.83(4) A broker-dealer shall notify the administrator in writing that it is executing unsolicited orders in a security when both of the following conditions are met:

a. More than six unsolicited orders or offers to buy such security are received during any three consecutive business days; and

b. The broker-dealer is relying solely upon the exemption provided by Iowa Code section 502.202(6).

This rule is intended to implement Iowa Code section 502.202(6).

191—50.84(502) Solicitation of interest exemption.

50.84(1) An offer, but not a sale, of a security made by or on behalf of an issuer for the sole purpose of soliciting an indication of interest in receiving a prospectus (or its equivalent) for such security is exempt from registration pursuant to Iowa Code section 502.301 if:

a. The issuer is or will be a business entity organized under the laws of one of the states or possessions of the United States or one of the provinces or territories of Canada, is engaged in or proposes to engage in a business other than petroleum exploration or production or mining or other extractive industries, and is not a blind pool offering or other offering for which the specific business or properties cannot now be described.

b. The offerer intends to register the security in Iowa and conduct its offering pursuant to either Regulation A or Rule 504 of Regulation D, as promulgated by the SEC.

c. The offerer files with the administrator a SOIF along with any other materials to be used to conduct solicitations of interest including, but not limited to, the script of any broadcast to be made and a copy of any notice to be published no less than ten business days prior to the initial solicitation of interest.

d. The issuer files with the administrator all amendments to any materials filed pursuant to paragraph "c" or additional materials it proposes to use in conducting solicitations of interest, except for materials provided to a particular investor solely pursuant to a request by that investor, no less than five business days prior to use.

e. The offerer does not use any SOIF, script, advertisement, or other material which the administrator has ordered or notified the offerer may not be used for the purpose of solicitations of interest.

f. Except for scripted broadcasts and except to the extent necessary to obtain information needed to provide a SOIF, the offerer does not orally communicate with any prospective investor about the

contemplated offering unless the investor is provided with the most current SOIF at or before the time of the communication or within five days after the communication.

g. The offerer does not solicit or accept money or a commitment to purchase securities during the solicitation of interest period.

h. The offerer does not make a sale until at least seven days after delivery to the purchaser of a final prospectus or delivery of a preliminary prospectus as provided by Iowa Code section 502.202(17).

50.84(2) Unless the offerer does not know, and in the exercise of reasonable care could not know, the exemption under this rule is not available for securities of an offerer, if any of the issuer's officers, directors, promoters, or 10 percent shareholders:

a. Have filed a registration statement which is the subject of a current effective registration stop order entered under any federal or state securities law within five years prior to filing the SOIF.

b. Have been convicted within five years prior to filing the SOIF of any felony or misdemeanor regarding the offer, purchase or sale of any security or any felony involving fraud or deceit including, but not limited to, forgery, embezzlement, obtaining money under false pretenses, larceny, or conspiracy to defraud.

c. Are currently subject to any federal or state administrative enforcement order or judgment entered by any state securities administrator or the SEC within five years prior to filing the SOIF in which fraud or deceit, including, but not limited to, the making of untrue statements of material facts and omitting to state material facts, was found.

d. Are subject to any federal or state administrative order or judgment prohibiting, denying, or revoking the use of any exemption from registration regarding the offer, purchase or sale of securities.

e. Are currently subject to any order, judgment, or decree of any court of competent jurisdiction entered within five years prior to filing the SOIF temporarily, preliminarily, or permanently restraining or enjoining the person or entity from engaging in or continuing any conduct or practice regarding the purchase or sale of any security or the making of any false filing with any state.

The disqualifications listed in this subrule shall not apply if the person or entity subject to the disqualification is licensed or registered to conduct securities-related business in the state in which the administrative order or judgment was entered against the person or entity, or if the broker-dealer employing the person or entity is licensed or registered in Iowa and the Form BD filed with the administrator discloses the order, conviction, judgment, or decree. No person disqualified under this subrule may act in a capacity other than that for which the person is licensed or registered. Any disqualification caused by this subrule is automatically waived if the agency creating the disqualification determines for good cause shown that the exemption should not be denied.

50.84(3) The failure to comply with a term, condition or requirement of this rule shall not result in the loss of the exemption from the requirements of Iowa Code section 502.301 for an offer to a particular individual or entity if the offerer establishes all of the following:

a. The failure to comply did not pertain to a term, condition or requirement directly intended to protect that particular individual or entity; and

b. The failure to comply was insignificant regarding the offering as a whole; and

c. A good-faith and reasonable attempt was made to comply with all applicable terms, conditions and requirements of this rule.

Where an exemption is established only through reliance upon subrule 50.84(2), the failure to comply is still actionable as a violation of the Act by the administrator under Iowa Code section 502.603 or 502.604.

50.84(4) The offerer shall comply with the following requirements:

a. Any published notice or script for broadcast and any printed material delivered apart from the SOIF, unless a SOIF containing the disclosures described below was previously delivered to the person, shall contain, at a minimum, the identity of the chief executive officer of the issuer, a brief and general description of the issuer's business and products, and the following disclosure printed in capital letters and boldface type at least as large as that used in the body of the printed materials:

(1) NO MONEY OR OTHER CONSIDERATION IS BEING SOLICITED AND NONE WILL BE ACCEPTED.

(2) NO SALES OF SECURITIES WILL BE MADE OR A COMMITMENT TO PURCHASE ACCEPTED UNTIL THE DELIVERY OF AN OFFERING CIRCULAR THAT INCLUDES COMPLETE INFORMATION ABOUT THE ISSUER AND THE OFFERING.

(3) AN INDICATION OF INTEREST MADE BY A PROSPECTIVE INVESTOR INVOLVES NO OBLIGATION OR COMMITMENT OF ANY KIND.

(4) THIS OFFER IS BEING MADE PURSUANT TO AN EXEMPTION UNDER FEDERAL AND STATE SECURITIES LAWS. NO SALE MAY BE MADE UNTIL THE OFFERING STATEMENT IS QUALIFIED BY THE U.S. SECURITIES AND EXCHANGE COMMISSION AND IS REGISTERED IN IOWA.

b. All communications with prospective investors made in reliance upon this rule shall cease after a registration statement is filed with the administrator, and no sale may be made until at least 20 calendar days after the last communication made in reliance upon this rule.

c. A preliminary prospectus may be used with an offering for which indications of interest have been solicited under this rule only if the offering is conducted by a registered broker-dealer.

Failure to comply with the requirements of this subrule shall not result in losing the exemption from the requirements of Iowa Code section 502.301, but is a violation of the Act, is actionable by the administrator under Iowa Code section 502.603 or 502.604, and constitutes grounds for denying or revoking the exemption for specific transactions.

50.84(5) Upon written application by the offerer and for good cause shown, the administrator may waive any condition of the solicitation of interest exemption. Neither compliance nor attempted compliance with this rule, nor the absence of any objection or order by the administrator regarding an offer of securities made under this rule, constitutes a waiver of any condition of the rule or a confirmation by the administrator of the availability of the rule.

50.84(6) Offers made in reliance upon this rule shall not be integrated with subsequent offers or sales of securities registered in Iowa. Issuers on whose behalf indications of interest are solicited under this rule may not make offers or sales in reliance upon Iowa Code section 502.202(14) or rule 191—50.80(502) until at least 12 months after the last communication with a prospective investor made pursuant to this rule.

50.84(7) Nothing in this rule limits the application of Iowa Code section 502.401, 502.402, 502.501 or 502.509 to offers made in reliance upon this rule.

50.84(8) The administrator may review the materials filed under this rule. Materials filed, if reviewed, will be judged under antifraud principles. Any discussion in the offering documents of the potential rewards of the investment must be balanced by a discussion of the possible risks.

50.84(9) Any offer effected in violation of this rule may constitute an unlawful offer of an unregistered security for which civil liability attaches under Iowa Code section 502.501 et seq. Any misrepresentation or omission may also give rise to civil liability under the Act. A subsequent registration of the security does not cure the previous unlawful offer. Only a rescission offer made in compliance with the Act can effect a cure.

This rule is intended to implement Iowa Code section 502.202(17).

191—50.85(502) Internet offers exemption. Offers of securities made by, or on behalf of, issuers on or through the Internet are exempt from registration pursuant to Iowa Code sections 502.301 and 502.504 if:

1. The Internet offer states, directly or indirectly, that the securities are not being offered to state residents; and

2. The Internet offer is not specifically directed to any person in Iowa by, or on behalf of, the issuer of the securities; and

3. No sales of the issuer's securities are made in Iowa as a result of the Internet offering until such time as the securities being offered have been registered under Iowa Code sections 502.301 and 502.504, and a final prospectus or Form U-7 is delivered to Iowa investors prior to such sales, or the issuer qualifies for the exemption provided in Iowa Code section 502.202(13).

This rule is intended to implement Iowa Code section 502.203.

191—50.86(502) Denial, suspension, revocation, condition, or limitation of limited offering transaction exemption. The administrator shall view the following as reasons for entering an order under Iowa Code section 502.204 to deny or revoke an exemption provided under Iowa Code section 502.202(14):

1. A public advertisement is used to promote the sale of securities for which such exemption is claimed; or
 2. The offering is part of a registered offering under the Securities Act of 1933.
- This rule is intended to implement Iowa Code section 502.204.

191—50.87(502) Nonprofit securities exemption.

50.87(1) Church extension funds or similar organizations making continuous offerings shall be exempt pursuant to Iowa Code section 502.201(7) “*b*” provided the issuer:

- a. Applies for the exemption;
- b. Files an offering circular and otherwise substantially complies with the NASAA Statement of Policy Regarding Church Extension Funds as adopted by the NASAA membership on April 17, 1994, and amended by the NASAA membership on April 18, 2004, and published in CCH NASAA Reports at paragraph 1951;
- c. Files all sales and advertising literature;
- d. Files a consent to service of process;
- e. Unless disallowed by the administrator within 15 days after the applicant has filed the items required by paragraphs 50.87(1) “*a*” to “*d*,” is authorized beginning 15 days after the filing is received to sell pursuant to the exemption;
- f. After authorization, may sell securities for a period of 12 months; and
- g. Upon the expiration of the 12-month period in paragraph 50.87(1) “*f*,” files a renewal application that complies with the requirements of this subrule.

50.87(2) Church bonds and other one-time offerings for a single specific project shall be exempt pursuant to Iowa Code section 502.201(7) “*a*” provided the issuer:

- a. Files a notice specifying the material terms of the offering that comply with the NASAA Statement of Policy Regarding Church Bonds as adopted by the NASAA membership on April 14, 2002, and published in CCH NASAA Reports at paragraph 1001; and
- b. Files a consent to service of process.

This rule is intended to implement Iowa Code section 502.201(7).

[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.88(502) Transactions with specified investors. The administrator grants the exemption for transactions with specified investors to the following persons:

50.88(1) Any director, executive officer, or general partner of the issuer of the securities being offered or sold, or any director, executive officer, or general partner of a general partner of that issuer.

50.88(2) Any natural person whose individual net worth, or joint net worth with that person’s spouse, at the time of the purchase exceeds \$1 million, excluding the value of the primary residence of the natural person.

50.88(3) Any natural person who had an individual income in excess of \$200,000 in each of the two most recent years or joint income with that person’s spouse in excess of \$300,000 in each of those years and has a reasonable expectation of reaching the same income level in the current year.

50.88(4) Any venture or seed capital company. For purposes of this subrule, a venture or seed capital company is a corporation, partnership or association that has been in existence for five years or whose net assets exceed \$250,000 and whose primary business is investing in developmental stage companies or “eligible small business companies” as that term is defined in the regulations of the Small Business Administration.

This rule is intended to implement Iowa Code section 502.202(13).

[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.89(502) Designated securities manuals. Nationally recognized securities manuals for purposes of Iowa Code section 502.202(2) “d” include Mergent’s Manuals, S & P Capital IQ Standard Corporation Descriptions, Fitch Investment Services, and Best’s Insurance Reports, Life-Health.

This rule is intended to implement Iowa Code section 502.202(2) “d.”
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

191—50.90 to 50.99 Reserved.

DIVISION VII
FRAUD AND OTHER PROHIBITED CONDUCT

191—50.100(502) Fraudulent practices.

50.100(1) An issuer of securities registered under the Act, or any person who is an officer, director or controlling person of such issuer, is presumed to employ a “device, scheme or artifice to defraud” the purchasers of such securities under Iowa Code section 502.501(1) if such person applies, authorizes or causes to be applied any material part of the proceeds from the sale of such securities in any material way contrary to the purposes specified in the prospectus used in offering such securities and not reasonably related to the business of the issuer as described in the prospectus.

50.100(2) A broker-dealer or agent employing one or more of the following practices engages in an “act, practice, or course of business which operates or would operate as a fraud” under Iowa Code section 502.501(3):

a. Entering into any security transaction with a customer at an unreasonable price or at a price not reasonably related to the current market price of the security or receiving an unreasonable commission or profit.

b. Contradicting or negating the importance of any information contained in a prospectus or other offering materials with intent to deceive or mislead or using any advertising or sales presentation in a deceptive or misleading manner.

c. In connection with the offer, sale, or purchase of a security, falsely leading a customer to believe that the broker-dealer or agent possesses material, nonpublic information impacting the value of the security.

d. In connection with the solicitation of a sale or purchase of a security, engaging in a pattern or practice of making contradictory recommendations to different investors of similar investment objectives for some to sell and others to purchase the same security, at or about the same time, when the recommendation is not justified by the particular circumstances of each investor.

e. Failing to make a bona fide public offering of all the securities allotted to a broker-dealer for distribution by, among other things, (1) transferring securities to a customer, another broker-dealer or a fictitious account with the understanding that those securities will be returned to the broker-dealer or its nominees, or (2) parking or withholding securities.

f. Effecting any transaction in, or inducing the purchase or sale of, any security by means of any manipulative, deceptive or other fraudulent device or contrivance including, but not limited to, the use of “boiler-room” tactics such as repeated or harassing unsolicited telephone calls or the use of fictitious or nominee accounts.

50.100(3) Although nothing in this rule precludes applying the general antifraud provisions to any person who engages in practices similar to paragraphs “a” through “h” listed below, the listed practices apply only to soliciting a purchase or sale of OTC non-NASDAQ equity securities and excludes interests in direct participation programs and shares in open-end mutual funds:

a. Failing to disclose the entity’s present bid and ask price of a particular security at the time of solicitation.

b. Failing to advise the customer, both at the time of solicitation and on confirmation, of the total of all charges and fees related to a specific securities transaction.

c. In connection with a principal transaction, failing to disclose, both at the time of solicitation and upon confirmation, a short inventory position in the entity’s account of more than 5 percent of the

issued and outstanding shares of that class of securities of the issuer, if the entity is a market maker at the time of solicitation.

- d. Conducting sales contests in a particular security.
- e. After a solicited purchase by a customer, failing or refusing, for a principal transaction, to promptly execute sell orders.
- f. Refusing to sell existing securities held by the customer unless the customer executes a purchase transaction.
- g. Soliciting a secondary market when there has not been a bona fide distribution in the primary market.
- h. Engaging in a pattern of compensating an agent in different amounts for effecting sales and purchases in the same security.

This list is not intended to be all-inclusive. Engaging in other conduct including, but not limited to, forgery, embezzlement, conversion, nondisclosure, incomplete disclosure or misstatement of material facts may also be deemed fraudulent.

This rule is intended to implement Iowa Code section 502.501.

191—50.101(502) Rescission offers.

50.101(1) Rescission offers made pursuant to Iowa Code section 502.510 shall be typed or printed and shall be captioned “RESCISSON OFFER” in boldface print or type. The rescission offer shall be delivered to each offeree personally or shall be sent by certified mail to the offeree’s last-known address and shall contain the following information:

- a. The name of the security which is the subject of the offer.
- b. A reasonably detailed statement indicating why liability under Iowa Code section 502.509 may have arisen and fairly and adequately advising the offeree of the offeree’s rights pursuant to the Act.
- c. An offer to repurchase the security pursuant to Iowa Code section 502.510(1) “b” to “f,” as applicable.
- d. A statement that the offeree’s right to bring an action under the Act may be lost unless the offeree accepts the offer within 30 days after receiving the offer, or any shorter period, of not less than three days, that the administrator, by order, specifies.
- e. Sufficient information about the issuer and the security offered to permit the offeree to make an informed decision regarding acceptance of the rescission offer including, but not limited to, information about the issuer’s organization and management, its operations and plan of business, and its financial condition as shown by a current financial statement prepared under generally accepted accounting principles.
- f. A form by which the offeree may accept the offer and a statement explaining that the offeree may accept the offer by returning the form to the offerer at the provided address by first-class mail, or any other type of mail.
- g. If the basis for relief under Iowa Code section 502.510 alleges a violation of Iowa Code section 502.509 which employed a device, scheme, or artifice to defraud, made an untrue statement of material fact necessary in order to make the statement made, in light of the circumstances under which it was made, not misleading, or engaged in an act, practice, or course of business that operated or would operate as a fraud or deceit on another person, in capital letters and boldface type at least as large as that used in the body of the printed materials, and placed immediately before the signature of the offerer, the following statement:

THIS IS A RESCISSION OFFER MADE PURSUANT TO IOWA CODE SECTION 502.510, A COPY OF WHICH IS ON FILE WITH THE IOWA SECURITIES AND REGULATED INDUSTRIES BUREAU. THE BUREAU MAKES NO RECOMMENDATION AS TO WHETHER THE OFFER SHOULD BE ACCEPTED OR REJECTED NOR HAS THE BUREAU PASSED UPON THE ADEQUACY OR ACCURACY OF THIS OFFER.

50.101(2) If the basis for relief under Iowa Code section 502.510 alleges a violation of Iowa Code section 502.509 which employed a device, scheme, or artifice to defraud, made an untrue statement of material fact necessary in order to make the statement made, in light of the circumstances under which it was made, not misleading, or engaged in an act, practice, or course of business that operated or would

operate as a fraud or deceit on another person, prior to making a rescission offer pursuant to Iowa Code section 502.510, the offerer shall file with the administrator:

- a. A copy of the rescission offer;
- b. The names and addresses of all holders or sellers who are to receive the rescission offer; and
- c. Financial statements proving that the offerer's assets are sufficient to meet its obligations should all offerees accept the rescission offer.

50.101(3) Rescission offers made pursuant to Iowa Code section 502.510 shall be tendered to all persons to whom liability exists or may exist pursuant to Iowa Code section 502.509.

50.101(4) A rescission offer may be accepted at any time during the period stated in the rescission offer even if an offeree previously rejected the offer.

50.101(5) Rescission offers are subject to the provisions of Iowa Code sections 502.501, 502.501A, 502.505, 502.506, and 502.506A.

50.101(6) The administrator may, in the administrator's discretion, require proof by the offerer of compliance with this rule and the terms of the rescission offer.

50.101(7) A proposal or the making of a rescission offer shall not limit the administrator's administrative or enforcement authority provided by the Act.

This rule is intended to implement Iowa Code sections 502.509 and 502.510.

191—50.102(502) Fraudulent, deceptive or manipulative act, practice, or course of business in providing investment advice.

50.102(1) It shall constitute a fraudulent, deceptive or manipulative act, practice, or course of business for an investment adviser or an investment adviser representative acting as principal for such person's own account, knowingly to sell any security to or purchase any security from a client or, acting as broker for a person other than such client, knowingly to effect any sale or purchase of any security for the account of such client, without disclosing to such client in writing before the completion of such transaction the capacity in which the investment adviser is acting and obtaining the consent of the client to such transaction. The prohibitions of this subrule shall not apply to any transaction with a customer of a broker-dealer if such broker-dealer is not acting as an investment adviser in relation to such transaction.

50.102(2) It shall constitute a fraudulent, deceptive or manipulative act, practice, or course of business for an investment adviser or an investment adviser representative to fail to disclose to any client or prospective client all material facts regarding financial and disciplinary information as provided in 17 CFR Section 275.206(4)-4.

50.102(3) Pooled investment vehicles.

a. It shall constitute a fraudulent, deceptive, or manipulative act, practice, or course of business within the meaning of Iowa Code section 502.502(2) for any investment adviser to a pooled investment vehicle to:

(1) Make any untrue statement of a material fact or to omit to state a material fact necessary to make the statements made, in the light of the circumstances under which they were made, not misleading, to any investor or prospective investor in the pooled investment vehicle; or

(2) Otherwise engage in any act, practice, or course of business that is fraudulent, deceptive, or manipulative with respect to any investor or prospective investor in the pooled investment vehicle.

b. For purposes of this subrule, "pooled investment vehicle" means any investment company as defined in Section 3(a) of the Investment Company Act of 1940 (15 U.S.C. 80a-3(a)) or any company that would be an investment company under Section 3(a) of that Act but for the exclusion provided from that definition by either Section 3(c)(1) or Section 3(c)(7) of that Act (15 U.S.C. 80a-3(c)(1) or (7)).

This rule is intended to implement Iowa Code section 502.502(2).

191—50.103(502) Investment advisory contracts.

50.103(1) It is unlawful for any investment adviser to enter into, extend, or renew any investment advisory contract unless the contract provides in writing all of the following:

a. That the investment adviser shall not be compensated on the basis of a share of capital gains or capital appreciation of the funds or any portion of the funds of the client.

b. That no assignment of the contract may be made by the investment adviser without the consent of the other party to the contract.

c. That the investment adviser, if a partnership, shall notify the other party to the contract of any change in the membership of the partnership within a reasonable time after the change.

50.103(2) The provisions of subrule 50.103(1) shall be construed consistent with Sections 205(b) through (d) of the Investment Advisers Act of 1940, the terms of which shall be defined by Investment Advisers Act of 1940 Rules 275.205-1 and 275.205-2.

50.103(3) The provisions of subrule 50.103(1) shall not prohibit compensation on the basis of a share of capital gains or capital appreciation of the funds or any portion of the funds of the client in compliance with the exemption in 17 CFR Section 275.205-3.

This rule is intended to implement Iowa Code section 502.502(3).

191—50.104 to 50.109 Reserved.

DIVISION VIII
VIATICAL SETTLEMENT INVESTMENT CONTRACTS

191—50.110(502) Application by viatical settlement investment contract issuers and registration of agents to sell viatical settlement investment contracts.

50.110(1) Under this rule, the term “viatical settlement investment contract issuer” includes, but is not limited to, any individual, company, corporation or other entity that offers or sells, directly or indirectly, viatical settlement investment contracts to investors.

50.110(2) A viatical settlement investment contract issuer employing agents in Iowa must make prior application to the administrator for this authority. The application shall be made by letter and shall include:

a. A statement of the issuer’s intent to employ agents for the sale of its viatical settlement investment contracts; and

b. The name, address, social security number and proof of satisfaction of subrule 50.110(3) for each agent.

50.110(3) An applicant for registration as an Iowa-registered agent of an issuer of viatical settlement investment contracts shall file with the administrator:

a. Proof of obtaining a passing grade on the FINRA Series 7 examination;

b. Proof of obtaining a passing grade on the FINRA Series 63 examination;

c. An accurate, complete and signed Form U-4; and

d. A \$30 filing fee.

This rule is intended to implement Iowa Code sections 502.102(2), 502.301 and 502.402.

[ARC 9169B, IAB 10/20/10, effective 11/24/10]

191—50.111(502) Risk disclosure. Viatical settlement investment contract issuers and registered agents of issuers must provide specific, written disclosures of risk to Iowa investors at the time of the initial offer to sell a viatical settlement investment contract. These disclosures must be preceded by the following caption, which must be in bold, 16-point typeface:

IMPORTANT RISK DISCLOSURE INFORMATION—READ BEFORE SIGNING ANY
VIATICAL SETTLEMENT INVESTMENT CONTRACT.

The disclosure must include, at a minimum, the following information:

1. That the actual annual rate of return on any viatical settlement investment contract is dependent upon an accurate projection of the viator’s life expectancy and the actual date of the viator’s death and that an annual “guaranteed” rate of return is not possible;

2. Whether, after purchasing the viatical settlement investment contract, the investor will be responsible for payment of premiums on the contract if the viator lives longer than projected and if the

investor will be responsible for such premiums, the amount of the premium payment and any resulting negative effect on the investor's return;

3. Whether any premium payments on the contract have been escrowed and, if so, the date upon which the escrowed funds will be depleted, who is responsible for payment of premiums after depletion of the funds, and, if applicable, the amount of the premiums;

4. Whether any premium payments on the contract have been waived, whether the investor will be responsible for payment of the premiums if the insurer who wrote the policy terminates the waiver after purchase, and, if applicable, the amount of the premiums;

5. Whether the investor is responsible for payment of premiums on the contract if the viator returns to health and, if applicable, the amount of the premiums;

6. Whether the investor is entitled to all or part of the investor's investment under the contract if the viator's underlying policy is later determined to be null and void;

7. Whether the insurance policy is a group policy and, if so, the special risks associated with group policies including, but not limited to, whether the investor is responsible for payment of additional premiums if the policies are sold or converted;

8. Whether the insurance policy is term insurance and, if so, the special risks associated with term insurance including, but not limited to, whether the investor is responsible for additional premium costs if the viator continues the term policy at the end of the current term;

9. Whether the investor will be the beneficiary or owner of the insurance policy and, if the investor is the beneficiary, the special risks associated with beneficiary status;

10. Whether the insurance policy is contestable and, if so, the special risks associated with contestability including, but not limited to, the risk that the investor will have no claim or only a partial claim to death benefits should the insurer cancel the policy within the contestability period;

11. Who is making the projection of the viator's life expectancy, the information upon which the projection is based, and the relationship of the projection maker to the issuer;

12. Who is monitoring the viator's condition, how often the monitoring is done, how the date of death is determined, and how and when this information will be transmitted to the investor;

13. Whether the insurer who wrote the viator's underlying policy has any additional rights which could negatively affect or extinguish the investor's rights under the viatical settlement investment contract, what these rights are, and under what conditions these rights are activated;

14. That a viatical settlement investment contract is not a liquid investment and that there is no established secondary market for resale of these products by the investor;

15. That the investor will receive no returns (i.e., dividends and interest) until the viator dies; and

16. That the investor may lose all benefits or receive substantially reduced benefits if the insurer goes out of business during the term of the viatical investment.

This rule is intended to implement Iowa Code sections 502.102, 502.201(9E) and 502.301.

191—50.112(502) Advertising of viatical settlement investment contracts.

50.112(1) The issuer and agent shall file all viatical settlement investment contract advertisements with the administrator at least ten business days prior to the date of use or a shorter period as the administrator may permit. The administrator shall mark the advertisements with allowance for use or expressly disapprove them during this time frame. The advertisement shall not be used in Iowa until a copy thereof, marked with allowance for use, has been received from the administrator.

50.112(2) Viatical settlement investment contract advertisements shall contain no more than the following:

- a. The name of the issuer;
- b. The address and telephone number of the issuer;
- c. A brief description of the security, including minimum purchase requirements and liquidity aspects;

d. If a rate of return is advertised, it must be stated as the annual average rate of return, with a disclaimer that this is an annual average rate of return, that individual investor rates of return will vary

based upon the viator's projected and actual date of death, and that an annual rate of return on a viatical settlement investment contract cannot be guaranteed;

e. The name, address and telephone number of the agent of the issuer authorized to sell the viatical settlement investment contracts;

f. A statement that the advertisement is neither an offer to sell nor a solicitation of an offer to purchase and that any offer or solicitation may only be made by providing a disclosure document; and

g. How a copy of the disclosure document may be obtained.

50.112(3) Notwithstanding the provisions of rule 191—50.69(502), certain viatical settlement investment contract advertisements may be deemed false and misleading on their face by the administrator and are prohibited pursuant to Iowa Code sections 502.501 and 502.504. False and misleading viatical settlement investment contract advertisements include, but are not limited to, the following representations:

a. "Fully secured," "100% secured," "fully insured," "secure," "safe," "backed by rated insurance company(ies)," "backed by federal law," "backed by state law," or similar representations;

b. "No risk," "minimal risk," "low risk," "no speculation," "no fluctuation," or similar representations;

c. "Qualified or approved for IRA, Roth IRA, 401K, SEP, 403B, Keogh plans, TSA, other retirement account rollovers," "tax deferred," or similar representations;

d. "Guaranteed fixed return," "guaranteed annual return," "guaranteed principal," "guaranteed earnings," "guaranteed profits," "guaranteed investment," or similar representations;

e. "No sales charges or fees" or similar representations;

f. "High yield," "superior return," "excellent return," "high return," "quick profit," or similar representations;

g. "Perfect investment," "proven investment," or similar representations;

h. Purported favorable representations or testimonials about the benefits of viaticals as an investment, taken out of context from newspapers, trade papers, journals, radio or television programs, or any other form of print or electronic media.

50.112(4) For purposes of this rule, the term "advertisement" includes any written, electronic or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet, or similar communications media, including filmstrips, motion pictures, and videos, published in connection with the offer or sale of a viatical settlement investment contract.

This rule is intended to implement Iowa Code sections 502.102, 502.301, and 502.504.

191—50.113(502) Duty to disclose. Issuers and agents equally share an affirmative duty to disclose all relevant and material information to prospective investors in viatical settlement investment contracts. The required disclosure is the registration statement required by Iowa Code section 502.304 which has been reviewed and made effective by the administrator.

This rule is intended to implement Iowa Code sections 502.102 and 502.201(9E).

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ACCOUNTANCY EXAMINING BOARD[193A]

[Prior to 7/13/88, see Accountancy, Board of[10]]

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CHAPTER 1

DEFINITIONS

[Prior to 7/13/88, see Accountancy, Board of[10]]

193A—1.1(542) Definitions. The following definitions shall be applicable to the rules of the board of accountancy.

“*Act*” means the Accountancy Act of 2001 as amended by 2008 Iowa Acts, chapter 1106.

“*AICPA*” means the American Institute of Certified Public Accountants.

“*Attest*” or “*attest service*” means providing any of the following services:

1. An audit or other engagement to be performed in accordance with the statements on auditing standards.

2. A review of a financial statement to be performed in accordance with the statements on standards for accounting and review services.

3. Any engagement to be performed in accordance with the statements on standards for attestation engagements.

4. Any engagement to be performed in accordance with the auditing standards of the PCAOB.

The standards specified in the definition of “attest” are those standards adopted by the board, by rule, by reference to the standards developed for general application by the AICPA, the PCAOB, or other recognized national accountancy organization.

“*Attest engagement team*” means the team of individuals participating in attest service, including those who perform concurring and second partner reviews. The “attest engagement team” includes all employees and contractors retained by the firm who participate in attest service, irrespective of their functional classification.

“*Audit*” means the procedures performed in accordance with applicable auditing standards for the purpose of expressing or disclaiming an opinion on the fairness with which the historical financial or other information is presented in conformity with generally accepted accounting principles, another comprehensive basis of accounting, or basis of accounting described in the report.

“*Board*” means the accountancy examining board established by Iowa Code section 542.4.

“*Bureau*” means the professional licensing and regulation bureau of the division of banking of the department of commerce.

“*Certificate*” means the certificate of a certified public accountant granted under Iowa Code section 542.6 or 542.19 or a certificate issued under prior corresponding law.

“*Client*” means a person or entity that agrees with a licensee or licensee’s employer to receive a professional service.

“*Commission*” means any form of compensation in a fixed or variable amount or percent received for selling, recommending or referring any product or service of another. “*Commission*” includes a referral fee.

“*Compensation*” means anything of value received by a CPA or LPA while practicing public accounting for selling, recommending or referring a product or service of another.

“*Compilation*” means presenting in the form of a financial statement information that is the representation of any other person without the undertaking to express any assurance on the statement.

“*Contingent fee*” means a fee established for the performance of any service pursuant to an arrangement in which no fee will be charged unless a specified finding or result is attained, or in which the amount of the fee is otherwise dependent upon the finding or result of such service. “*Contingent fee*” does not mean a fee fixed by a court or other public authority or a fee related to any tax matter which is based upon the results of a judicial proceeding or the findings of a governmental agency.

“*CPA*” means certified public accountant.

“*Examination of prospective financial information*” means an evaluation by a CPA of a forecast or projection, the support underlying the assumptions in the forecast or projection, whether the presentation of the forecast or projection is in conformity with AICPA presentation guidelines, and whether the assumptions in the forecast or projection provide a reasonable basis for the projection or forecast.

“*FASB*” means the Financial Accounting Standards Board.

“Financial statement” means a presentation of financial data, including accompanying notes derived from accounting records and intended to communicate an entity’s economic resources or obligations at a point in time or the changes therein for a period of time in conformity with a comprehensive basis of accounting, but does not include incidental financial data included in management advisory services reports to support recommendations to a client, nor does it include tax returns and supporting documents.

“Firm” means a sole proprietorship, partnership, corporation, professional corporation, professional limited liability company, limited liability partnership or any other form of organization issued a permit to practice as a firm under Iowa Code section 542.7 or 542.8 or the office of the auditor of state, state of Iowa, when the auditor of state is a certified public accountant.

“Forecast” means prospective financial statements that present, to the best of the responsible party’s knowledge and belief, an entity’s expected financial position, results of operations, and changes in financial position or cash flows that are based on the responsible party’s assumptions reflecting conditions it expects to exist and the course of action it expects to take.

“GASB” means the Governmental Accounting Standards Board.

“Home office” means the location specified by the client as the address to which an attest or compilation service is directed, which may be a subunit or subsidiary of an entity or the principal office of an entity.

“IASB” means International Accounting Standards Board.

“IFRS” means International Financial Reporting Standards.

“IRS” means the Internal Revenue Service, United States Department of the Treasury.

“License” means a certificate issued under Iowa Code section 542.6 or 542.19, a permit issued under Iowa Code section 542.7 or a license or permit issued under Iowa Code section 542.8 or a certificate, permit or license issued under corresponding prior law.

“Licensed public accountant” means a person licensed by the board pursuant to Iowa Code section 542.8 who does not hold a certificate as a certified public accountant under this chapter. A “licensed public accountant” is not authorized to perform attest services, but may offer to perform or perform for the public any of the following public accounting services:

1. Recording financial transactions in books of record.
2. Making adjustments of financial transactions in books of record.
3. Making trial balances from books of record.
4. Preparing internal verification and analysis of books or accounts of original entry.
5. Preparing financial statements, schedules, or reports.
6. Devising and installing systems or methods of bookkeeping, internal controls of financial data, or the recording of financial data.
7. Preparing compilations.

“Licensed public accounting firm” means a sole proprietorship, corporation, professional corporation, partnership, professional limited liability company, limited liability partnership or any other form of organization issued a permit to practice as a firm of licensed public accountants under Iowa Code section 542.8.

“Licensee” means the holder of a license.

“LPA” means licensed public accountant.

“Managing partner,” “managing shareholder,” or “managing member” means the designated individual with ultimate responsibility for the operation of a firm’s practice.

“NASBA” means the National Association of State Boards of Accountancy.

“NSA” means the National Society of Accountants.

“Office” means any Iowa workspace identified or advertised to the general public as a location where public accounting services are performed.

“Owner” means any person who has equity ownership interest in a CPA or LPA firm.

“PCAOB” means Public Company Accounting Oversight Board. The PCAOB is a private-sector, nonprofit corporation, created by the Sarbanes-Oxley Act of 2002, to oversee the auditors of public companies in order to protect the interests of investors and further the public interest.

“Peer review,” as used in Chapters 11 and 12 of these rules, means a study, appraisal, or review of one or more aspects of the professional work of a licensee or firm that issues attest or compilation reports, by a licensed person or persons not affiliated with the licensee or firm being reviewed. “Peer review” does not include a peer review conducted pursuant to Iowa Code chapter 272C in connection with a disciplinary investigation.

“Person,” unless the context indicates otherwise, means individuals, sole proprietorships, partnerships, corporations, limited liability companies, limited liability partnerships or other forms of entities.

“Person associated with a CPA or LPA” means any owner, partner, shareholder, member, employee, assistant, or independent contractor of a CPA or LPA firm.

“Practice of public accounting” means the performance or the offering to perform, by a person holding oneself out to the public as a certified public accountant or a licensed public accountant, one or more kinds of professional services involving the use of accounting, attest, or auditing skills, including the issuance of reports on financial statements, or of one or more kinds of management advisory, financial advisory, or consulting services, or the preparation of tax returns or the furnishing of advice on tax matters. However, with respect to licensed public accountants, the “practice of public accounting” shall not include attest or auditing services or the rendering of an opinion attesting to the reliability of any representation embracing financial information.

“Practice privilege” means an authorization to practice public accounting in Iowa or for clients with a home office in Iowa without licensure under this chapter, as provided in Iowa Code section 542.20.

“Principal place of business” means the primary location from which public accounting services are performed. A person or firm may only have one principal place of business at any one time. Persons who perform public accounting services at multiple or rotating locations, such as CPAs who perform attest services on assignment as needed in multiple jurisdictions, may designate as their principal place of business the location that most often serves as the person’s home base of operations.

“Projection” means prospective financial statements that present, to the best of the responsible party’s knowledge and belief given one or more hypothetical assumptions, an entity’s expected financial position, results of operations, and changes in financial position or cash flows that are based on the responsible party’s assumptions reflecting conditions it expects would exist and the course of action it expects would be taken given such hypothetical assumptions.

“Report,” when used with reference to any attest or compilation services, means a report, opinion, or other form of a writing that states or implies assurance as to the reliability of the attested information or compiled financial statements and that includes or is accompanied by a statement or implication that the person or firm issuing the report has special knowledge or competence in accounting or auditing. Such statement or implication of special knowledge or competence may arise from use by the issuer of the report of names or titles indicating that the person or firm is an accountant or auditor, or from the language of the report itself. “Report” includes any form of language which disclaims an opinion when such form of language is conventionally understood to imply a positive assurance as to the reliability of the attested information or compiled financial statements referred to or special knowledge or competence on the part of the person or firm issuing the language, and any other form of language that is conventionally understood to imply such assurance or such special knowledge or competence.

“Respondent” means any person against whom a formal statement of charges has been filed or any person whose legal right provided for in Iowa Code chapter 542 shall be determined or affected.

“Review” means to perform inquiry and analytical procedures that permit a CPA to determine whether there is a reasonable basis for expressing limited assurance that there are no material modifications that should be made to financial statements in order for them to be in conformity with generally accepted accounting principles or, if applicable, with another comprehensive basis of accounting.

“SAS” means statements on auditing standards.

“SEC” means the United States Securities and Exchange Commission.

“SSARS” means the statements on standards for accounting and review services.

“*State*” means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or Guam.

“*Substantial equivalency*” means a determination by the board that the education, examination, and experience requirements contained in the statutes and administrative rules of another jurisdiction are comparable to, or exceed, the education, examination, and experience requirements contained in these rules or that an individual licensee’s education, examination, and experience qualifications are comparable to or exceed the education, examination, and experience requirements contained in Iowa Code section 542.6.

“*Year*,” when used in the context as a time measurement of experience in accounting work, means a period of 365 days.

This rule is intended to implement Iowa Code chapter 542.

[ARC 7715B, IAB 4/22/09, effective 7/1/09; ARC 9483B, IAB 5/4/11, effective 6/1/11; ARC 9482B, IAB 5/4/11, effective 6/8/11; ARC 9676B, IAB 8/10/11, effective 7/22/11; ARC 0174C, IAB 6/13/12, effective 7/18/12; ARC 2152C, IAB 9/30/15, effective 11/4/15]

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CHAPTER 3
CERTIFICATION OF CPAS
[Prior to 7/13/88, see Accountancy, Board of[10]]

193A—3.1(542) Qualifications for a certificate as a certified public accountant.

3.1(1) A person of good moral character who makes application pursuant to Iowa Code section 542.6 may be granted a certificate as a certified public accountant if the person satisfies all of the following qualifications:

- a. Satisfactory completion of the educational requirements of Iowa Code section 542.5(7) and rule 193A—3.2(542);
- b. No less than one year of verified experience including the types of services described in Iowa Code section 542.5(12) and rule 193A—3.12(542); and
- c. Successful completion of the examination described in Iowa Code section 542.5(8) and rule 193A—3.5(542) and the ethics course and examination outlined in 193A—3.13(542).

3.1(2) An application may be denied if the applicant:

- a. Has been convicted of a crime described in Iowa Code section 542.5(2);
- b. Has had a professional license of any kind revoked in this or any other jurisdiction, as provided in Iowa Code section 542.5(3);
- c. Makes a false statement of material fact on an application for a certificate or is otherwise implicated in the submission of a false application as provided in Iowa Code section 542.5(4);
- d. Has violated a provision of Iowa Code section 542.20 or has been assessed penalties pursuant to Iowa Code section 542.14 or 193A—Chapter 17;
- e. Is the subject of a notice of noncompliance as provided in 193—Chapter 8;
- f. Demonstrates a lack of moral character in a manner which the board reasonably believes will impair the applicant's ability to practice public accountancy in full compliance with the public interest and state policies described in Iowa Code section 542.2. While it is not possible to itemize all actions or behaviors which may demonstrate a lack of moral character, the following nonexclusive list of factors will guide the board in making its determination:
 - (1) A pattern and practice of making false or deceptive representations, or of omitting material facts, while providing the public any of the services described in Iowa Code section 542.3(20);
 - (2) Fraud or dishonesty while advertising or selling goods or services to the public;
 - (3) Willful or repeated failure to timely file tax returns or other mandatory submittals due a governmental body;
 - (4) Fiscally irresponsible behavior in the absence of mitigating circumstances;
- g. Is subject to discipline on any ground that would form the basis for discipline against a licensee; or
- h. Has had a practice privilege revoked in this or another jurisdiction.

[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—3.2(542) Colleges or universities recognized by the board. Iowa Code section 542.5, in providing for educational qualifications for a certificate as a certified public accountant, refers to colleges or universities "recognized by the board." For such purpose, the board recognizes educational institutions accredited by the Association to Advance Collegiate Schools of Business and the regional accrediting bodies listed in the current publication of the Accredited Institutions of Post Secondary Education, which listing is made a part of these rules by reference.

This rule is intended to implement Iowa Code section 542.5.

[ARC 2152C, IAB 9/30/15, effective 11/4/15]

193A—3.3(542) Accounting concentration.

3.3(1) A candidate will be deemed to have met the educational requirement if, as part of the 150 semester hours of education as outlined in Iowa Code section 542.5, the candidate has met one of the following four conditions:

a. Earned a graduate degree with a concentration in accounting from a program that is accredited in accounting by an accrediting agency recognized by the board.

b. Earned a graduate degree in business from a program that is accredited in business by an accrediting agency recognized by the board and completed at least 24 semester hours in accounting including courses covering the subjects of financial accounting, auditing, taxation, and management accounting. Such accounting hours shall not include elementary accounting or principles of accounting, internships or life experience.

c. Earned a baccalaureate degree in business or accounting from a program that is accredited in business by an accrediting agency recognized by the board and completed at least 24 semester hours in accounting courses covering the subjects of financial accounting, auditing, taxation, and management accounting. Such accounting hours shall not include elementary accounting or principles of accounting, internships or life experience.

d. Earned a baccalaureate or higher degree and completed the following hours from an accredited institution recognized by the board:

(1) At least 24 semester hours in accounting courses above elementary accounting or principles of accounting covering the subjects of financial accounting, auditing, taxation, and management accounting, not including internships or life experience; and

(2) At least 24 additional semester hours in business-related courses, not including internships or life experience. Elementary accounting hours that do not qualify under subparagraph 3.3(1) "d"(1) above may apply toward business-related courses.

Quarter hours will be accepted in lieu of semester hours at a 3:2 ratio; that is, three quarter hours is equivalent to two semester hours. Internships and life experience hours may apply toward the total 150 hours' requirement.

3.3(2) The board will consider correspondence study and study in other schools not meeting the above requirements on an individual basis if the candidate can provide evidence that such study would be acceptable for credit by a college or university recognized by the board; provided, however, that at least 18 of the required hours in accounting and at least 16 of the required hours in business-related subjects must be obtained in a college or university recognized by the board.

3.3(3) The applicant's claim to college or university credits must be confirmed by an official transcript of credit issued by the institution in question. The applicant shall be responsible for having such transcripts sent to the board's test administrator at the time of making application. The applicant shall also be responsible for having any institution not listed under rule 193A—3.2(542) furnish the board evidence that it meets the accreditation requirements of the board.

3.3(4) Graduates of foreign colleges or universities shall have their education evaluated by a foreign credentials evaluation advisory service specified by the board.

193A—3.4(542) Examination applications.

3.4(1) An individual desiring to take the certified public accountant examination as an initial candidate should apply to the board's test administrator. An application shall not be approved until complete in all respects. A complete application includes a completed application form, the designated fee, and all applicable college transcripts.

3.4(2) To be eligible to make application for the examination, a candidate shall fulfill the requirements of rule 193A—3.3(542).

3.4(3) A candidate for the examination who has been convicted in a court of competent jurisdiction in this state, or another state, territory, or a district of the United States, or in a foreign jurisdiction of forgery, embezzlement, obtaining money under false pretenses, theft, extortion, conspiracy to defraud, or other similar offense, or of any crime involving moral character or dishonesty may be denied admittance to the examination by the board on the grounds of the conviction. For purposes of this subrule, "conviction" means a conviction for an indictable offense and includes a guilty plea, deferred judgment from the time of entry of the deferred judgment until the time the defendant is discharged by the court without entry of judgment, or other finding of guilt by a court of competent jurisdiction.

3.4(4) A candidate for examination who has had a professional license of any kind revoked in this or any other jurisdiction may be denied admittance to the examination by the board on the grounds of the revocation.

3.4(5) A candidate who makes a false statement of material fact on an application for examination for a certificate, or who causes to be submitted or has been a party to preparing or submitting a false application for a certificate, may be denied a certificate by the board on the grounds of the false statement or submission.

3.4(6) A candidate may be considered as a reexamination applicant regardless of whether or not the candidate sat for the examination once initially approved. Reexamination applicants may apply by telephone to the board's test administrator or may apply on-line if the technology is available.

3.4(7) A nonrefundable proctoring fee shall be collected from a candidate who wishes to be proctored in Iowa.

193A—3.5(542) Content and grading of the examination.

3.5(1) The board may make use of the uniform certified public accountant's examination prepared by the American Institute of Certified Public Accountants or another nationally recognized organization under a plan of cooperation with the boards of all states and territories of the United States.

3.5(2) The board may also make use of the advisory grading service provided by the American Institute of Certified Public Accountants or another nationally recognized organization under a plan of cooperation with the boards of all states and territories of the United States.

3.5(3) A grade of at least 75 in each subject shall be considered passing.

193A—3.6(542) Conditional requirements.

3.6(1) Effective with the implementation of the computer-based examination, a candidate may take the required test subjects individually and in any order. Except as provided in rule 193A—3.7(542), credit for any subjects passed shall be valid for 18 months from the actual date the candidate sat for the subject, without the candidate's having to attain a minimum score on any failed subject(s) and without regard to whether the candidate sat for any other subjects. The candidate shall also be subject to the following:

a. The candidate must pass all four subjects of the examination within a rolling 18-month period that begins on the date that the first subject is passed. If all four subjects are not passed within the 18-month period, credit for any subject taken outside the 18-month period shall expire.

b. If a candidate fails a subject, the candidate cannot retake the same failed subject in an examination window. An examination window refers to a three-month period in which a candidate has the opportunity to take the examination (comprised of two months when the examination is offered and one month when the examination will not be offered while routine maintenance is performed and the item bank is refreshed). Thus, the candidate will be able to sit for the examination two out of three months within an examination window.

3.6(2) A candidate shall be deemed to have passed the examination once the candidate holds, at the same time, valid credit for passing each of the four subjects of the examination. For purposes of this rule, credit for passing a subject of the examination is valid from the actual date of the testing event for that subject, regardless of the date the candidate actually received notice of the passing score.

This rule is intended to implement Iowa Code section 542.5.

[ARC 9482B, IAB 5/4/11, effective 6/8/11]

193A—3.7(542) Extension of conditional status.

3.7(1) The time limit within which a candidate is required to pass all subjects under these rules shall not include any period during which the candidate was serving in the armed forces of the United States. This exception does not apply if the candidate takes an examination while so serving. The board may extend the time limit in particular instances on a case-by-case basis.

3.7(2) The time limit within which a candidate is required to pass all subjects under these rules may be extended for hardship cases, such as when the applicant for the examination is prevented from

attending for such reasons as unexpected illness, verified by a medical doctor, or a death in the family, verified in writing.

3.7(3) The time limit within which a candidate is required to pass all subjects under these rules may be extended if circumstances occur which prevent the score from an examination from reaching the candidate in a reasonable period of time. Such circumstances would allow the candidate the opportunity to retake a failed subject.

193A—3.8(542) Transfer of credit from another jurisdiction.

3.8(1) A candidate requesting transfer of grades from any other jurisdiction will be subject to the same provisions of these rules as an Iowa candidate, provided that the examination given by the licensing authority in the other state was an examination approved by the Iowa board.

3.8(2) A candidate requesting transfer of grades from any other jurisdiction who does not meet the provisions of these rules, but who meets all of the requirements for issuance of an original certificate in the examining state other than residency, may, at the board's discretion, be required to take at least one section of the examination designated by the board.

193A—3.9(542) Examination procedures.

3.9(1) At the examination, a candidate must provide evidence of identification with two forms of official documentation such as a driver's license, student identification, service identification, or passport that contains the candidate's photograph and signature.

3.9(2) The candidate may be photographed by the test administrator at each appearance for the examination. The test administrator may collect from the candidate a fee for the processing of the photograph.

3.9(3) Scratch paper and supplies furnished by the board's test administrator shall remain the administrator's property and must be returned whether used or not.

3.9(4) In the event that a computer malfunction or failure occurs while the examination is being conducted, the liability of the board or its test administrator will be limited to the fee paid by the applicant for the examination.

193A—3.10(542) Conduct of the examination.

3.10(1) Any individual who subverts or attempts to subvert the examination process may, at the discretion of the board, have the individual's examination scores declared invalid for the purpose of certification in Iowa, be barred from accountancy licensing and certification examinations in Iowa, or be subject to the imposition of other sanctions the board deems appropriate.

3.10(2) Conduct that subverts or attempts to subvert the examination process includes, but is not limited to:

a. Conduct which violates the security of the examination materials, such as removing from the examination room any of the examination materials; reproducing or reconstructing any portion of the licensing examination; aiding by any means in the reproduction or reconstruction of any portion of the licensing examination; selling, distributing, buying, receiving, or having unauthorized possession of any portion of a future, current, or previously administered licensing examination.

b. Conduct which violates the standards of test administration, such as communicating with any other examination candidate during the administration of the licensing examination; communicating with others outside of the examination site during the administration of the examination; copying answers from another candidate or permitting one's answers to be copied by another candidate during the administration of the examination; having in one's possession during the administration of the licensing examination any books, notes, written or printed materials or data of any kind, other than the examination materials distributed.

c. Conduct which violates the examination process, such as falsifying or misrepresenting educational credentials or other information required for admission to the licensing examination; impersonating an examination candidate or having an impersonator take the licensing examination on one's behalf.

3.10(3) Any examination candidate who wishes to appeal a decision of the board under this rule may request a contested case hearing. The request for hearing shall be in writing, shall briefly describe the basis for the appeal, and shall be filed in the board's office within 30 days of the date of the board decision being appealed. Any hearing requested under this subrule shall be governed by the rules applicable to contested case hearings under 193—Chapter 7.

193A—3.11(542) Refunding of examination fees. Examination fees shall not be refunded except in hardship cases, such as when the candidate for the examination is prevented from attending for such reasons as unexpected illness, verified by a medical doctor, a death in the family, or a call to active military service, 50 percent of the fee may be returned. Written documentation including evidence of the hardship shall be provided to the board's test administrator.

193A—3.12(542) Experience for certificate.

3.12(1) Experience shall include providing any type of service or advice involving the use of accounting, attest, compilation, management advisory, financial advisory, tax or consulting skills. Experience may be gained through employment in government, industry, academia, or public practice.

3.12(2) One year of experience shall consist of full- or part-time employment that extends over a period of no less than one year and no more than three years and includes no fewer than 2,000 hours of performance of services outlined in subrule 3.12(1). Experience may be gained in more than one employment situation, including an internship.

3.12(3) An applicant seeking qualification as an attest CPA shall have at a minimum two years of experience as more fully described in 193A—subrule 6.3(1).

3.12(4) All experience shall be verified by a licensee with direct supervisory control over the applicant or by a licensee who can attest that the experience gained by the applicant meets the requirements of subrule 3.12(1) if the applicant is not supervised by a licensee.

3.12(5) Teaching experience shall be in the employment of an institution of higher education and shall include teaching a minimum of 24 semester hours of accounting courses for which the course participants receive credit on an official transcript. Teaching of noncredit continuing education courses shall not qualify under this rule.

193A—3.13(542) Ethics course and examination. A successful candidate shall also be required to pass an examination covering the code of ethical conduct prior to issuance of the certificate.

193A—3.14(542) Obtaining the certificate.

3.14(1) A candidate who successfully passes the examination, completes the ethics course and examination and meets all of the requirements outlined in rule 193A—3.1(542) shall make application for the certificate on a form which may be obtained from the board office or on the board's Web site. An applicant for a certificate may be denied the certificate for reasons outlined in subrule 3.4(3), 3.4(4), or 3.4(5) regardless of when the incident occurred.

3.14(2) A candidate who meets the requirements for a certificate outlined in rule 193A—3.1(542) shall file an application for a certificate within three years of the date of passing the examination. If the candidate does not file an application for a certificate within the required time frame, the candidate must comply with the basic continuing education requirements outlined in rule 193A—10.5(542) prior to filing an application. The required continuing education hours shall include a minimum of eight hours of continuing education every three years devoted to financial statement presentation, such as courses covering the statements on standards for accounting and review services (SSARS) and accounting and auditing updates.

[ARC 9482B, IAB 5/4/11, effective 6/8/11]

193A—3.15(542) Use of title.

3.15(1) Only a person who holds an active, unexpired certificate and who complies with the requirements of 193A—Chapters 5 and 10 or a person lawfully exercising a practice privilege under Iowa Code section 542.20 may use or assume the title “certified public accountant” or the abbreviation

“CPA” or any other title, designation, words, letters, abbreviation, sign, card, or device tending to indicate that such person is a certified public accountant.

3.15(2) Rules regarding the use of the title “CPA” in a firm name are found at 193A—subrule 13.4(14).

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CHAPTER 5
LICENSURE STATUS AND RENEWAL OF CERTIFICATES AND LICENSES
[Prior to 7/13/88, see Accountancy, Board of[10]]
[Prior to 5/1/02, see 193A—Chapter 6]

193A—5.1(542) Licensure status and practice privilege.

5.1(1) Licenses issued by the board pursuant to Iowa Code section 542.6, 542.8, or 542.19 may be in active, inactive, or lapsed status, as follows:

a. An initial license is issued in active status with an expiration date. Maintaining active status requires periodic renewal as provided in rule 193A—5.3(542). Renewal in active status requires satisfaction of continuing education as provided in 193A—Chapter 10.

b. A license may be renewed in inactive status as provided in rule 193A—5.9(272C,542) if the licensee does not satisfy the continuing education required for renewal in active status. A renewal license issued in inactive status shall lapse if not timely renewed pursuant to rule 193A—5.3(542). An inactive license may be reinstated to active status at any time pursuant to subrule 5.9(7).

c. An active or inactive license that is not timely renewed shall be in lapsed status. A lapsed license may be reinstated to active or inactive status at any time pursuant to subrule 5.6(3).

5.1(2) An individual holding an active license is authorized to use the title “CPA” or “LPA,” as applicable, in the individual’s practice of public accounting in Iowa or for a client with a home office in Iowa.

5.1(3) An individual holding an inactive or lapsed license is not authorized to practice public accounting in Iowa or for a client with a home office in Iowa using the title “CPA” or “LPA.”

5.1(4) Practicing public accounting in Iowa or for a client with a home office in Iowa while holding an inactive or lapsed license is a ground for discipline under Iowa Code section 542.10 and may also or alternatively provide grounds for the regulatory actions described in Iowa Code section 542.14.

5.1(5) Out-of-state individuals holding an inactive or lapsed Iowa CPA certificate and out-of-state individuals to whom an Iowa CPA certificate has never been issued under Iowa Code chapter 542 or prior law may exercise a practice privilege under Iowa Code section 542.20 if they hold an active CPA certificate in the jurisdiction in which they maintain their principal place of business and otherwise satisfy all of the conditions described in Iowa Code section 542.20 and 193A—Chapter 20.

5.1(6) Exercising a practice privilege in Iowa or for a client with a home office in Iowa while holding an inactive or lapsed Iowa CPA certificate places a special burden on the individual to ensure that the public is informed about the individual’s licensure status in Iowa and in the jurisdiction of active licensure, as provided in 193A—paragraphs 20.8(2) “b” and 20.8(3) “b.” As a practical matter, an individual’s failure to clarify licensure status in Iowa and in the jurisdiction of the individual’s principal place of business may confuse the public. However, the public may consult CPAVerify, a comprehensive national data bank, to verify an individual’s licensure in another jurisdiction. CPAVerify may be accessed at www.cpaverify.org. A client contacting the board or consulting the board’s Web site will be informed of the individual’s licensure status in Iowa.

[ARC 7715B, IAB 4/22/09, effective 7/1/09; ARC 9482B, IAB 5/4/11, effective 6/8/11; ARC 2152C, IAB 9/30/15, effective 11/4/15]

193A—5.2(542) Renewal of license that expires on or before June 30, 2010. Rescinded IAB 5/4/11, effective 6/8/11.

193A—5.3(542) License renewal.

5.3(1) Licenses issued pursuant to Iowa Code section 542.6 (CPA certificates), 542.8 (LPA licenses), or 542.19 (CPA certificates by substantial equivalency) shall be renewed on an annual basis and shall expire on June 30 of each year. Licenses shall be renewed through electronic on-line renewal, except that licensees who are ineligible to renew on-line because they must disclose a criminal conviction or disciplinary order, or for other cause, shall renew upon forms that may be obtained from the board office or on the board’s Web site. An annual renewal fee will be charged.

5.3(2) The board plans to develop a renewal process in which a firm permit to practice and the individual licenses associated with the firm may be renewed together. The board shall adopt rules

governing the combined renewal process when further details are known and the technological means to implement the process are in place.

[ARC 7715B, IAB 4/22/09, effective 7/1/09; ARC 8691B, IAB 4/21/10, effective 3/26/10; ARC 2152C, IAB 9/30/15, effective 11/4/15]

193A—5.4(542) Notices.

5.4(1) The board typically mails a notice to licensees in the May preceding license expiration, but neither the failure of the board to mail nor a licensee's failure to receive a renewal notice shall excuse the requirement to timely renew a license.

5.4(2) A licensee shall notify the board within 30 days of any change of address or firm affiliation.
[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—5.5(542) Renewal procedures.

5.5(1) A licensee shall submit an electronic on-line renewal or file a timely and sufficient renewal application with the board by the June 30 deadline in the renewal year. An application shall be deemed filed on the date of electronic renewal or when received by the board or, if mailed, on the date postmarked, but not the date metered.

5.5(2) An applicant for renewal under this chapter shall disclose on the application all background and character information requested by the board including, but not limited to:

- a. All states or foreign jurisdictions in which the applicant has applied for or holds a CPA certificate or license, an LPA license, or a substantially equivalent designation from a foreign country;
- b. Any past denial, revocation, suspension, or refusal to renew a CPA certificate, license or permit to practice, or LPA license, or voluntary surrender of a CPA certificate, license or permit or LPA license to resolve or avoid disciplinary action, or similar actions concerning a substantially equivalent foreign designation;
- c. Any other form of discipline or other penalty imposed against a CPA certificate, license or permit, LPA license, or a substantially equivalent foreign designation, or a practice privilege;
- d. The conviction of any crime; and
- e. The revocation of a professional license of any kind in this or any other jurisdiction.

5.5(3) A licensee who performs compilation services for the public other than through a certified public accounting or licensed public accounting firm shall submit a certification of completion of a peer review conducted in accordance with 193A—Chapter 11 no less often than once every three years.

5.5(4) Within the meaning of Iowa Code section 17A.18(2), a timely and sufficient renewal application shall be:

- a. Received by the board in person or electronic form or postmarked with a nonmetered United States Postal Service postmark on or before the date the license is set to expire or lapse;
- b. Signed by the licensee if submitted in person or mailed, or certified as accurate if submitted electronically;
- c. Fully completed, including continuing education, if applicable; and
- d. Accompanied with the proper fee. The fee shall be deemed improper if, for instance, the amount is incorrect, the fee was not included with the application, the credit card number provided by the applicant is incorrect, the date of expiration of a credit card is omitted or incorrect, the attempted credit card transaction is rejected, or the applicant's check is returned for insufficient funds or a closed account.

5.5(5) The administrative processing of an application to renew an existing license shall not prevent the board from subsequently commencing a contested case to challenge the licensee's qualifications for continued licensure if grounds exist to do so.

5.5(6) If grounds exist to deny a timely and sufficient application to renew, the board shall send written notification to the applicant by restricted certified mail, return receipt requested. Grounds may exist to deny an application to renew if, for instance, the licensee failed to satisfy the continuing education as required as a condition for licensure. If the basis for denial is pending disciplinary action or disciplinary investigation which is reasonably expected to culminate in disciplinary action, the board shall proceed as provided in 193—Chapter 7. If the basis for denial is not related to a

pending or imminent disciplinary action, the applicant may contest the board's decision as provided in 193—subrule 7.39(1).

5.5(7) When a licensee appears to be in violation of mandatory continuing education requirements, the board may, in lieu of proceeding to a contested case hearing on the denial of a renewal application as provided in rule 193—7.39(546,272C), offer a licensee the opportunity to renew in inactive status or to sign a consent order. While the terms of the consent order will be tailored to the specific circumstances at issue, the consent order will typically impose a penalty between \$50 and \$250, depending on the severity of the violation; establish deadlines for compliance; and may impose additional educational requirements on the licensee. A licensee is free to accept or reject the offer. If the offer of settlement is accepted, the licensee will be issued a renewed license and will be subject to disciplinary action if the terms of the consent order are not complied with. If the offer of settlement is rejected, the matter will be set for hearing, if timely requested by the applicant pursuant to 193—subrule 7.39(1). A licensee who falsely reports continuing education to the board shall be subject to additional sanctions including, when appropriate, suspension or revocation.

5.5(8) A certificate or license holder who continues to practice public accounting as a CPA or an LPA in Iowa after the certificate or license has expired shall be subject to disciplinary action. Such unauthorized activity may also be grounds to deny a licensee's application for reinstatement.
[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—5.6(542) Failure to renew.

5.6(1) A license or certificate holder who fails to renew the certificate or license by the expiration date, but does so within 30 days following its expiration date, shall be assessed a penalty as provided in rule 193A—12.1(542).

5.6(2) If the holder fails to renew the certificate or license within the 30-day grace period outlined in subrule 5.6(1), the certificate or license will lapse and the licensee shall be required to reinstate in accordance with subrule 5.6(3). The licensee is not authorized to practice during the period of time that the certificate or license is lapsed, including the 30-day grace period.

5.6(3) The board may reinstate a lapsed certificate or license upon the applicant's submission of an application to reinstate and completion of all of the following:

- a. Paying a penalty as provided in rule 193A—12.1(542); and
- b. Paying the current renewal fee; and
- c. Providing evidence of completed continuing education outlined in rule 193A—10.5(542), if the licensee wishes to reinstate to active status; and
- d. Providing a written statement outlining the professional activities of the applicant during the period in which the applicant's license was lapsed. The statement shall describe all services performed which constitute the practice of accounting including, but not limited to, those professional practice activities described in subrule 5.9(2). Such statement shall state whether the applicant exercised a practice privilege in the period during which the license was lapsed and, if so, the jurisdiction of the applicant's principal place of business and status of out-of-state licensure.

5.6(4) A licensee holding a lapsed CPA certificate is not authorized to perform attest or compilation services or to otherwise practice public accounting using the title "CPA" in Iowa or for a client with a home office in Iowa. A licensee holding a lapsed LPA license is not authorized to perform compilation services or to otherwise practice public accounting in Iowa using the title "LPA." A licensee holding a lapsed CPA certificate or LPA license shall not use the title "CPA" or "LPA" in any context unless the licensee discloses that the certificate or license has lapsed. Additionally, a person holding a lapsed Iowa CPA certificate and who is actively licensed as a CPA in another jurisdiction in which the person maintains the principal place of business may be eligible to exercise a practice privilege pursuant to Iowa Code section 542.20 and 193A—Chapter 20.

5.6(5) Practicing public accounting on a lapsed license is a ground for discipline. The board may find probable cause to file charges if the individual continues to offer services defined as the practice of public accounting while using the title "CPA" or "LPA" during the period of lapsed licensure. In addition to the disciplinary sanctions described in rule 193A—16.3(272C,542), individuals found to have practiced

public accounting on a lapsed license will be required to notify clients upon such terms as the board shall order.

[ARC 7715B, IAB 4/22/09, effective 7/1/09; ARC 9482B, IAB 5/4/11, effective 6/8/11]

193A—5.7(272C,542) Certificates and licenses—property of the board. Every certificate or license granted by the board shall, while it remains in the possession of the holder, be preserved by the holder but shall, nevertheless, always remain the property of the board. In the event that the certificate or license is revoked or suspended, or is not renewed in the manner prescribed by Iowa Code chapter 542 or 272C, it shall, on demand, be delivered by the holder to the board. However, a person shall be entitled to retain possession of a lapsed certificate or license which has not been revoked, suspended or voluntarily surrendered in a disciplinary action as long as the person complies with all provisions of Iowa Code sections 542.10 and 542.13. A lapsed certificate or license may be reinstated to active or inactive status at any time pursuant to subrule 5.6(3).

[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—5.8(542) Licensee's continuing duty to report. An active or inactive licensee shall notify the board in writing of the licensee's conviction of a crime within 30 days of the date of conviction. "Conviction" is defined in Iowa Code section 542.5(2). Licensees shall also notify the board in writing within 30 days of the date of any issuance, denial, revocation, or suspension of a certificate, license or permit by another state.

[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—5.9(272C,542) Inactive status.

5.9(1) General purpose. This rule establishes a procedure under which a person issued a certificate as a certified public accountant or a license as a licensed public accountant may apply to the board for licensure in inactive status. Inactive licensure under this rule is available to a certificate or license holder residing within or outside the state of Iowa who is not engaged in Iowa or for a client with a home office in Iowa in any practice for which an active certificate or license is required. A person eligible for inactive status may, as an alternative, allow the person's certificate or license to lapse. The board will continue to maintain a database on licensees in inactive status, including information which may not routinely be maintained after a certificate or license has lapsed through failure to renew. An inactive licensee will accordingly receive board newsletters and other mass communications from the board.

5.9(2) Eligibility. A person holding a lapsed or active certificate or license which has not been revoked or suspended may apply on forms provided by the board to renew in inactive status if the person is not engaged in the state of Iowa or for clients with a home office in Iowa in any practice for which an active certificate or license is required, including:

- a. Supervising or performing any attest services, such as audits, reviews or agreed-upon procedures (which may only be performed by a CPA within a CPA firm that holds a permit to practice);
- b. Supervising or performing compilation services or otherwise issuing compilation reports (which may only be performed by a CPA or LPA); or
- c. Performing any accounting, tax, consulting, or financial or managerial advisory services for any client, business, employer, government body, or other entity while holding oneself out as a CPA or LPA, or otherwise using titles restricted in Iowa Code section 542.13.

5.9(3) Affirmation. The application form shall contain a statement in which the applicant affirms that the applicant will not engage in any of the practices in Iowa listed in subrule 5.9(2) without first complying with all rules governing reinstatement to active status. A person in inactive status may reinstate to active status at any time pursuant to subrule 5.9(7).

5.9(4) Renewal. A person licensed in inactive status may renew the person's certificate or license on the schedule described in rule 193A—5.1(542). Such person is exempt from the continuing education requirements and will be charged a reduced renewal fee as provided in rule 193A—12.1(542). An inactive certificate or license shall lapse if not timely renewed.

5.9(5) Permitted practices. A person may, while registered as inactive, perform for a client, business, employer, government body, or other entity those accounting, tax, consulting, or financial or managerial

advisory services which may lawfully be performed by a person to whom a certificate or license has never been issued as long as the person does not in connection with such services use the title "CPA" or "LPA," or any other title restricted for use only by CPAs or LPAs in Iowa Code section 542.13 (with or without additional designations such as "inactive"). Restricted titles may only be used by active CPAs or LPAs who are subject to continuing education requirements to ensure that the use of such titles is consistently associated with the maintenance of competency through continuing education. Additionally, individuals who are actively licensed as CPAs in another jurisdiction in which they maintain their principal place of business may be eligible to exercise a practice privilege pursuant to Iowa Code section 542.20 and 193A—Chapter 20.

5.9(6) Prohibited practices. A person who, while licensed in inactive status, engages in any of the practices described in subrule 5.9(2) or violates any provision of rule 193A—14.2(17A,272C,542) is subject to disciplinary action. A person in inactive status is not authorized to verify the experience of an applicant for a CPA certificate under Iowa Code section 542.5(12) or an applicant for an LPA license under Iowa Code section 542.8(8).

5.9(7) Reinstatement to active status. A person licensed in inactive status shall, prior to engaging in any of the practices in Iowa listed in subrule 5.9(2) or for a client with a home office in Iowa, apply to the board to reinstate to active status. Such person shall pay the applicable renewal fee for active status, but shall be given credit for renewal fees previously paid for inactive status if the person applies for reinstatement at a date other than the person's regular renewal date. Such person must demonstrate compliance with all applicable continuing education and peer review requirements. A person who has engaged in the practice of public accounting as an active licensee of another jurisdiction while licensed as inactive in Iowa will be deemed to have satisfied the continuing education required for reinstatement if the person demonstrates that the person has satisfied substantially equivalent continuing education in the other jurisdiction.

5.9(8) Retired status. A person holding an inactive license who does not reasonably expect to return to the workforce in any capacity for which an active certificate or license is required due to bona fide retirement or disability may use the title "CPA, retired" or "LPA, retired," as applicable, in the context of non-income-producing personal activities.

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These rules are intended to implement Iowa Code chapters 272C and 542 and Iowa Code section 546.10.

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CHAPTER 6

ATTEST AND COMPILATION SERVICES

193A—6.1(542) Who may perform attest services.

6.1(1) Only a CPA may perform audit, review, or other attest services, as defined in Iowa Code section 542.3(1).

6.1(2) CPAs who perform attest services in Iowa or for a client with a home office in Iowa must hold an active Iowa CPA certificate or exercise a practice privilege under Iowa Code section 542.20. CPAs are cautioned, however, that the auditor of state, the department of agriculture and land stewardship, another governmental official or body, or a client may require that an individual be licensed in Iowa as a condition of performing attest services in Iowa or for a client with a home office in Iowa, whether or not the individual may otherwise satisfy the conditions for a practice privilege. Iowa licensure as a certified public accountant is required, for example, to perform certain audit services described in Iowa Code chapter 11.

6.1(3) CPAs performing attest services, whether the CPAs are certified in Iowa or exercising a practice privilege, must do so in a CPA firm that holds a permit to practice pursuant to Iowa Code section 542.7. However, a CPA exercising a practice privilege who works for an out-of-state CPA firm that does not hold a permit to practice under Iowa Code section 542.7 may provide review services in Iowa or for a client with a home office in Iowa as long as the firm complies with Iowa Code section 542.20, subsections 5 and 6, and associated rules.

6.1(4) CPAs who are responsible for supervising attest services for a CPA firm or who sign or authorize someone to sign the accountant's report on behalf of a CPA firm shall satisfy the experience or competency requirements established by nationally recognized professional standards that are applicable to the attest services performed and shall, at a minimum, satisfy the experience requirements of rule 193A—6.2(542).

[ARC 7715B, IAB 4/22/09, effective 7/1/09; ARC 0413C, IAB 10/31/12, effective 12/5/12; ARC 2152C, IAB 9/30/15, effective 11/4/15]

193A—6.2(542) Attest experience required.

6.2(1) A CPA who is responsible for supervising attest services or who signs or authorizes someone to sign the accountant's report on behalf of a firm shall have two years of full-time or part-time equivalent experience that extends over a period of no less than two years and includes no fewer than 4,000 hours, at least 2,000 of which shall be in providing attest services under the supervision of one or more CPAs responsible for supervising attest services on behalf of a CPA firm that holds a permit to practice in Iowa or an equivalent form of CPA firm licensure in another jurisdiction.

6.2(2) Experience shall include all of the following:

a. Experience in applying a variety of auditing procedures and techniques to the usual and customary financial transactions recorded in accounting records.

b. Experience in the preparation of audit working papers covering the examination of the accounts usually found in accounting records.

c. Experience in the planning of the program of audit work including the selection of the procedures to be followed.

d. Experience in the preparation of written explanations and comments on the findings of the examinations and on the content of the accounting records.

e. Experience in the preparation and analysis of reports and financial statements together with explanations and notes thereon.

6.2(3) Verification of attest experience shall be provided by the applicant and by a CPA who supervised the applicant or, if a supervising CPA is unavailable, by a CPA or CPA firm with sufficient factual documentation to verify the applicant's attest qualification.

6.2(4) Any applicant or CPA who has been requested to submit to the board evidence of an applicant's attest experience and has refused to do so shall, upon request by the board, explain in writing or in person the basis for the refusal. The board may require any applicant or CPA who furnished the evidence of an applicant's experience to substantiate the information provided. An applicant may be

required to appear before the board to supplement or verify evidence of experience. The board may inspect documentation relating to an applicant's claimed experience.

[ARC 7715B, IAB 4/22/09, effective 7/1/09; ARC 2152C, IAB 9/30/15, effective 11/4/15]

193A—6.3(542) Attest qualification.

6.3(1) Attest qualification is required before a CPA may perform attest services in Iowa or for a client with a home office in Iowa. "Attest qualification" or "attest qualified" means that the CPA has satisfied the experience requirements of rule 193A—6.2(542).

6.3(2) All CPAs who held an individual permit to practice in Iowa at any point prior to July 1, 2002, are deemed to be attest qualified. Under Iowa law prior to July 1, 2002, CPAs were only issued an individual permit to practice if they verified qualification to perform attest services. Individual permits to practice were discontinued under Iowa law effective July 1, 2002.

6.3(3) CPAs who did not hold a permit to practice prior to July 1, 2002, may attain or establish attest qualification as follows:

a. Applicants may apply for attest qualification when initially applying for a certificate as an Iowa CPA under Iowa Code section 542.6 or when applying for reciprocal Iowa certification under Iowa Code section 542.19.

b. Iowa CPA certificate holders may apply for attest qualification at any time at which they are qualified to do so.

c. Out-of-state CPAs performing attest services while exercising a practice privilege under Iowa Code section 542.20 are not required to individually apply to the board for attest qualification, but the Iowa CPA firm in which such attest services are performed shall affirm when applying for an initial or renewal firm permit to practice that the CPAs who supervise attest services for the firm or who sign or authorize someone to sign the accountant's report on behalf of the firm, as such attest services are or will in the following year be performed in Iowa or for a client with a home office in Iowa, have been qualified to perform attest services in Iowa or another jurisdiction.

[ARC 7715B, IAB 4/22/09, effective 7/1/09; ARC 2152C, IAB 9/30/15, effective 11/4/15]

193A—6.4(542) Compilation services.

6.4(1) Only a CPA licensed under Iowa Code section 542.6 or 542.19, an LPA licensed under Iowa Code section 542.8, or a person exercising a practice privilege under Iowa Code section 542.20 shall issue a report in standard form upon a compilation of financial information or otherwise provide compilation services in Iowa or for a client with a home office in Iowa.

6.4(2) An individual described in subrule 6.4(1) may perform compilation services through a CPA firm which holds a permit to practice under Iowa Code section 542.7, an LPA firm which holds a permit to practice under Iowa Code section 542.8, a CPA firm exercising a practice privilege under Iowa Code section 542.20, or, if both the individual and business comply with the requirements of Iowa Code section 542.13(13), through any other form of business.

6.4(3) All individuals described in subrule 6.4(1) who are responsible for supervising compilation services or who will sign or authorize someone to sign the accountant's compilation report on financial statements, as such compilation services will be performed in Iowa or for a client with a home office in Iowa, shall comply with the nationally recognized professional standards that are applicable to compilation services, including SSARS.

6.4(4) All individuals described in subrule 6.4(1) shall satisfy peer review requirements, individually or through the peer review of a CPA or LPA firm holding a permit to practice pursuant to Iowa Code section 542.7 or 542.8 or a CPA firm exercising a practice privilege under Iowa Code section 542.20.

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CHAPTER 7
CERTIFIED PUBLIC ACCOUNTING FIRMS
[Prior to 5/1/02, see 193A—Chapter 8]

193A—7.1(542) When licensure is required.

7.1(1) Except as provided in subrule 7.1(6), a sole proprietorship, corporation, partnership, limited liability company, or any other form of organization shall apply for a permit to practice as a firm of certified public accountants prior to:

- a. Performing or offering to perform audit, review or other attest services in Iowa or for a client with a home office in Iowa; or
- b. Establishing an office in Iowa at which the firm uses the title “CPAs,” “CPA firm,” “certified public accountants,” or “certified public accounting firm.”

7.1(2) A firm which is not subject to subrule 7.1(1) may practice public accounting in Iowa or for a client with a home office in Iowa without a permit issued by the board in conformance with Iowa Code section 542.20 and 193A—Chapter 21.

7.1(3) Unless individual Iowa licensure is required by the auditor of state, the department of agriculture and land stewardship, other governmental official or body, or a client, the public accounting services provided by a CPA firm holding an Iowa permit to practice may be performed in Iowa or for a client with a home office in Iowa by Iowa CPAs or wholly by persons exercising a practice privilege under Iowa Code section 542.20.

7.1(4) If a CPA firm that is issued a permit to practice by the board has one or more offices in Iowa, the public accounting services performed at each such office must be supervised by an Iowa CPA with an unexpired certificate issued under Iowa Code section 542.6 or 542.19.

7.1(5) A CPA firm issued a permit to practice by the board is accountable to the board and subject to discipline by the board for the acts of its owners or other agents, pursuant to 193A—subrule 14.2(4), whether or not such persons are individually licensed by the board. In order to ensure public accountability, all CPA firms issued a permit to practice under Iowa Code section 542.7 shall:

a. Designate an Iowa CPA or a person with a practice privilege under Iowa Code section 542.20 who is responsible for the proper licensure of the firm and the firm’s compliance with all applicable laws and rules of the state;

b. Designate an Iowa CPA or Iowa CPAs who are responsible for the proper registration of each Iowa office and each office’s compliance with all applicable laws and rules of this state;

c. Designate an Iowa CPA or person with a practice privilege under Iowa Code section 542.20 who is responsible for supervising attest services or who will sign or authorize someone to sign the accountant’s report on behalf of the firm, as such attest services will be performed in Iowa or for a client with a home office in Iowa; and

d. Designate an Iowa CPA or LPA or person with a practice privilege under Iowa Code section 542.20 who is responsible for supervising compilation services or who will sign or authorize someone to sign the accountant’s compilation report on financial statements, as such compilation services will be performed in Iowa or for a client with a home office in Iowa.

7.1(6) An out-of-state CPA firm exercising a practice privilege may perform review services in Iowa or for a client with a home office in Iowa without first obtaining a firm permit to practice in Iowa as long as the firm complies with Iowa Code section 542.20, subsections 5 and 6, as amended by 2012 Iowa Acts, Senate File 2122, and associated rules.

[**ARC 7715B**, IAB 4/22/09, effective 7/1/09; **ARC 0413C**, IAB 10/31/12, effective 12/5/12; **ARC 2152C**, IAB 9/30/15, effective 11/4/15]

193A—7.2(542) Application process.

7.2(1) Application forms may be obtained from the board office or on the board’s Web site. The board shall only process fully completed applications accompanied by the proper fee. A nonrefundable application fee shall be charged.

7.2(2) Fraud or deceit, by commission or omission, in obtaining a firm permit to practice is a ground for discipline, including permanent revocation of the firm's permit to practice, the individual certificate of an Iowa CPA, or an individual's practice privilege, as applicable to the entity or persons responsible.

7.2(3) An initial or renewal application for a firm permit to practice may be denied:

a. Upon any ground that would form a basis for discipline against the firm pursuant to Iowa Code section 542.10 or 193A—Chapter 14; or

b. Based on the firm's failure to comply with the requirements of Iowa Code section 542.7 including, but not limited to, a failure to make the designations described in subrule 7.1(5) or a failure to sustain the simple majority of ownership required by Iowa Code section 542.7(3); or

c. Based on a regulatory or disciplinary action or criminal conviction described in subrules 7.3(14) and 7.3(15) against any of the firm's licensed or unlicensed owners.

[ARC 7715B, IAB 4/22/09, effective 7/1/09; ARC 2152C, IAB 9/30/15, effective 11/4/15]

193A—7.3(542) Application contents. Applicants for a firm permit to practice shall provide such information as the board may require, including:

7.3(1) The lawful name of the firm.

7.3(2) The legal form and jurisdiction of the firm's organization.

7.3(3) Contact information for the principal place of business of the firm and each Iowa office.

7.3(4) All jurisdictions in which the firm is licensed or has applied for licensure.

7.3(5) The names, licensure, and contact information for all persons described in subrule 7.1(5).

7.3(6) The highest level of public accounting services offered by the firm, such as compilation or attest.

7.3(7) Evidence of satisfactory completion of the last firm peer review, when applicable.

7.3(8) Sufficient information from which the board can determine that a simple majority of owners hold a CPA certificate under Iowa Code section 542.6 or 542.19 or hold a CPA certificate in another state and are eligible to exercise a practice privilege under Iowa Code section 542.20. The board reserves the right to require at any time a full list of owners, or a targeted sublist, such as a list of those persons who perform services from an Iowa office or those who perform attest or compilation services in Iowa or for a client with a home office in Iowa.

7.3(9) The affirmation described in 193A—paragraph 6.3(3) “c.”

7.3(10) Affirmation that all CPAs who are responsible for supervising attest services for the CPA firm or who sign or authorize someone to sign the accountant's report on behalf of the CPA firm satisfy the experience or competency requirements established by nationally recognized professional standards that are applicable to the attest services performed in Iowa or for clients with a home office in Iowa.

7.3(11) Affirmation that all CPAs or LPAs who are responsible for supervising compilation services or who sign or authorize someone to sign the accountant's compilation report on the financial statements on behalf of the firm comply with nationally recognized professional standards that are applicable to the compilation services performed in Iowa or for a client with a home office in Iowa.

7.3(12) Affirmation that all nonlicensee owners are active participants in the firm or affiliated entity.

7.3(13) Affirmation that the firm and its licensed or unlicensed owners will comply with all applicable Iowa laws and rules, including rules of professional conduct, when practicing in Iowa or for a client with a home office in Iowa.

7.3(14) Details of any past denial, cancellation, revocation, suspension, refusal to renew, or voluntary surrender of a professional license of any kind, authority to practice, or practice privilege by the board or another state agency in any jurisdiction, a federal agency, or the PCAOB, regarding the firm and the firm's current owners (e.g., partners, shareholders, or members).

7.3(15) Details of any past felony conviction or the conviction of any crime, any element of which is dishonesty or fraud, as provided in Iowa Code section 542.5(2), under the laws of any state or the United States, regarding the firm and the firm's current owners (e.g., partners, shareholders, or members).

[ARC 7715B, IAB 4/22/09, effective 7/1/09; ARC 2152C, IAB 9/30/15, effective 11/4/15]

193A—7.4(542) Annual renewal of permit. Permits to practice must be renewed annually and shall expire on June 30 of each year. Applications to renew a permit to practice may be obtained from the

board office or on the board's Web site or through electronic on-line renewal. While the board generally mails a renewal notice in the May preceding permit expiration, neither the board's failure to mail a notice nor a permit holder's failure to receive a notice shall excuse the requirement to timely renew and pay the renewal fee.

[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—7.5(542) Renewal procedures.

7.5(1) The permit holder shall submit an electronic on-line renewal or file a timely and sufficient renewal application with the board by the June 30 deadline each year. Applications shall be deemed filed on the date of electronic renewal or when received by the board or, if mailed, on the date postmarked, but not the date metered.

7.5(2) The permit holder shall list on the renewal application all states in which the applicant has applied for or holds a permit as a certified public accounting firm and list any past denial, revocation, suspension, refusal to renew or voluntary surrender to avoid disciplinary action of a permit to practice or practice privilege. Renewal applications may request such additional information as the board requires, including all of the information described in rule 193A—7.3(542).

7.5(3) Within the meaning of Iowa Code chapters 17A, 272C and 542, a timely and sufficient renewal application shall be:

a. Received by the board in person or electronic form or postmarked with a nonmetered United States Postal Service postmark on or before the date the permit is set to expire or lapse;

b. Signed by the licensee in charge of the firm's practice if submitted in person or mailed, or certified as accurate if submitted electronically;

c. Fully completed and accompanied with the proper fee. The fee shall be deemed improper if, for instance, the amount is incorrect, the fee was not included with the application, the credit card number provided by the applicant is incorrect, the date of expiration of a credit card is omitted or incorrect, the attempted credit card transaction is rejected, or the applicant's check is returned for insufficient funds or a closed account.

[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—7.6(542) Failure to renew permit.

7.6(1) A firm that fails to renew the permit by the expiration date, but does so within 30 days following the expiration date, shall be assessed a penalty as provided in rule 193A—12.1(542).

7.6(2) If the firm fails to renew the permit within the 30-day grace period outlined in subrule 7.6(1), the permit will lapse and the firm shall be required to reinstate in accordance with subrule 7.6(3). The firm is not authorized to practice during the period of time that the permit is lapsed, including the 30-day grace period.

7.6(3) The board may reinstate the permit upon payment of the proper renewal fee and a penalty as provided in rule 193A—12.1(542). The board shall also require a written statement outlining the firm's professional activities during the period of lapsed licensure, including a list of Iowa clients and the services performed.

7.6(4) The board may find probable cause to file charges for unlicensed practice if the firm engaged in any activity that required licensure pursuant to subrule 7.1(1) during the period of lapsed licensure. In addition to the disciplinary sanctions described in rule 193A—16.3(272C,542), firms found to have practiced public accounting in violation of subrule 7.1(1) on a lapsed license will be required to notify clients upon such terms as the board shall order.

[ARC 7715B, IAB 4/22/09, effective 7/1/09; ARC 9482B, IAB 5/4/11, effective 6/8/11]

193A—7.7(542) Notices required. A holder of or applicant for a permit shall notify the board in writing within 30 days after an occurrence of any of the following:

7.7(1) A change in the number or location of offices within this state.

7.7(2) A change in the identity of a person in charge of such offices.

7.7(3) The denial, revocation, suspension, refusal to renew, or voluntary surrender of a permit to practice, other professional license of any kind, authority to practice, or practice privilege by another

state, a state agency in any jurisdiction, a federal agency, or the PCAOB, regarding the firm or any of the firm's owners (e.g., partners, shareholders, or members).

7.7(4) A change of physical or mailing address of the primary office of the firm or of any office located in Iowa, or of any person designated by the firm pursuant to subrule 7.1(5).
[ARC 7715B, IAB 4/22/09, effective 7/1/09; ARC 2152C, IAB 9/30/15, effective 11/4/15]

193A—7.8(542) Firms not in compliance with requirements. A firm that, after receiving or renewing a permit, is not in compliance with Iowa Code section 542.7 as a result of a change in firm ownership or personnel shall take corrective action to bring the firm back into compliance as quickly as possible or apply to modify or amend the permit. The board may grant a reasonable period of time, usually 90 days, for a firm to take such corrective action. Failure to comply within a reasonable period as deemed by the board shall result in the suspension or revocation of the firm permit.
[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—7.9(542) Peer review required. As a condition of renewal of a permit to practice as a certified public accounting firm, the firm shall undergo, at least once every three years, a peer review conducted under the provisions outlined in 193A—Chapter 11.
[ARC 7715B, IAB 4/22/09, effective 7/1/09]

These rules are intended to implement Iowa Code chapters 17A, 272C and 542 and Iowa Code section 546.10.

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CHAPTER 8
LICENSED PUBLIC ACCOUNTING FIRMS
[Prior to 7/13/88, see Accountancy, Board of[10]]

193A—8.1(542) Initial permit to practice.

8.1(1) A sole proprietorship, corporation, partnership, limited liability company, or any other form of organization shall apply for a permit to practice under Iowa Code section 542.8 and these rules as a firm of licensed public accountants in order to use the title “LPAs” or “LPA firm.” A nonrefundable application fee shall be charged.

8.1(2) The application may be obtained from the board office or on the board’s Web site and shall provide sufficient information from which the board can determine that a simple majority of owners hold licenses issued under Iowa Code section 542.8 or certificates issued under Iowa Code section 542.6 or 542.19, are eligible to practice under practice privilege pursuant to Iowa Code section 542.20, or otherwise hold a license or certificate to practice public accounting in another state. At least one owner must be licensed under Iowa Code section 542.8.

8.1(3) The application shall list the name, licensure, and contact information for each licensee or practice privilege practitioner who is responsible for supervising compilation services and who signs or authorizes someone to sign the accountant’s report on financial statements on behalf of the firm. The application shall affirm that any licensee listed meets the competency requirements set forth in SSARS and holds a valid license or certificate issued under Iowa Code section 542.6, 542.8, or 542.19 or is eligible to exercise a practice privilege under Iowa Code section 542.20.

8.1(4) The application shall list the physical location and contact information for all offices within this state and the licensee in charge of each such office.

8.1(5) Persons in charge of an office located in Iowa shall be licensed in Iowa under Iowa Code section 542.6, 542.8, or 542.19.

8.1(6) The application shall designate an individual who holds a valid license or certificate issued under Iowa Code section 542.6, 542.8 or 542.19 or who is eligible to exercise a practice privilege under Iowa Code section 542.20 as the person responsible for ensuring that the firm has complied with all of the requirements for a permit to practice, and shall provide contact and licensure information for such individual.

8.1(7) The application shall affirm that all nonlicensee owners are active participants in the firm or an affiliated entity.

8.1(8) The application shall affirm that all nonlicensee owners shall comply with all applicable rules of professional conduct.

8.1(9) The application for initial issuance of a permit shall list all states in which the applicant or any of the individuals described in subrules 8.1(2) to 8.1(5) have applied for or hold a permit as a licensed public accounting firm, certified public accounting firm, or individual license or certificate, and list any past denial, revocation, surrender, or suspension of a permit, license or certificate by another state.

8.1(10) The application shall list the names of any licensed or unlicensed owner who has been convicted of a felony or other crime described in Iowa Code section 542.5(2) or has had a professional license of any kind revoked in this or any other jurisdiction.

8.1(11) Fraud or deceit, by commission or omission, in obtaining a firm permit to practice is a ground for discipline, including permanent revocation of the firm’s permit to practice, the individual certificate of an Iowa LPA or CPA, or an individual’s practice privilege, as applicable to the entity or persons responsible.

8.1(12) An initial or renewal application for a firm permit to practice may be denied:

a. Upon any ground that would form a basis for discipline against the firm pursuant to Iowa Code section 542.10 or rule 193A—14.3(17A,272C,542) including, but not limited to, the regulatory and disciplinary actions and criminal convictions described in subrules 8.1(9) and 8.1(10);

b. Based on the firm’s failure to comply with the requirements of Iowa Code section 542.8 including, but not limited to, a failure to make the designations described in subrules 8.1(3), 8.1(4),

and 8.1(6), or a failure to sustain the simple majority of ownership required by Iowa Code section 542.8(12) "a"; or

c. Based on a regulatory or disciplinary action or criminal conviction described in subrules 8.1(9) and 8.1(10) against any of the firm's owners (e.g., partners, shareholders, or members).

[ARC 7715B, IAB 4/22/09, effective 7/1/09; ARC 2152C, IAB 9/30/15, effective 11/4/15]

193A—8.2(542) Annual renewal of permit. A permit issued under the provisions of Iowa Code section 542.8 shall be renewed annually by June 30 upon forms provided by the board. Applications to renew a permit to practice may be obtained from the board office or on the board's Web site or through electronic on-line renewal. While the board generally mails a renewal notice in the May preceding permit expiration, neither the board's failure to mail a notice nor a permit holder's failure to receive a notice shall excuse the requirement to timely renew and pay the renewal fee.

[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—8.3(542) Renewal procedures.

8.3(1) The permit holder shall submit an electronic on-line renewal or file a timely and sufficient renewal application with the board by the June 30 deadline each year. Applications shall be deemed filed on the date of electronic renewal or when received by the board or, if mailed, the date postmarked, but not the date metered.

8.3(2) The permit holder shall list on the renewal application all states in which the applicant has applied for or holds a permit as a licensed public accounting firm and list any past denial, revocation, suspension, refusal to renew or voluntary surrender to avoid disciplinary action of a permit. Permit holders shall notify the board in writing within 30 days after the occurrence of any issuance, denial, revocation, suspension or refusal to renew or voluntary surrender to avoid disciplinary action of a permit to practice as a licensed public accounting firm by another state. Renewal applications may request such additional information as the board requires of initial applicants.

8.3(3) Within the meaning of Iowa Code chapters 17A, 272C, and 542, a timely and sufficient renewal application shall be:

a. Received by the board in person or electronic form, or postmarked with a nonmetered United States Postal Service postmark on or before the date the permit is set to expire or lapse;

b. Signed by the licensee in charge of the firm's practice if submitted in person or mailed, or certified as accurate if submitted electronically;

c. Fully completed and accompanied with the proper fee. The fee shall be deemed improper if, for instance, the amount is incorrect, the fee was not included with the application, the credit card number provided by the applicant is incorrect, the date of expiration of a credit card is omitted or incorrect, the attempted credit card transaction is rejected, or the applicant's check is returned for insufficient funds or a closed account.

[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—8.4(542) Failure to renew permit.

8.4(1) A firm that fails to renew the permit by the expiration date, but does so within 30 days following the expiration date, shall be assessed a penalty of 25 percent of the annual renewal fee.

8.4(2) If the firm fails to renew the permit within the 30-day grace period outlined in subrule 8.4(1), the permit will lapse and the firm shall be required to reinstate in accordance with subrule 8.4(3). The firm is not authorized to practice as an LPA firm during the period of time that the permit is lapsed, including the 30-day grace period.

8.4(3) The board may reinstate the permit upon payment of the proper renewal fee and a penalty as provided in rule 193A—12.1(542). The board shall also require a written statement outlining the firm's professional activities during the period of lapsed licensure.

8.4(4) The board may find probable cause to file charges for unlicensed practice if the firm continues to offer services defined as the practice of accounting while using the title "LPAs" or "LPA firm" during the period of lapsed licensure.

[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—8.5(542) Notices required. A holder of or an applicant for a permit shall notify the board in writing within 30 days after an occurrence of any of the following:

8.5(1) A change in the identity of an owner (e.g., partner, shareholder, or member) who performs professional services in this state or for clients with a home office in this state. This is a statutory requirement the board will enforce consistent with the disclosures and affirmations required on initial and renewal application forms.

8.5(2) A change in the number or location of offices within this state.

8.5(3) A change in the identity of a person in charge of such offices.

8.5(4) The issuance, denial, revocation, suspension, refusal to renew, or voluntary surrender of a permit to practice, other professional license of any kind, authority to practice, or practice privilege by another state, or a state or federal agency in any jurisdiction, regarding the firm or any of the persons described in subrule 8.1(3), 8.1(4), or 8.1(6).

8.5(5) A change of physical or mailing address of the primary office of the firm or of any office located in Iowa or of any person designated by the firm pursuant to subrule 8.1(3), 8.1(4), or 8.1(6).
[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—8.6(542) Firms not in compliance with requirements. A firm which, after receiving or renewing a permit, is not in compliance with Iowa Code section 542.8 as a result of a change in firm ownership or personnel shall take corrective action to bring the firm back into compliance as quickly as possible or apply to modify or amend the permit. The board may grant a reasonable period of time, usually 90 days, for a firm to take such corrective action. Failure to comply within a reasonable period as deemed by the board shall result in the suspension or revocation of the firm permit.
[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—8.7(542) Peer review required. As a condition for renewal of a permit to practice as a licensed public accounting firm, the firm shall undergo, at least once every three years, a peer review conducted under the provisions outlined in 193A—Chapter 11.
[ARC 7715B, IAB 4/22/09, effective 7/1/09]

These rules are intended to implement Iowa Code chapters 17A, 272C and 542 and Iowa Code section 546.10.

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CHAPTER 10
CONTINUING EDUCATION
[Prior to 7/13/88, see Accountancy, Board of[10]]

193A—10.1(542) Scope. The right to use the title “Certified Public Accountant” and “Licensed Public Accountant” is regulated in the public interest and imposes a duty on accounting professionals to maintain public confidence and current knowledge, skills, and abilities in all areas of services. CPAs and LPAs must accept and fulfill their ethical responsibilities to the public and the profession regardless of their fields of employment.

10.1(1) The development of professional competence involves a continued commitment to learning and professional improvement. A CPA and an LPA performing professional services must have a broad range of knowledge, skills and abilities. A program that promotes professional competence in the practice of accountancy is defined as one that refers to the process, methods, or principles of accounting or is directly related to the CPA’s and LPA’s employment and is above the level of the CPA’s and LPA’s current knowledge.

10.1(2) Acceptable subjects for continuing professional education include accounting, assurance/auditing, consulting services, specialized knowledge and applications, management, taxation, and ethics. Other subjects, including nontechnical professional skills, may be approved by the board if they maintain or improve CPAs’ and LPAs’ competence in their current employment.
[ARC 9002B, IAB 8/11/10, effective 1/1/11]

193A—10.2(542) Definitions. The following definitions shall be applicable to the rules of this chapter.

“*Continuing professional education (CPE)*” means education that is acquired by a licensee in order to maintain, improve, or expand skills and knowledge present at initial licensure or to develop new and relevant skills and knowledge.

“*Firm meeting*” means a formally arranged gathering/assembly of staff or management groups or both to inform them of administrative matters.

“*Formal program*” means a structured learning activity based on clearly defined learning objectives and outcomes that articulate achievable knowledge, skills and abilities.

“*In-house or on-site training*” means a formally organized professional educational program sponsored by the employer.

“*Live instruction*” means an educational program delivered in a classroom setting or through videoconferencing whereby the instructor and student carry out essential tasks while together. Examples include distance learning and Webcasts.

“*Nontechnical professional skills*” means formal programs of learning which contribute to the professional competence of a certificate holder or license holder in fields of study that indirectly relate to the holder’s field of business. “Nontechnical professional skills” includes, but is not limited to, the following programs or courses:

1. Communication;
2. Interpersonal management;
3. Leadership and personal development;
4. Client and public relations;
5. Practice development;
6. Marketing;
7. Motivational and behavioral; and
8. Speed reading and memory building.

“*Qualified instructor*” means an individual whose training and experience adequately prepares the individual to carry out specified training assignments.

“*Self-study*” means a computer-generated program, such as CD-ROM, or written materials or exercises intended for self-study which do not include simultaneous interaction with an instructor but do include tests transmitted to the provider for review and grading.

“*Technical professional skills*” means formal programs of learning which contribute to the professional competence of a certificate holder or license holder in fields of study that directly relate

to the holder's field of business. "Technical professional skills" includes, but is not limited to, the following programs or courses:

1. Auditing standards or procedures;
2. Compilation and review of financial statements;
3. Financial statement preparation and disclosures;
4. Attestation standards and procedures;
5. Projection and forecast standards or procedures;
6. Accounting and auditing;
7. Management advisory services;
8. Personal financial planning;
9. Taxation;
10. Management information systems;
11. Budgeting and cost analysis;
12. Asset management;
13. Professional ethics;
14. Specialized areas of industry;
15. Human resource management;
16. Economics;
17. Business law;
18. Mathematics, statistics and quantitative applications in business;
19. Business management and organization;
20. General computer skills, computer software training, information technology planning and management;
21. Operations management, inventory, and production; and
22. Negotiation or dispute resolution.

[ARC 9002B, IAB 8/11/10, effective 1/1/11]

193A—10.3(542) Applicability. Each active certificate holder or license holder, including persons working in private industry or education, is required to comply with the continuing professional education requirements as a condition precedent to the renewal of the certificate or license.

[ARC 9002B, IAB 8/11/10, effective 1/1/11]

193A—10.4(542) Cost of continuing professional education. All costs of complying with the continuing professional education requirements of the board are the responsibility of the certificate holder or license holder wishing to maintain registration in this state.

[ARC 9002B, IAB 8/11/10, effective 1/1/11]

193A—10.5(542) Basic requirement.

10.5(1) Except as provided in subrules 10.5(2) to 10.5(7), an applicant for renewal shall have completed 120 hours of qualifying continuing professional education during the three-year period ending on the December 31 or June 30 preceding the July 1 renewal date of the certificate or license. The following conditions shall apply:

a. On each online or paper renewal, a CPA or LPA shall self-select December 31 or June 30 as the date by which continuing education requirements must be satisfied in order to be eligible to renew the certificate or license.

b. A CPA or LPA applying to renew a certificate or license may declare a continuing education deadline of December 31 in one renewal cycle and a continuing education deadline of June 30 in a subsequent renewal cycle, and vice versa.

c. Licensees shall maintain continuing education records in a manner that corresponds with the self-selected continuing education deadline of December 31 or June 30.

d. When declaring a June 30 continuing education deadline, licensees must be cautious to ensure that the continuing education is fully completed on or prior to the date the renewal application is submitted to the board.

e. Licensees who renew with penalty during the 30-day grace period following June 30 must declare either December 31 or June 30 as the continuing education deadline and may not extend the deadline beyond June 30.

10.5(2) At the first annual renewal date of July 1 that is less than 12 months from the date of filing of the initial application for the certificate or license, the certificate holder or license holder shall not be required to report continuing professional education.

10.5(3) At the annual renewal date of July 1 that is 12 months or more than 12 months, but less than 24 months, from the date of filing of the initial application for the certificate or license, the certificate holder or license holder shall report 40 hours of continuing professional education earned in the one-year period ending December 31 or June 30 prior to the July 1 renewal date.

10.5(4) At the annual renewal date of July 1 that is 24 months or more than 24 months, but less than 36 months, from the date of filing of the initial application for the certificate or license, the certificate holder or license holder shall report 80 hours of continuing professional education earned in the two-year period ending December 31 or June 30 prior to the July 1 renewal date.

10.5(5) A licensee shall be deemed to have complied with the requirements of this rule if, for the period that the licensee is a resident of another state or district having a continuing professional education requirement, the licensee met the resident state's mandatory requirement.

10.5(6) The board shall have authority to make exceptions for reasons of individual hardship including health, certified by a medical doctor, military service, foreign residency, retirement, or other good cause. No exceptions shall be made solely because of age. Applicants entitled to a full or partial exception under the provisions of Iowa Code section 272C.2, subsection 4, for active military service or government service outside of the United States may request an exception by submitting acceptable documentation as applicable to the exception requested. Applicants seeking an exception on other grounds of undue hardship must submit an application for waiver or variance as provided in 193—Chapter 5.

10.5(7) Licensees who apply to reinstate a lapsed or inactive certificate or license to active status pursuant to 193A—subrule 5.6(3) or 5.9(7) shall satisfy the basic requirement of 120 hours of continuing professional education earned in the preceding three-year period prior to the date of the application, including all required mandatory education described in rule 193A—10.7(542). Once the certificate or license is reinstated, the basic requirement shall apply at each subsequent renewal. The 120-hour requirement described in this subrule shall be modified as needed to incorporate the phase-in schedule for initial licensees described in subrules 10.5(2) to 10.5(4).

[ARC 9002B, IAB 8/11/10, effective 1/1/11; ARC 1360C, IAB 3/5/14, effective 4/9/14; ARC 2152C, IAB 9/30/15, effective 11/4/15]

193A—10.6(542) Measurement standards. The following standards will be used to measure the hours of credit to be given for qualifying continuing professional education programs completed by individual applicants:

10.6(1) Credit is measured with one 50-minute period equaling one contact hour of credit. Half-hour credits may be allowed (equal to not less than 25 minutes) after the first hour of credit has been earned.

10.6(2) Only class hours or the equivalent, and not student hours devoted to preparation, will be counted.

10.6(3) Credit expressed as continuing education units (CEUs) shall be counted as ten contact hours for each continuing professional education unit. (.1 CEU = 1 CPE)

10.6(4) Service as lecturer or discussion leader of continuing professional education programs will be counted to the extent that this service contributes to the applicant's professional competence.

[ARC 9002B, IAB 8/11/10, effective 1/1/11]

193A—10.7(542) Mandatory education required.

10.7(1) Every CPA certificate holder or LPA license holder who is responsible for supervising compilation services or who signs or authorizes someone to sign the accountant's compilation report on the financial statements on behalf of a firm shall complete, as a condition of certificate or license renewal, a minimum of eight hours of continuing professional education devoted to financial statement presentation, such as courses covering the statements on standards for accounting and review services

(SSARS) and accounting and auditing updates. When required, the financial statement presentation continuing education shall be completed within the three-year period ending on the December 31 or June 30 preceding the application for certificate or license renewal. For credit to be claimed for a course covering multiple topics, a minimum of one hour as outlined in subrule 10.6(1) shall be devoted to financial statement presentation. For example, if a seminar or presentation is conducted for a total of four hours and only one hour is devoted to financial statement presentation, then only one hour shall be claimed toward meeting the requirement of this subrule.

10.7(2) Every CPA certificate holder or LPA license holder shall complete a minimum of four hours of continuing education devoted to ethics and rules of professional conduct during the three-year period ending December 31 or June 30, prior to the July 1 annual renewal date. For a course to qualify to meet this requirement, the course description shall clearly outline the subject matter covered as professional or business ethics. If credit is to be claimed for a course covering multiple topics, a minimum of one hour as outlined in rule 193A—10.6(542), measurement standards, specifically in subrule 10.6(1), shall be devoted to business or professional ethics. For example, if a seminar or presentation is conducted for a total of four hours and only one hour is devoted to business or professional ethics, then only one hour shall be claimed toward meeting the requirement of this subrule. Ethics courses, which are defined as courses dealing with regulatory and behavioral ethics, shall be limited to courses on the following:

- a. Professional standards;
- b. Licenses and renewals;
- c. SEC oversight;
- d. Competence;
- e. Acts discreditable;
- f. Advertising and other forms of solicitation;
- g. Independence;
- h. Integrity and objectivity;
- i. Confidential client information;
- j. Contingent fees;
- k. Commissions;
- l. Conflicts of interest;
- m. Full disclosure;
- n. Malpractice;
- o. Record retention;
- p. Professional conduct;
- q. Ethical practice in business;
- r. Personal ethics;
- s. Ethical decision making; and
- t. Corporate ethics and risk management as these topics relate to malpractice and relate solely to the practice of certified public accounting.

[ARC 9002B, IAB 8/11/10, effective 1/1/11; ARC 2152C, IAB 9/30/15, effective 11/4/15]

193A—10.8(542) Programs that qualify and CPE limitations.

10.8(1) The overriding consideration in determining whether a specific program qualifies as acceptable continuing education is that it be a formal program of learning which contributes directly to the professional competence of an individual certified or licensed in this state. It will be left to each individual certificate holder or license holder to determine the technical or nontechnical professional skills courses of study to be pursued. Thus, the auditor may study accounting and auditing, the tax practitioner may study taxes, and the management advisory services practitioner may study subjects related to such practice. Job-related continuing professional education shall qualify as acceptable provided the courses selected from nontechnical professional skills contribute to the professional competence of the certificate holder or license holder.

10.8(2) Program standards:

- a. Learning activities must be based on clearly defined, relevant learning objectives and outcomes that clearly articulate the knowledge, skills, and abilities that can be achieved by participants.
- b. Learning activities must be developed in a manner consistent with the prerequisite education, experience, and advanced preparation of the participants.
- c. Activities, materials, and delivery systems must be current, technically accurate, and effectively designed. Providers, sponsors, or contractors must be competent in the subject matter. Competence may be demonstrated through practical experience or education.
- d. Learning programs must be reviewed by qualified persons other than those who develop the program to ensure that the program is technically accurate and current and addresses the stated learning objectives. This requirement is waived for single presentations such as lectures that are given once.

10.8(3) Continuing professional education programs will qualify only if:

- a. An outline of the program is prepared in advance and preserved.
- b. The program is at least one hour (50-minute period) in length.
- c. The program is conducted by a qualified instructor, discussion leader or lecturer. A qualified instructor, discussion leader or lecturer is anyone whose background, training, education or experience makes it appropriate for that person to lead a discussion on the subject matter of the particular program.
- d. A record of attendance or certification of completion or transcript is maintained.

10.8(4) The following programs are deemed to qualify provided all other requirements of this rule are met.

- a. Professional development programs of recognized national and state accounting organizations.
- b. Technical sessions at meetings of recognized national and state accounting organizations and their chapters.
- c. Formally organized in-house or on-site educational programs provided by the certificate holder's or license holder's employer.
- d. Distance learning programs or group study Webcast programs.
- e. University or college courses meet the continuing professional education requirements of those attending.

Each semester hour shall be equal to 15 contact hours of credit. Each quarter hour shall be equal to 10 contact hours of credit.

- f. Technical or nontechnical sessions offered by employers in business and industry, as well as firms of certified public accountants.

10.8(5) Formal correspondence and formal self-study programs contributing directly to the professional competence of an individual that require registration and provide evidence of satisfactory completion will be considered for credit. The amount of credit to be allowed for correspondence and formal self-study programs (including tested study programs) shall be recommended by the program sponsor and based upon appropriate "field tests" and shall not exceed 50 percent of the renewal requirement. A licensee claiming credit for correspondence or formal self-study courses is required to obtain evidence of satisfactory completion of the course from the program sponsor. Credit will be allowed in the renewal period in which the course is completed.

10.8(6) Credit may be allowed for self-study programs on the basis of one hour of credit for each 50 minutes spent on the self-study program if the developer of such programs is approved by either the national continuing professional education registry or by the NASBA continuing education registry and the program sponsor has not designated the amount of credit to be claimed for completing the course of study. The licensee must estimate the equivalent number of hours and justify the amount of hours claimed. The maximum credit shall not exceed 50 percent of the renewal requirement. Credit will be allowed in the renewal period in which the course is completed.

10.8(7) The credit allowed an instructor, discussion leader, or speaker will be on the basis of two hours for subject preparation for each hour of teaching. Credit for teaching college or university coursework may be claimed for courses taught above the elementary accounting or principles of accounting level. Repetitious presentations shall not be considered. The maximum credit for such preparation and teaching shall not exceed 50 percent of the renewal period requirement.

10.8(8) Credit may be awarded for published articles and books. The amount of credit so awarded will be determined by the board. Credit may be allowed for published articles and books provided they contribute to the professional competence of the licensee. Credit for preparation of such publications may be given on a self-declaration basis up to 25 percent of the renewal period requirement. In exceptional circumstances, a licensee may request additional credit by submitting the article(s) or book(s) to the board with an explanation of the circumstances that the licensee believes justify additional credit.

10.8(9) Credit may be allowed for the successful completion of professional examinations as detailed below. Credit is calculated at the rate of five times the length of each examination, which is presumed to include all preparation time, claimed in the calendar year of the examination, and limited to 50 percent of the total renewal requirement.

- a. Certified Management Accountant/CMA.
- b. Certified Information Systems Auditor/CISA.
- c. Certified Information Technology Professional/CITP.
- d. Certified Financial Planner/CFP.
- e. Enrolled Agent/EA.
- f. Certified Governmental Financial Manager/CGFM.
- g. Certified Government Auditing Professional/CGAP.
- h. Certified Internal Auditor/CIA.
- i. Accredited Business Valuation/ABV.
- j. Certified Financial Forensics/CFF.
- k. Certified Valuation Analyst/CVA.
- l. Certified Insolvency & Restructuring Advisor/CIRA.
- m. Forensic Certified Public Accountant/FCPA.
- n. Certified Fraud Examiner/CFE.
- o. Certified Business Analyst/CBA.
- p. Certified Trust and Financial Advisor/CTFA.
- q. Chartered Financial Analyst/CFA.
- r. Registered Representative, Series 6 and 7 and other examinations.
- s. Registered Investment Advisor/RIA.
- t. Certified Forensic Accountant/CrFA.
- u. Personal Financial Specialist/PFS.
- v. Chartered Life Underwriter/CLU.
- w. Fellow of the Society of Actuaries/FSA.
- x. Chartered Property & Casualty Underwriter/CPCU.
- y. Fellow Life Management Institute/FLMI.
- z. Other similar examinations approved by the board.

10.8(10) Firm meetings for staff or management groups for the purpose of administrative and firm matters do not meet the standards set forth in subrule 10.8(1).

10.8(11) Dinner, luncheon and breakfast meetings of recognized organizations may qualify if they meet the appropriate requirements and shall be limited to 25 percent of the total renewal requirements if the individual meeting is no more than two hours long.

10.8(12) Continuing professional education taken in nontechnical skills area as defined in rule 193A—10.2(542) shall be limited to 50 percent of the total renewal requirement.

10.8(13) The board may look to recognized state or national accounting organizations for assistance in interpreting the acceptability of and credit to be allowed for individual courses.

10.8(14) The right is specifically reserved to the board to approve or deny credit for continuing professional education claimed under these rules.

[ARC 9002B, IAB 8/11/10, effective 1/1/11]

193A—10.9(542) Controls and reporting.

10.9(1) An applicant for renewal may be requested to provide, in such manner and at such time as prescribed by the board, a signed statement, under penalty of perjury, on forms provided by the

board, setting forth the continuing professional education in which the licensee has participated. The board, in certain instances, may allow for attestation that the licensee has met the requirements in lieu of providing a listing. If requested to provide a listing of the continuing professional education completed, the documentation shall include:

- a. School, firm or organization conducting the course and contact information.
- b. Location of course.
- c. Title of course or description of content.
- d. Principal instructor.
- e. Dates attended.
- f. Hours claimed.
- g. Certificate of completion.
- h. Name of participant.
- i. Course field of study.
- j. Type of instruction or delivery method.
- k. Amount of CPE recommended.
- l. Verification by CPE program sponsor representative.

Canceled checks and registration forms are NOT proof of attendance.

10.9(2) The board may require sponsors of courses to furnish an attendance record, a certification of completion or any other information the board deems essential for administration of these continuing professional education rules.

10.9(3) The board will verify, on a test basis, information submitted by licensees. If an application for renewal is not approved, the applicant will be so notified and may be granted a period of time by the board in which to correct the deficiencies noted.

10.9(4) Primary responsibilities for documenting the requirements shall be with the licensee, and evidence to support fulfillment of those requirements must be retained for a period of three years subsequent to submission of the report claiming the credit. (Refer to 193A—subrule 14.3(1) and Iowa Code section 542.10(1)(a), which provides for permanent revocation based on fraud or deceit in procuring a license.) Satisfaction of the requirements, including retention of attendance records, certification of completion records, and written outlines, may be accomplished as follows:

- a. For courses taken for scholastic credit in accredited universities and colleges (state, community, or private) or high school districts, evidence of satisfactory completion of the course will be sufficient; for noncredit courses taken, a statement of the hours of attendance, signed by the instructor, must be obtained by the licensee.
- b. For correspondence and formal independent self-study courses, written evidence or a certificate of completion from the sponsor or course provider shall be obtained by the licensee.
- c. In all other instances, the licensee must maintain a record of the information as listed in subrule 10.8(3).

[ARC 9002B, IAB 8/11/10, effective 1/1/11]

193A—10.10(542) Grounds for discipline. A licensee or an applicant is subject to discipline, including permanent revocation, if the licensee or applicant provides false information to the board in connection with an application to renew or reinstate a certificate or license. A licensee or an applicant is also subject to discipline if the licensee or applicant is unable to document the continuing professional education hours reported to the board in connection with an audit or other request for documentation. False information of this nature will subject the licensee or applicant to discipline whether the false information was supplied intentionally or with reckless disregard for the truth or accuracy of the number of hours claimed. Licensees and applicants are accordingly cautioned to supply the board with accurate continuing professional education information.

[ARC 9002B, IAB 8/11/10, effective 1/1/11]

193A—10.11(272C,542) Alternative continuing education cycles authorized.

10.11(1) Purpose. For a variety of reasons, some CPAs and LPAs may wish to satisfy continuing education requirements on a three-year cycle ending on a date other than December 31. By way of

illustration, some licensees may prefer to take courses on particular substantive topics that are not always offered at the same time each year. Some licensees may wish to schedule continuing education to comply with the differing requirements of multiple jurisdictions. This rule is intended to authorize a more flexible time frame within which continuing education may be satisfied. This rule does not alter any other requirement of this chapter.

10.11(2) Alternative cycle. Starting with the 2013 renewal cycle, a CPA or LPA may self-select June 30 as the date by which continuing education requirements must be satisfied in order to be eligible to renew the license or certificate. Online and paper renewal forms will require the renewal applicant to declare whether the continuing education was satisfied within the three-year period preceding December 31 or the three-year period preceding June 30. When declaring a June 30 date, licensees must be cautious to ensure the continuing education is fully completed on or prior to the date the renewal application is submitted. Licensees who renew with penalty during the 30-day grace period following June 30 must declare either December 31 or June 30 and may not extend the deadline beyond June 30.

10.11(3) Declaration may vary by renewal cycle. A CPA or LPA applying to renew a certificate or license may declare a continuing education deadline of December 31 in one renewal cycle and a continuing education deadline of June 30 in a subsequent renewal cycle, and vice versa. Licensees shall be expected to maintain continuing education records in a manner that complies with the self-selected declaration in any particular renewal cycle.

[ARC 0558C, IAB 1/9/13, effective 2/13/13]

These rules are intended to implement Iowa Code chapters 272C and 542.

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CHAPTER 11
PEER REVIEW
[Prior to 5/1/02, see 193A—Chapter 17]

193A—11.1(542) Peer review required. As a condition of renewal for a CPA or LPA who issues compilation reports other than through a CPA or LPA firm which holds a permit to practice, and as a condition of permit renewal for LPA firms which issue compilation reports or CPA firms which provide attest services or issue compilation reports, the applicant shall submit certification of completion of a peer review issued pursuant to this chapter. Such review shall be completed at the highest level of service provided by the firm or licensee. The performance of preparation services under SSARS 21 does not alone subject a firm or individual to peer review, although if a firm or individual is otherwise subject to peer review, the reviewer may include preparation services in the scope of practices reviewed. [ARC 7715B, IAB 4/22/09, effective 7/1/09; ARC 2152C, IAB 9/30/15, effective 11/4/15]

193A—11.2(542) How often required. During the three-year period ending December 31 preceding the application for renewal of a certificate, license, or permit to practice, the individual licensee or firm shall have completed a peer review in accordance with this chapter. A peer review shall be completed no less often than once every three years.

[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—11.3(542) System of internal quality control. If the firm has not performed any attest or compilation services prior to the application for renewal, the firm shall have in place a system of internal quality control prior to the commencement of an engagement including attest or compilation services and shall come into compliance with the peer review requirement within 18 months of completion of an engagement including attest or compilation services.

[ARC 7715B, IAB 4/22/09, effective 7/1/09; ARC 2152C, IAB 9/30/15, effective 11/4/15]

193A—11.4(542) Peer review programs that qualify. A firm's completion of a peer review program endorsed or supported by the AICPA, National Society of Accountants or other substantially similar review programs in Iowa or other states approved by the board shall satisfy the requirements of this chapter.

[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—11.5(542) Waiver of peer review requirement. At the time of renewal, a licensee or firm may request, in writing upon a form provided by the board, a waiver from the requirements of this chapter, as provided in Iowa Code sections 542.7(9) and 542.8(19).

[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—11.6(542) Submission of peer review reports. Unless the subject of a peer review timely objects in writing to the administering entity of the peer review program, the administering entity shall make available to the board within 30 days of the issuance of the peer review acceptance letter the final peer review report or such peer review records as are designated by the peer review program in which the administering entity participates. The subject of a peer review may voluntarily submit the final peer review report directly to the board.

[ARC 7715B, IAB 4/22/09, effective 7/1/09]

These rules are intended to implement Iowa Code chapter 542.

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CHAPTER 13
RULES OF PROFESSIONAL ETHICS AND CONDUCT
[Prior to 5/1/02, see 193A—Chapter 11]

193A—13.1(542) Guiding interpretative principles. The public places trust and confidence in CPAs and LPAs and the services they provide; consequently, licensees have a duty to conduct themselves in a manner that will be beneficial to the public and that fosters such trust and confidence. The rules of professional ethics and conduct identify seven fundamental principles of conduct that are intended to govern licensees' professional performance whether they are practicing in a CPA firm, LPA firm, industry, not-for-profit organization, or a government, education or other setting. These principles, with the exception of independence, apply to all services and activities performed by licensees in all aspects of their professional conduct. Independence is a unique principle that applies only to those professional services where it is required in accordance with professional standards. Users of the licensee's services draw confidence from the knowledge that the licensee is bound to a framework which requires continued dedication to professional excellence and commitment to ethical behavior that will not be subordinated to personal gain.

13.1(1) *Public interest.*

a. The grant of a license indicates that an individual has met the criteria established by Iowa Code chapter 542 and the board to perform services in a manner that protects the public interest. The licensee must, therefore, have a keen consciousness of the public interest. The public consists of clients, credit grantors, governments, employers, investors, the business and financial community, and others who use the services of licensees.

b. Because the licensee is seen as a representative of the profession by those who retain or use the licensee's services, the licensee shall avoid conduct that might conflict with the public interest or erode public respect for, and confidence in, the profession.

13.1(2) *Integrity.*

a. Integrity is a character trait demonstrated by acting honestly and candidly and by not knowingly misrepresenting facts, accommodating deceit, or subordinating ethical principles. Acting with integrity is essential to maintaining credibility and public trust.

b. A licensee shall act with integrity in the performance of all professional activities in whatever capacity performed.

13.1(3) *Objectivity.*

a. Objectivity is a distinguishing feature of the accounting profession and is critical to maintaining the public's trust and confidence. It is a state of mind that imposes the obligation to be impartial and free of bias that may result from conflicts of interest or subordination of judgment. Objectivity requires a licensee to exercise an appropriate level of professional skepticism in carrying out all professional activities.

b. A licensee shall maintain objectivity in the performance of all professional activities in whatever capacity performed.

13.1(4) *Due care.*

a. Due care imposes the obligation to perform professional activities with concern for the best interest of those for whom the activities are performed and consistent with the profession's responsibility to the public. It is essential to preserving the public's trust and confidence. Due care requires the licensee to discharge professional responsibilities with reasonable care and diligence and to adequately plan and supervise all professional activities for which the licensee is responsible.

b. A licensee shall act with due care in the performance of all professional activities in whatever capacity performed.

13.1(5) *Competence.*

a. Competence is derived from a combination of education and experience. It begins with a mastery of the common body of knowledge, skills, and abilities and requires a commitment to lifelong learning and professional improvement. A licensee shall possess a level of competence, sound

professional judgment, and proficiency to ensure that the quality of the licensee's activities meets the high level of professionalism required by these principles.

b. A licensee shall be competent in the performance of all professional activities, in whatever capacity performed, and comply with applicable professional standards.

13.1(6) Confidentiality.

a. A licensee has an obligation to maintain and respect the confidentiality of information obtained in the performance of all professional activities. Maintaining such confidentiality is vital to the proper performance of the licensee's professional activities.

b. This obligation continues after the termination of the relationship between the licensee and the client or employer and extends to information obtained by the licensee in professional relationships with prospective clients and employers.

c. This principle shall not be construed to prohibit a licensee from disclosing information as required to meet professional, regulatory or other legal obligations.

13.1(7) Independence.

a. Independence, where required by professional standards, is essential to establishing and maintaining the public's faith and confidence in, and reliance on, information on which the licensee reported.

b. A licensee in the practice of public accounting shall be independent in fact and appearance when engaged to provide services where independence is required by professional standards. Independence in fact is the state of mind that permits a licensee to perform an attest service without being affected by influences that compromise professional judgment, thereby allowing the licensee to act with integrity and exercise objectivity and professional skepticism. Independence in appearance is the avoidance of circumstances that would cause a reasonable and informed third party, having knowledge of all relevant information, to conclude that the integrity, objectivity or professional skepticism of a licensee had been compromised.

[ARC 9003B, IAB 8/11/10, effective 1/1/11]

193A—13.2(542) Scope.

13.2(1) The following rules of professional ethics and conduct have been adopted by the board as authorized by Iowa Code chapter 542, in particular, sections 542.4(9) "e" through "p" and "t." These rules complement the grounds for discipline set out in 193A—Chapter 14. These rules cover a broad range of behavior and do not enumerate every possible unethical act or act of misconduct.

13.2(2) In the interpretation and enforcement of the rules of professional ethics and conduct, the board may give consideration, but not necessarily dispositive weight, to relevant interpretations, rulings and opinions issued by other state boards of accountancy and by appropriately authorized committees on ethics of professional organizations.

[ARC 9003B, IAB 8/11/10, effective 1/1/11]

193A—13.3(542) Applicability.

13.3(1) The rules of professional ethics and conduct which follow rest upon the premise that the reliance of the public in general and of the business community in particular on sound financial reporting and on the implication of professional competence inherent in the authorized use of a legally restricted title relating to the practice of public accountancy imposes on persons engaged in such practice certain obligations both to their clients and to the public. These obligations, which the rules of professional ethics and conduct are intended to enforce where necessary, include the obligation to maintain independence of thought and action and a continued commitment to learning and professional improvement, to observe applicable generally accepted accounting principles and generally accepted auditing standards, to promote public interest through sound and informative financial reporting, to hold the affairs of clients in confidence, and to maintain high standards of personal conduct in all professional activities in whatever capacity performed.

13.3(2) Acceptance of a certificate as a CPA or a license as an LPA to practice public accounting involves acceptance by the CPA or LPA of the obligations set forth in subrule 13.3(1) and accordingly a duty to abide by the rules of professional ethics and conduct.

13.3(3) The rules of professional ethics and conduct have application to all professional services performed by all CPAs and LPAs whether or not they are engaged in the practice of public accountancy, except where the wording of a rule clearly indicates that the applicability is more limited.

13.3(4) A CPA or LPA who is engaged in the practice of public accountancy outside the United States will not be subject to discipline by the board for departing, with respect to such foreign practice, from any of the rules, so long as the CPA's or LPA's conduct is in accordance with the standards of professional conduct applicable to the practice of public accountancy in the country in which the CPA or LPA is practicing. However, even in such a case, if a CPA's or LPA's name is associated with financial statements in such manner as to imply that the CPA or LPA is acting as an independent public accountant and under circumstances that would entitle the reader to assume that United States practices are followed, the CPA or LPA will be expected to comply with subrules 13.4(3) (engagement standards) and 13.4(16) (accounting principles).

13.3(5) A CPA or LPA may be held responsible for compliance with the rules of professional ethics and conduct by all persons associated with the accountant in the practice of public accounting who are either under the accountant's supervision or are licensees, partners or shareholders in the accountant's practice.

13.3(6) CPAs and CPA firms exercising a practice privilege in Iowa or for a client with a home office in Iowa are subject to the professional standards set forth in this chapter.

[ARC 9003B, IAB 8/11/10, effective 1/1/11]

193A—13.4(542) Rules applicable to all CPAs and LPAs.

13.4(1) Integrity, objectivity and conflicts of interest.

a. A CPA or LPA shall not knowingly misrepresent facts and, when engaged in the performance of professional services, shall not subordinate judgment to others or allow professional judgment and objectivity to be impaired by self-interest or by a conflict of interest between the licensee and a client or between clients. In tax practice, a licensee may resolve doubt in favor of the client as long as there is reasonable support for that position.

b. When offering or rendering accounting or related financial, tax, or management advice, a CPA or LPA shall be objective and shall not place the CPA's or LPA's own financial interests or the financial interests of a third party ahead of the legitimate financial interests of the client or the public in any context in which a client or the public can reasonably expect objectivity from one using the CPA or LPA title.

c. When faced with a conflict of interest that may impair professional judgment and objectivity, the licensee shall decline or cease the engagement, take steps to remove the conflict or, when reasonably feasible and appropriate under the circumstances and consistent with independence requirements, disclose the conflict or potential conflict and secure from all clients informed consent to proceed with the engagement. In no event, however, shall a licensee proceed with an engagement through informed consent when the nature of the conflict impairs the licensee's objectivity whether or not the client consents.

d. A conflict of interest may arise, for instance, when a licensee represents multiple clients whose interests are adverse to each other. Whether a licensee can provide competent, diligent, and objective representation to clients whose interests are or may be adverse to each other's interests or the interests of the licensee, with informed consent, will depend on the factual circumstances of the engagement. Licensees are cautioned that, when in doubt as to whether informed consent will effectively address an actual or potential conflict of interest, the most prudent course is to decline or cease the engagement and to advise one or more of the multiple clients to seek alternative professional representation.

13.4(2) Professional competencies and compliance with applicable technical standards. A CPA or LPA who accepts a professional engagement implies that the CPA or LPA has the necessary competence to complete the engagement according to professional standards. All CPAs and LPAs shall comply with the following general standards as interpreted by bodies designated by the American Institute of Certified Public Accountants and must justify any departure.

a. *Professional competence.* A CPA or LPA shall undertake only those engagements which the CPA, LPA or firm can reasonably expect to complete with professional competence. Competence relates

both to knowledge of the profession's standards, techniques and the technical subject matter involved and to the capability to exercise sound judgment in applying such knowledge to each engagement.

b. *Due professional care.* A CPA or LPA shall exercise due professional care in the performance of an engagement.

c. *Planning and supervision.* A CPA or LPA shall adequately plan and supervise an engagement.

d. *Sufficient relevant data.* A CPA or LPA shall obtain sufficient relevant data to afford a reasonable basis for conclusions or recommendations in relation to an engagement.

13.4(3) Engagement standards. Unless they have complied with applicable generally accepted engagement standards, CPAs and LPAs shall not permit their names to be linked with a report associated with any attest or compilation service. The board will consider the American Institute of Certified Public Accountants Professional Standards, Public Company Accounting Oversight Board, International Accounting Standards Board, Statements on Auditing Standards, and Statements on Standards for Accounting and Review Services as sources of interpretations of generally accepted engagement standards.

13.4(4) Discreditable conduct. A CPA or LPA shall not commit any act that reflects adversely on the CPA's or LPA's fitness to engage in the practice of public accountancy. The board may consider discipline by any other agency or jurisdiction when determining probable cause to take action against a CPA or LPA for acts discreditable. Conduct discreditable to the public accounting profession is further defined in 193A—subrule 14.3(12).

13.4(5) Requirements of governmental bodies, commissions, or other regulatory agencies.

a. Many governmental bodies, commissions, or other regulatory agencies have established requirements, such as audit standards, guides, rules and regulations, that CPAs are required to follow in preparation of reports, financial statements or related information, such as management's discussion or analysis, and in performing attest or similar services for entities subject to the jurisdiction of the governmental bodies, commissions, or regulatory agencies. For example, the Securities and Exchange Commission, Government Accountability Office, office of auditor of state, state insurance division and other regulatory agencies have established such requirements.

b. A CPA shall not prepare reports, financial statements or related information for the purposes of reporting to such bodies, commissions, or regulatory agencies, unless the CPA agrees to follow the requirements of such organizations in addition to generally accepted auditing standards, where applicable, unless the CPA discloses in the financial statements or the accountant's report that such requirements were not followed.

13.4(6) Confidentiality. A CPA or LPA shall not, without the consent of the client, disclose any confidential information pertaining to the client obtained in the course of performing professional services. This rule does not:

a. Relieve a CPA or LPA of any obligations under subrules 13.4(3) (engagement standards) and 13.4(16) (accounting principles); or

b. Affect in any way a CPA's or LPA's obligation to comply with a validly issued subpoena or summons enforceable by order of a court; or

c. Prohibit disclosures in the course of a peer review of a CPA's or LPA's professional services; or

d. Preclude a CPA or LPA from responding to any inquiry made by the board or any investigative or disciplinary body established by law or formally recognized by the board. Members of the board and its peer reviewers, staff and other agents shall not disclose any confidential information which comes to their attention from a CPA or LPA in disciplinary proceedings or otherwise in carrying out their responsibilities, except that they may furnish such information to an investigative or disciplinary body.

13.4(7) Records.

a. *Definitions.*

"*Client-provided records*" means all documents or written or electronic material provided to the licensee, or obtained by the licensee in the course of the licensee's representation of the client, that preexisted the retention of the licensee by the client.

“Client records prepared by the licensee” means accounting or other records (tax returns, general ledgers, subsidiary journals, and supporting schedules such as detailed employee payroll records and depreciation schedules) that the licensee was engaged to prepare for the client.

“Licensee’s working papers” means, but is not limited to, supporting records, audit programs, analytical review schedules, and statistical sampling results, analyses, and schedules prepared by the client at the request of the licensee.

“Supporting records” means information not reflected in the client’s books and records that are otherwise not available to the client with the result that the client’s financial information is incomplete. For example, supporting records include adjusting, closing, combining, or consolidating journal entries (including computations supporting such entries) that are produced by the licensee during an engagement (for example, an audit).

b. Furnishing client records.

(1) A CPA or LPA shall furnish within a reasonable time of a client’s or former client’s request:

1. All client-provided records, including any accounting or other records belonging to, or obtained from or on behalf of, the client which the CPA or LPA removed from the client’s premises or received for the client’s account, including a copy of all disclosures required by subrule 13.4(19). The CPA or LPA may make and retain copies of such documents when they form the basis for work done by the CPA or LPA.

2. All client records prepared by the CPA or LPA and supporting records to the extent that such records would ordinarily constitute part of the client’s books and records and are not otherwise available to the client or easily reconstructed by the client or successor CPA or LPA. Examples of such records include depreciation schedules and LIFO inventory work papers. Whether a particular record falls into this category is a mixed question of law and fact. When requested by a client or former client, the CPA or LPA has the burden to demonstrate that a particular record does not fall within this category.

(2) A “reasonable time” for furnishing clients or former clients the records described in paragraph 13.4(7) “a” is dependent upon the facts and circumstances. A CPA or LPA shall strive to be as responsive as the situation requires in light of the possible adverse consequence of delay to the client or former client. As a general rule, the CPA or LPA shall provide such records within 30 days of a written request.

13.4(8) Records retention. A CPA or LPA shall comply with all professional standards on records retention applicable to particular engagements including, but not limited to, standards adopted by recognized standards-setting bodies such as the American Institute of Certified Public Accountants, the Public Company Accounting Oversight Board, the Comptroller General of the United States, the Auditing Standards Board, the Internal Revenue Service, or other applicable regulatory body.

13.4(9) Nonpayment of fees.

a. *General rule.* A CPA or LPA shall not withhold the records described in paragraph 13.4(7) “b” from a client or former client based on nonpayment of fees. However, if a CPA or LPA has already issued a tax return, report or other record to a client or former client, the CPA or LPA may, but is not required to, request payment of outstanding fees prior to providing a second copy of such records.

b. *Copy expenses.* A licensee may, but is not required to, charge the actual cost of furnishing electronic or paper copies of records if consistent with the engagement arrangements with the client.

c. *Incomplete engagement.* Nothing in this subrule requires a licensee to complete an engagement if, under the engagement arrangement, completion is contingent upon payment of fees. For example, if a client engages a licensee to complete a tax return and the completion of the engagement is contingent upon payment of fees, the licensee is not required to complete the engagement and furnish the client records prepared by the licensee or associated supporting records if the client does not pay as agreed. In that event, the licensee is only required to return to the client those records constituting client-provided records. If, however, the licensee completes the engagement and furnishes the client a tax return to file or files the tax return with taxing authorities, the licensee is required to comply with paragraph 13.4(9) “a” whether or not fully paid.

13.4(10) Cooperation with board inquiry. A CPA or LPA shall, when requested, respond to communications from the board within 30 days of the mailing of such communications by certified mail.

13.4(11) Violation of tax laws. A CPA or LPA shall not violate any tax laws in handling the CPA's or LPA's personal business affairs, or the business affairs of an employer or client, or the business affairs of any company owned by the CPA or LPA.

13.4(12) Reporting convictions, judgments, and disciplinary actions. In addition to any other reporting requirement in Iowa Code chapter 542 or these rules, a CPA or LPA shall notify the board within 30 days of:

a. Imposition upon the CPA or LPA of discipline including, but not limited to, censure, reprimand, sanction, probation, civil penalty, fine, consent decree or order, or suspension, revocation or modification of a license, certificate, permit or practice rights by:

(1) The SEC, Public Company Accounting Oversight Board, or IRS (by the Director of Practice); or

(2) Another state board of accountancy for cause other than failure to pay a professional fee by the due date or failure to meet the continuing education requirements of another state board of accountancy; or

(3) Any other federal or state agency regarding the CPA's or LPA's conduct while rendering professional services; or

(4) Any foreign authority or credentialing body that regulates the practice of accountancy;

b. Occurrence of any matter that must be reported by the CPA or LPA to the Public Company Accounting Oversight Board pursuant to Sarbanes-Oxley Section 102(b)(2)(f) and Public Company Accounting Oversight Board rules and forms adopted pursuant thereto;

c. Any judgment, award or settlement of a civil action or arbitration proceeding in which the CPA or LPA was a party if the matter included allegations of gross negligence, violation of specific standards of practice, fraud, or misappropriation of funds in the practice of accounting; provided, however, licensed firms shall notify the board regarding civil judgments, settlements or arbitration awards directly involving the firm's practice of public accounting in this state; or

d. Criminal charges, deferred prosecution or conviction or plea of no contest to which the CPA or LPA is a defendant if the crime is:

(1) Any felony under the laws of the United States or any state of the United States or any foreign jurisdiction; or

(2) Any crime, including a misdemeanor, if an essential element of the offense is dishonesty, deceit or fraud, as more fully described in Iowa Code section 542.5, subsection 2.

13.4(13) Firm's duty to report. The CPA or LPA designated by each firm as responsible for the proper licensure of the firm or registration of an office of the firm shall report any matter reportable under this rule to which a nonlicensee owner with a principal place of business in this state is a party.

13.4(14) Advertising. A CPA or LPA shall not use or participate in the use of any form of public communication having reference to professional services that contains a false, fraudulent, misleading, deceptive or unfair statement or claim. A false, fraudulent, misleading, deceptive or unfair statement or claim includes, but is not limited to, a statement or claim which:

a. Contains a misrepresentation of fact; or

b. Is likely to mislead or deceive because it fails to make full disclosure of relevant facts; or

c. Contains any testimonial or laudatory statement, or other statement or implication that the CPA's or LPA's professional services are of exceptional quality; or

d. Is intended to likely create false or unjustified expectations of favorable results; or

e. Implies educational or professional attainments or licensing recognition not supported in fact; or

f. States or implies that the CPA or LPA has received formal recognition as a specialist in any aspect of the practice of public accountancy, if this is not the case; or

g. Represents that professional services can or will be competently performed for a stated fee when this is not the case or makes representations with respect to fees for professional services that do not disclose all variables affecting the fees that will in fact be charged; or

h. Contains other representations or applications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived.

13.4(15) Misleading firm names.

a. A firm name is misleading within the meaning of Iowa Code section 542.13 if, among other things:

- (1) The firm name implies the existence of a corporation when the firm is not a corporation.
 - (2) The firm name implies the existence of a partnership when there is not a partnership (e.g., "Smith & Jones, CPAs" or "Smith and Jones, LPAs").
 - (3) The CPA firm name includes the name of a person who is not a CPA if the title "CPAs" or "Certified Public Accountants" is included in the firm name.
 - (4) The LPA firm name includes the name of a person who is not an LPA if the title "LPAs" or "Licensed Public Accountants" is included in the firm name.
 - (5) The firm name contains any wording that would be a violation of subrule 13.4(14) (advertising).
- b. Names of one or more past partners or shareholders may be included in the firm name of a partnership or corporation or its successor, and a partner surviving the death or withdrawal of all other partners may continue to practice under a partnership name for up to two years after becoming a sole practitioner.

13.4(16) Accounting principles. A CPA or LPA shall not state in the CPA's or LPA's report that the financial or other information is presented in conformity with generally accepted accounting principles if such report contains any departure from such accounting principles which has a material effect on the report taken as a whole, unless the CPA or LPA can demonstrate that by reason of unusual circumstances the report would otherwise have been misleading. In such cases, the accountant's report must describe the departure, the approximate effects thereof, if practicable, and the reasons why compliance with the principle(s) would result in a misleading statement. The board will consider the pronouncements issued by the Financial Accounting Standards Board and its predecessor entities as sources of interpretations of generally accepted accounting principles.

13.4(17) Forecasts. A CPA or LPA shall not in the performance of professional services permit the CPA's or LPA's name to be used in conjunction with any forecast of future transactions in a manner which may lead to the belief that the CPA or LPA vouches for the achievability of the forecast.

13.4(18) Competence. A CPA or LPA shall not undertake any engagement for the performance of professional services which the CPA or LPA or the CPA's or LPA's firm cannot reasonably expect to complete with due professional competence, including compliance, where applicable, with subrules 13.4(3) (engagement) and 13.4(16) (accounting principles). A CPA or LPA who accepts a professional engagement implies that the CPA or LPA has the necessary competence to complete the engagement according to professional standards, applying the CPA's or LPA's knowledge and skill with reasonable care and diligence, but the CPA or LPA does not assume a responsibility for infallibility of knowledge or judgment.

13.4(19) Commissions. A CPA or LPA may accept a commission subject to the prohibitions set forth in Iowa Code section 542.13(15) and the restrictions set forth in these rules.

a. A CPA or LPA engaged in the practice of public accounting must act in the best interests of the client and shall not allow integrity, objectivity or professional judgment to be impaired by the self-interest a commission-based fee may create.

b. A CPA or LPA who anticipates receiving a commission in connection with the recommendation, referral or sale of a product or service must establish such procedures as are reasonably necessary to avoid the prohibitions set forth in Iowa Code section 542.13(15).

c. A CPA or LPA engaged in the practice of public accounting who is paid or expects to be paid a commission shall disclose that fact to any person or entity to which the CPA or LPA recommends, refers or sells a product or service to which the commission relates.

d. To ensure full and effective disclosure, a CPA or LPA shall substantially adhere to the following guidelines when recommending, referring or selling a product or service to which a commission relates:

(1) The disclosure shall be in writing, signed and dated by the person to whom a product or service is recommended, referred or sold, and a copy shall be provided to the client.

(2) The disclosure shall be made at or prior to the time the product or service is recommended, referred or sold.

(3) The disclosure shall be legible, clear and conspicuous, and on a separate form.

(4) A copy of the disclosure shall be retained by the CPA or LPA for as long as the CPA or LPA deems appropriate to the transaction; however, the board recommends a minimum of three years.

(5) In the event of a continuing engagement or series of related transactions involving similar products or services, one written disclosure may cover more than one recommendation, referral or sale as long as the disclosure is provided at least annually and is not misleading.

e. This rule does not prohibit payments for the purchase of all, or a material part, of an accounting practice, or retirement payments to persons formerly engaged in the practice of public accountancy, or payments to heirs or estates of such persons.

13.4(20) Contingent fees. A CPA or LPA may accept contingent fees as defined in Iowa Code section 542.3(9) subject to the prohibitions set forth in Iowa Code section 542.13(15) and restrictions set forth in these rules.

13.4(21) Solicitation. A CPA or LPA shall not by any direct personal communication solicit an engagement to perform professional services:

a. If the communication would violate subrule 13.4(14) (advertising) if it were a public communication; or

b. By the use of coercion, duress, compulsion, intimidation, threats, overreaching, or harassing conduct; or

c. If the solicitation communication contains proposals which would improperly disclose confidential information or violate a professional standard established in this chapter.

13.4(22) Discrimination and harassment in employment practices. Whenever a CPA or LPA is determined by a court of competent jurisdiction to have violated any of the antidiscrimination laws of the United States or any state or municipality thereof, including those related to sexual and other forms of harassment, or has waived or lost the CPA's or LPA's right of appeal after a hearing by an administrative agency, the CPA or LPA will be presumed to have committed an act discreditable to the profession.

13.4(23) Preparation of financial statements or records. A CPA or LPA shall not:

a. Make, or permit or direct another to make, materially false or misleading entries in the financial statements or records of an entity;

b. Fail to correct an entity's financial statements that are materially false or misleading when the CPA or LPA has the authority to record an entry; or

c. Sign, or permit or direct another to sign, a document containing materially false or misleading information.

13.4(24) Solicitation or disclosure of CPA examination questions and answers. A CPA or LPA who solicits or knowingly discloses a Uniform CPA Examination question(s) or answer(s) without the written authorization of the American Institute of Certified Public Accountants shall be considered to have committed an act discreditable to the profession.

13.4(25) Falsely reporting continuing professional education (CPE). A CPA or LPA shall be considered to have committed an act discreditable to the profession when the CPA or LPA falsely reports CPE credits during the CPA's or LPA's required reporting renewal or board CPE audit.

13.4(26) Mandatory ethics continuing professional education. Every CPA certificate holder or LPA license holder shall complete a minimum of four hours of continuing professional education devoted to ethics and rules of professional conduct during the three-year period ending December 31 or June 30, prior to the July 1 annual renewal date. This requirement is more fully described in 193A—subrule 10.7(2).

[ARC 9003B, IAB 8/11/10, effective 1/1/11; ARC 2152C, IAB 9/30/15, effective 11/4/15]

193A—13.5(542) Rules applicable to CPAs and LPAs who use the titles in offering or rendering products or services to clients.

13.5(1) Use of title.

a. *Certified public accountant.* Only a person who holds an active, unexpired certificate and who complies with the requirements of 193A—Chapter 5, Licensure Status and Renewal of Certificates and

Licenses, and Chapter 10, Continuing Education, or a person lawfully exercising a practice privilege under Iowa Code section 542.20 may use or assume the title "certified public accountant" or the abbreviation "CPA" or any other title, designation, words, letters, abbreviation, sign, card or device tending to indicate that such person is a certified public accountant.

b. *Licensed public accountant.* Only a person holding a license as a licensed public accountant shall use or assume the title "licensed public accountant" or the abbreviation "LPA" or any other title, designation, words, letters, abbreviations, sign, card, or device tending to indicate that such person is a licensed public accountant.

13.5(2) Forms of practice.

a. *Certified public accountant firms.* A sole proprietorship, corporation, partnership, limited liability company, or any other form of organization shall apply for a permit to practice under Iowa Code section 542.7 and these rules as a firm of certified public accountants in order to use the title "CPAs" or "CPA firm," as more fully described in 193A—Chapter 7.

b. *Licensed public accounting firms.* A sole proprietorship, corporation, partnership, limited liability company, or any other form of organization shall apply for a permit to practice under Iowa Code section 542.8 and these rules as a firm of licensed public accountants in order to use the title "LPAs" or "LPA firm," as more fully described in 193A—Chapter 8.

13.5(3) Acting through others. A CPA or LPA shall not permit others to carry out on the CPA's or LPA's behalf, either with or without compensation, acts which, if carried out by the CPA or LPA, would violate the rules of professional ethics and conduct.

[ARC 9003B, IAB 8/11/10, effective 1/1/11]

193A—13.6(542) Audit, review and other attest services.

13.6(1) Definitions.

"*Attest*" or "*attest service*" means providing any of the following services:

1. An audit or other engagement to be performed in accordance with the statements on auditing standards.

2. A review of a financial statement to be performed in accordance with the statements on standards for accounting and review services.

3. Any engagement to be performed in accordance with the statements on standards for attestation engagements.

4. Any engagement to be performed in accordance with the auditing standards of the Public Company Accounting Oversight Board.

The standards specified in the definition of "attest" are those standards adopted by the board, by rule, by reference to the standards developed for general application by the American Institute of Certified Public Accountants, the Public Company Accounting Oversight Board, or other recognized national accountancy organization.

"*Attest engagement team*" means the team of individuals participating in attest service, including those who perform concurring or second partner reviews. The "attest engagement team" includes all employees and contractors retained by the firm who participate in attest service, irrespective of their functional classification.

"*Audit*" means the procedures performed in accordance with applicable auditing standards for the purpose of expressing or disclaiming an opinion on the fairness with which the historical financial or other information is presented in conformity with generally accepted accounting principles, another comprehensive basis of accounting, or basis of accounting described in the report.

"*Review*" means to perform inquiry and analytical procedures that permit a CPA to determine whether there is a reasonable basis for expressing limited assurance that there are no material modifications that should be made to financial statements in order for them to be in conformity with generally accepted accounting principles or, if applicable, with another comprehensive basis of accounting.

13.6(2) Practice privilege. All audit, review, and other attest services performed in Iowa or for a client with a home office in Iowa must be performed through a CPA firm that holds an active Iowa firm

permit to practice; provided that, an out-of-state CPA firm exercising a practice privilege may perform review services in Iowa or for a client with a home office in Iowa without first obtaining a firm permit to practice in Iowa as long as the firm complies with Iowa Code section 542.20, subsections 5 and 6, and associated rules. Unless Iowa certification is specifically required by a governmental body or client, the individual CPAs performing such attest services may either hold an active Iowa CPA certificate or exercise a practice privilege as more fully described in Iowa Code section 542.20. LPAs and LPA firms are not authorized to perform attest services.

13.6(3) Professional skepticism. A CPA shall not subordinate the CPA's professional judgment to a non-CPA. Professional judgment requires auditors to exercise professional skepticism, which is an attitude that includes a questioning mind and a critical assessment of evidence. Auditors use the knowledge, skills, and experience called for by their profession to diligently perform, in good faith and with integrity, the gathering of evidence and the objective evaluation of the sufficiency, competency, and relevancy of evidence. Since evidence is gathered and evaluated throughout the assignment, professional skepticism shall be exercised throughout the assignment.

13.6(4) Independence. A CPA or CPA firm shall not issue a report on a client in such a manner as to imply that the CPA is acting as an independent public accountant with respect thereto unless the CPA is independent with respect to such client. Independence will be considered to be impaired if, for example:

a. During the period of the professional engagement, or at the time of expressing an opinion, a CPA:

(1) Had, or was committed to acquire, any direct or material indirect financial interest in the client; or was a trustee of any trust or executor or administrator of any estate if such trust or estate had, or was committed to acquire, any direct or material indirect financial interest in the client; or

(2) Had any joint, closely held business investment with the client or any officer, director or principal stockholder which was material to the CPA; or

(3) Had any loan to or from the client or any officer, director or principal stockholder thereof other than loans of the following kinds made by a financial institution under normal lending procedures, terms and requirements: loans which are not material in relation to the net worth of the CPA; home mortgages; and other secured loans, except those secured solely by a guarantee of the CPA.

b. During the period covered by the reports, during the period of the professional engagement, or at the time of expressing an opinion, the licensee:

(1) Was connected with the client as a promoter, underwriter or voting trustee, a director or officer or in any capacity equivalent to that of a member of management or of an employee; or

(2) Was a trustee for any pension or profit-sharing trust of the client.

The foregoing examples are not intended to be all-inclusive.

13.6(5) Professional judgment. A CPA shall not, in the performance of audit, review or other attest services, knowingly misrepresent facts, subordinate judgment to others, or allow professional judgment and objectivity to be impaired by self-interest or by a conflict of interest between the licensee and a client or between clients.

13.6(6) Retention period of attest documentation and working papers. Unless otherwise required by applicable law, a CPA or CPA firm shall retain attest documentation and attest working papers for seven years, measured by the report date. If the CPA or CPA firm is notified within the seven-year period of a board investigation or disciplinary proceeding, criminal investigation or proceeding, or other governmental investigation or proceeding, which stems from or relates to the documents at issue, such attest documentation and attest working papers shall not be destroyed until the firm has been notified in writing that the investigation or proceeding has been closed or otherwise fully resolved or until seven years from the report date, whichever period is longer.

13.6(7) Peer review required. As a condition of renewal of a permit to practice as a CPA firm, the firm shall undergo, at least once every three years, a peer review conducted under the provisions outlined in 193A—Chapter 11 and Iowa Code section 542.7.

13.6(8) Failure to follow standards, procedures or other requirements in governmental audits. Engagements for audits of governmental grants, governmental units or other recipients of governmental moneys typically require that such audits be in compliance with government audit

standards, guides, procedures, statutes, rules, and regulations, in addition to generally accepted auditing standards. If a CPA has accepted such an engagement and undertakes an obligation to follow specified government audit standards, guides, procedures, statutes, rules and regulations, in addition to generally accepted auditing standards, the CPA is obligated to follow such requirements.

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193A—13.7(542) Compilation.

13.7(1) Who can perform. Only a CPA licensed under Iowa Code section 542.6 or 542.19, an LPA licensed under Iowa Code section 542.8, or a CPA exercising a practice privilege under Iowa Code section 542.20 shall issue a report in standard form upon a compilation of financial information or otherwise provide compilation services in Iowa or for a client with a home office in Iowa. (Refer to rule 193A—6.4(542).)

13.7(2) Peer review. All individuals described in 193A—subrule 6.4(1) shall satisfy peer review requirements, individually or through a peer review of a CPA or LPA firm holding a permit to practice pursuant to Iowa Code section 542.7 or 542.8 or a CPA firm exercising a practice privilege under Iowa Code section 542.20.

13.7(3) Mandatory financial statement presentation continuing professional education. In each renewal period in which compilation reports are issued, every CPA certificate holder or LPA license holder who is responsible for supervising compilation services or who signs or authorizes someone to sign the accountant's compilation report on the financial statements on behalf of a firm shall complete, as a condition of certificate or license renewal, a minimum of eight hours of continuing education devoted to financial statement presentation every three years, such as courses covering the Statements on Standards for Accounting and Review Services (SSARS) and accounting and auditing updates. This requirement is more fully described in 193A—subrule 10.7(1).

13.7(4) Compilation standards.

a. A compilation shall be performed by a person or persons having adequate technical training and proficiency to compile prospective financial statements.

b. Due professional care shall be exercised in the performance of the compilation and the preparation of the report.

c. The work shall be adequately planned, and assistants, if any, shall be properly supervised.

d. Applicable compilation procedures shall be performed as a basis for reporting on the compiled financial statements.

e. The report based on the licensee's compilation shall include the following:

(1) An identification of the financial statements presented by the responsible party;

(2) A statement that the licensee has compiled the financial statements in accordance with standards established by the American Institute of Certified Public Accountants;

(3) The manual or printed signature of the licensee's firm;

(4) The date of the compilation report.

13.7(5) Compilation standards for prospective financial statements.

a. Applicable compilation procedures shall be performed as a basis for reporting on the compiled prospective financial statements.

b. In addition to the four items included in paragraph 13.7(4) "e," the report based on the licensee's compilation shall include the following:

(1) A statement that a compilation is limited in scope and does not enable the licensee to express an opinion or any other form of assurance on the prospective financial statements or the assumptions;

(2) A caveat that the prospective results may not be achieved;

(3) A statement that the licensee assumes no responsibility to update the report for events and circumstances occurring after the date of the report.

[ARC 9003B, IAB 8/11/10, effective 1/1/11]

193A—13.8(542) Rules applicable to tax practice.

13.8(1) CPAs, LPAs, and persons who are not CPAs or LPAs may perform tax services in Iowa. The rules of professional ethics and conduct in this chapter and, more specifically, with respect to tax services, this rule shall apply to CPAs and LPAs who are licensed in Iowa and to CPAs exercising a practice privilege in Iowa whenever such persons inform the client or prospective client that they are a CPA or LPA. Clients may be so informed in a number of ways, including oral or written representations, the display of a CPA certificate or LPA license, or use of the CPA or LPA title in advertising, telephone or Internet directories, letterhead, business cards or E-mail. Clients and prospective clients who select a tax professional holding oneself out as a CPA or LPA have the right to expect compliance with these rules. A licensee shall not render services in the area of taxation unless the licensee has complied with Statements on Responsibilities in Tax Practice (SRTP), Internal Revenue Service Treasury Department Circular 230, Iowa department of revenue rules, and the Iowa Code.

13.8(2) Professional judgment—tax position. The licensee may resolve doubt in favor of the licensee's client as long as there is reasonable support for the client's tax return position. The licensee shall in good faith believe that the client's tax return position is warranted in existing law or can be supported by a good-faith argument for an extension, modification, or reversal of existing law. The licensees shall in good faith believe that:

a. The position has a realistic possibility of being sustained administratively or judicially on its merits if challenged.

b. The position is appropriately disclosed.

c. The taxpayer is advised regarding potential penalty consequences of the tax return position.

d. In addition to a duty to the taxpayer, the licensee has a duty to the tax system.

13.8(3) Licensees shall provide the following form and content of advice to taxpayers:

a. Establish the relevant background facts.

b. Consider the reasonableness of the assumptions and representations.

c. Apply the pertinent authorities to the relevant facts.

d. Consider the business purpose and economic substance of the transaction, if relevant to the tax consequences of the transaction.

e. Arrive at a conclusion supported by the authorities.

13.8(4) Before signing as preparer, a licensee shall make a reasonable effort to obtain from the taxpayer the information necessary to provide appropriate answers to all questions on a tax return.

a. The licensee must exercise due diligence in preparing, or assisting in the preparation of, approving, and filing tax returns.

b. A licensee shall perform due diligence in determining the correctness of oral or written representations made by the client.

13.8(5) Contingent fee.

a. A licensee may charge a contingent fee for services rendered in connection with the examination of, or challenge to:

(1) An original tax return, or

(2) An amended return or claim for refund or credit where the amended return or claim for refund or credit was filed within 120 days of the taxpayer's receiving a written notice of the examination of, or a written challenge to, the original tax return.

b. A licensee may charge a contingent fee for services rendered in connection with a claim for credit or refund filed solely in connection with the determination of statutory interest or penalties assessed by the Internal Revenue Service or other governmental agency, or in a judicial proceeding.

c. A licensee may charge a contingent fee for services rendered in connection with any judicial proceeding arising under the Internal Revenue Service.

13.8(6) Return of client's records.

a. At the request of a client, a licensee must promptly return any and all records of the client that are necessary for the client to comply with the client's tax obligations.

b. Records of the client include all documents, written or electronic, provided to the licensee, or obtained by the licensee in the course of the licensee's representation of the client, that preexisted the retention of the licensee by the client.

13.8(7) Conflict of interest.

a. A licensee shall not represent a client if the representation involves a conflict of interest. A conflict of interest exists if:

- (1) The representation of one client will be directly adverse to another client, or
- (2) There is significant risk that the representation of one or more clients will be materially limited by the licensee's responsibilities to another client, a former client, or a third person, or by a personal interest of the licensee.

b. Notwithstanding the existence of a conflict of interest under paragraph "a" of this subrule, the licensee may represent a client if:

- (1) The licensee reasonably believes that the licensee will be able to provide competent and diligent representation to each affected client;
- (2) The representation is not prohibited by law; and
- (3) Each affected client waives the conflict of interest and gives informed consent, confirmed in writing by each affected client, at the time the existence of the conflict of interest is known by the licensee. Copies of consents must be retained for at least 36 months from the date of the conclusion of the representation of the affected clients.

[ARC 9003B, IAB 8/11/10, effective 1/1/11]

193A—13.9(542) Consulting, advisory and other accounting services.

13.9(1) Introduction.

a. Consulting services that licensees provide to their clients have evolved from advice on accounting-related matters to a wide range of services involving diverse technical disciplines, industry knowledge, and consulting skills. Most licensees, including those who provide audit and tax services, also provide business and management consulting services to their clients.

b. Consulting services differ fundamentally from the licensee's function of attesting to the assertions of other parties. In a consulting service, the licensee develops the findings, conclusions, and recommendations presented. The nature and scope of work are determined solely by the agreement between the licensee and the client. Generally, the work is performed only for the use and benefit of the client.

13.9(2) Definitions.

"*Advisory services*" means the development and presentation of findings, conclusions, and recommendations for client consideration and decision making.

"*Business valuation*" means the act or process of determining the value of a business enterprise or ownership interest therein.

"*Consulting services*" means professional services that employ the practitioner's technical skills, education, observations, experience, and knowledge of the consulting process.

13.9(3) CPAs, LPAs, and persons who are not CPAs or LPAs may perform management or financial advisory services, financial investment or planning services, business valuation, and financial consulting services in Iowa. Some advisory or consulting services require licensure by bodies other than the board, such as insurance or securities licenses issued by the division of insurance. The rules of professional ethics and conduct in this chapter and, more specifically, with respect to advisory and consulting services, this rule shall apply to CPAs and LPAs who are licensed in Iowa and to CPAs exercising a practice privilege in Iowa whenever such persons inform the client or prospective client that they are a CPA or LPA. Clients may be so informed in a number of ways, including oral or written representations, the display of a CPA certificate or LPA license, or use of the CPA or LPA title in advertising, telephone or Internet directories, letterhead, business cards, or E-mail. Clients and prospective clients who select an advisory or consulting professional holding oneself out as a CPA or LPA have the right to expect compliance with these rules. A licensee shall comply with the applicable standards for the consulting, advisory and other accounting services to be provided to the licensee's client(s), such as Statements

on Standards for Valuation Services, Statements on Standards for Consulting Services, Statements on Responsibilities in Personal Financial Planning Practice, the Iowa uniform securities Act, the Iowa securities and regulated industries bureau, and the Iowa Code.

13.9(4) The consulting process requires the licensee to develop the findings, determine the conclusions, and present the recommendations. The nature and scope of work are determined by the agreement between the licensee and client.

13.9(5) Licensees shall follow these additional general standards for consulting services:

a. Client interest. The licensee shall serve the client interest by seeking to accomplish the objectives established by the understanding with the client while maintaining integrity and objectivity.

b. Understanding with client. The licensee shall establish with the client an oral or written understanding about the responsibilities of the parties and the nature, scope, and limitations of services to be performed and shall modify the understanding when circumstances require a significant change during the engagement.

c. Communication with client. The licensee shall inform the client of (1) conflicts of interest that may occur pursuant to interpretations of Rule 102 of the American Institute of Certified Public Accountants Code of Professional Conduct, (2) significant reservations concerning the scope or benefits of the engagement, and (3) significant engagement findings or events.

13.9(6) Performance of consulting services for an attest client does not, in and of itself, impair independence. Licensees and their firms performing attest services for a client shall comply with applicable independence standards, rules and regulations issued by the American Institute of Certified Public Accountants, the board, and other applicable regulatory agencies.

13.9(7) Licensees providing client service involving financial planning or the recommendation or sale of financial products or services may need to be licensed by applicable federal, state or local regulatory bodies.

[ARC 9003B, IAB 8/11/10, effective 1/1/11]

These rules are intended to implement Iowa Code chapters 272C and 542.

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CHAPTER 14

DISCIPLINARY AUTHORITY AND GROUNDS FOR DISCIPLINE

193A—14.1(17A,272C,542) Disciplinary authority. The board is empowered to administer Iowa Code chapters 17A, 272C and 542 and related administrative rules for the protection and well-being of those persons who may rely upon licensed individuals and firms for the performance of public accounting services within this state or for clients in this state. To perform these functions, the board is broadly vested with authority to review and investigate alleged acts or omissions of licensees, determine whether disciplinary proceedings are warranted, initiate and prosecute disciplinary proceedings, establish standards of professional conduct, and impose discipline, pursuant to Iowa Code sections 17A.13, 272C.3 to 272C.6, 272C.10, 542.4, and 542.10 to 542.16.

[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—14.2(17A,272C,542) Disciplinary policy.

14.2(1) In exercising its disciplinary authority and in construing the meaning of the phrase “conduct discreditable to the public accounting profession” as used in Iowa Code section 542.10, subsection 1 paragraph “i,”, the board shall be guided by the legislative policies, goals and standards set forth in Iowa Code section 542.2.

14.2(2) The board’s disciplinary policy rests upon the premise that the reliance of the public in general and of the business community in particular on sound financial reporting, and on the implication of professional competence inherent in the authorized use of a legally restricted title relating to the practice of public accountancy, imposes on persons and firms engaged in such practice certain obligations both to their clients and to the public. These obligations include the obligation to maintain independence of thought and action; to strive continuously to improve one’s professional skills; to observe, where applicable, generally accepted accounting principles, generally accepted auditing standards, and similar principles and standards; to promote sound and informative financial reporting; to hold the affairs of clients in confidence; and to maintain high standards of personal conduct in all matters affecting one’s fitness to practice public accountancy.

14.2(3) The public interest requires that persons professing special competence in accountancy or offering assurance as to the reliability or fairness of presentation of such information shall have demonstrated their qualifications to do so, and that persons who have not demonstrated and maintained such qualifications not be permitted to represent themselves as having such special competence or to offer such assurance; that the conduct of persons licensed as having special competence in accountancy be regulated in all aspects of their professional work; that a public authority competent to prescribe and assess the qualifications and to regulate the conduct of licensees be established; and that the use of titles that have a capacity or tendency to deceive the public as to the status or competence of the persons using such titles be prohibited.

14.2(4) A CPA or LPA firm is subject to discipline for its own violations of Iowa Code chapter 542 and administrative rules and the violations of the firm’s CPAs, LPAs, nonlicensee owners, persons acting or purporting to act under a practice privilege, and others performing professional services on the firm’s behalf. Whether a CPA or LPA firm will be charged based on the acts of such individuals will depend on the circumstances. Among the factors the board will consider are whether the firm took reasonable steps to prevent the violation, whether the violation was or could have been discovered by the firm upon reasonable inquiry, what steps the firm took upon discovering the violation, whether the acts or omissions involved licensees of the board or were committed by persons who are not individually licensed by the board, the nature of the services at issue, and whether the violations are isolated matters or more systemic to the firm’s performance.

[ARC 7715B, IAB 4/22/09, effective 7/1/09]

193A—14.3(17A,272C,542) Grounds for discipline. The board may initiate disciplinary action against a CPA or LPA, or a firm of CPAs or LPAs, which holds an active, inactive or lapsed certificate, license or permit to practice on any of the following grounds:

14.3(1) Fraud or deceit in procuring a license. Fraud or deceit in procuring or attempting to procure an initial, reciprocal, renewal, or reinstated certificate, license, or permit to practice includes any intentional perversion of the truth when submitting an application to the board, or when submitting information in support of another's application to the board, including:

- a. False representation of a material fact, whether by word or by conduct, by false or misleading allegation, or by concealment of that which should have been disclosed.
- b. Attempting to file or filing with the board any false or forged record or document, such as a college transcript, diploma or degree, examination report, verification of licensure, continuing education certificate, or verification of peer review.
- c. Failing or refusing to provide complete information in response to a question on an application.
- d. Reporting information, such as satisfaction of continuing education, peer review, or attest qualification, in a false manner through overt deceit or with reckless disregard for the truth or accuracy of the information asserted.
- e. Otherwise participating in any form of fraud or misrepresentation by act or omission.

14.3(2) Professional incompetence. Professional incompetence includes, but is not limited to:

- a. A substantial lack of knowledge or ability to discharge professional obligations within the practice of public accounting.
- b. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other practitioners in the state of Iowa acting in the same or similar circumstances.
- c. A failure to exercise the degree of care which is ordinarily exercised by the average practitioner acting in the same or similar circumstances.
- d. Failure to conform to the minimum standards of acceptable and prevailing practice of public accounting in this state.
- e. A willful, repeated, or material deviation from generally accepted engagement standards, generally accepted accounting standards, generally accepted auditing standards, or any other nationally recognized standard applicable to the public accounting services at issue, as provided in rule 193A—13.4(542).
- f. Any other act or omission that demonstrates an inability to safely practice in a manner protective of the public's interest.

14.3(3) Deceptive practices. Deceptive practices are grounds for discipline, whether or not actual injury is established, and include:

- a. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of public accounting.
- b. Use of untruthful or improbable statements in advertisements. Use of untruthful or improbable statements in advertisements includes, but is not limited to, an action by a licensee in making information or intention known to the public which is false, deceptive, misleading or promoted through fraud or misrepresentation.
- c. Acceptance of any fee by fraud or misrepresentation.
- d. Falsification of business or client records.
- e. Submission of false or misleading reports or information to the board including information supplied in an audit of continuing education, reports submitted as a condition of probation, or any reports identified in this rule or 193A—Chapter 18.
- f. Knowingly presenting as one's own a certificate, license, or permit to practice, or a certificate, license, or permit number, or the signature of another or of a fictitious licensee, or otherwise falsely impersonating a person holding a CPA certificate or LPA license, or a permit to practice as a firm of CPAs or LPAs.
- g. Representing oneself as a CPA, LPA, CPA firm, or LPA firm when the certificate, license, or permit to practice has been suspended, revoked, surrendered, or placed on inactive status, or has lapsed, except as allowed under Iowa Code section 542.20.
- h. Fraud in representations as to skill or ability.

14.3(4) Unethical, harmful or detrimental conduct. Licensees engaging in unethical conduct or practices harmful or detrimental to the public may be disciplined whether or not injury is established.

Behaviors and conduct which are unethical, harmful or detrimental to the public may include, but are not limited to, the following actions:

a. Verbal or physical abuse, or improper sexual contact, if such behavior occurs within the practice of public accounting or if such behavior otherwise provides a reasonable basis for the board to conclude that such behavior within the practice of public accounting would place the public at risk.

b. A violation of a rule of professional conduct relating to improper conflicts of interest, or lack of integrity, objectivity or independence, as provided in rule 193A—13.3(542).

c. A violation of a provision of Iowa Code section 542.13, or aiding or abetting any unlawful activity for which a civil penalty can be imposed under Iowa Code sections 542.13 and 542.14.

14.3(5) Lack of proper qualifications. Lack of proper qualifications includes, but is not limited to:

a. Continuing to practice as a CPA or LPA without satisfying the continuing education required for certificate or license renewal.

b. Continuing to perform attest services or compilation services without timely completion of peer review.

c. Performing attest services as an individual without proper certification or attest qualification, or without acting through a CPA firm holding a permit to practice pursuant to Iowa Code section 542.7.

d. Performing attest services as a firm without holding a permit to practice pursuant to Iowa Code section 542.7, or without ensuring that the individuals responsible for supervising attest services or signing or authorizing someone to sign the accountant's report are attest qualified, hold the required certification or are eligible to exercise a practice privilege, or otherwise performing attest services in a manner inconsistent with Iowa Code chapter 542 and 193A—Chapters 6 and 7.

e. Habitual intoxication or addiction to the use of drugs, or impairment which adversely affects the CPA's or LPA's ability to practice in a safe and competent manner.

f. Any act, conduct, or condition, including lack of education or experience and careless or intentional acts or omissions, that demonstrates a lack of qualifications which are necessary to ensure a high standard of professional care as provided in Iowa Code section 272C.3(2) "b," or that impairs a practitioner's ability to safely and skillfully practice the profession.

14.3(6) Negligence in the practice of public accounting. Negligence in the practice of public accounting includes the following acts, practices, or omissions, whether or not injury results:

a. Failure or refusal without good cause to exercise reasonable diligence in the practice of public accounting.

b. A failure to exercise due care including negligent delegation of duties in the practice of public accounting.

c. Neglect of contractual or other duties to a client.

14.3(7) Professional misconduct. Professional misconduct includes, but is not limited to, the following:

a. Violation of a generally accepted engagement standard, generally accepted accounting standard, generally accepted auditing standard, or any other nationally recognized standard applicable to the public accounting services at issue, as provided in rule 193A—13.4(542), or any other violation of a provision of 193A—Chapter 13.

b. Violation of a regulation or law of this state, another state, the United States, or the PCAOB in the practice of public accounting.

c. Engaging in any conduct that subverts or attempts to subvert a board investigation of a licensed or unlicensed firm, individual, or other entity, or failure to fully cooperate with a disciplinary investigation of a licensee or with an investigation of firms, individuals or other entities that are not licensed by the board, including, without limitation, failure to comply with a subpoena issued by the board or to respond to a board inquiry within 30 calendar days of the date of mailing by certified mail of a written communication directed to the licensee's last address on file at the board office.

d. Revocation, suspension, or other disciplinary action taken against a licensee or person or firm exercising a practice privilege by a licensing authority of this state or another state, territory, or country. A stay by an appellate court shall not negate this requirement; however, if such disciplinary action is

overturned or reversed by a court of last resort, discipline by the board based solely on such action shall be vacated.

e. Suspension or revocation of the right to practice before any state or federal agency, or the PCAOB.

- f. A violation of Iowa Code section 542.17 (confidential communication).
- g. A violation of Iowa Code section 542.18 (licensees' working papers—client records).
- h. Violating or aiding and abetting another's violation of Iowa Code section 542.13 or 542.20.
- i. Violation of the terms of an initial agreement with the impaired practitioner review committee or violation of the terms of an impaired practitioner recovery contract with the impaired practitioner review committee.
- j. A violation of a practice privilege afforded to an Iowa licensee in another state.
- k. Engaging in the practice of public accounting on a lapsed or inactive certificate, license or permit when the acts or practices require active Iowa licensure and, in the case of a firm, allowing such acts or practices by firm CPAs or LPAs.

14.3(8) Willful or repeated violations. The willful or repeated violation or disregard of any provision of Iowa Code chapter 272C or 542 or any administrative rule adopted by the board in the administration or enforcement of such chapters.

14.3(9) Failure to report.

- a. Failure by a CPA firm to timely report as provided in rule 193A—7.7(542).
- b. Failure of an LPA firm to timely report as provided in rule 193A—8.5(542).
- c. Failure to timely report judgments and settlements and reportable violations by others as provided in 193A—Chapter 18.
- d. Failure to report in writing to the board any issuance, denial, revocation, or suspension of a license by another state, or the voluntary surrender of a license to resolve a pending disciplinary investigation or action, within 30 calendar days of the licensing authority's final action.
- e. Failure to report the conviction of any felony, or a crime described in Iowa Code section 542.5(2), within 30 calendar days of the conviction.
- f. Failure to report to the board a change in the licensee's physical or mailing address within 30 calendar days of the change.
- g. Failure to report as provided in 193A—subrules 13.6(7) and 13.6(8).

14.3(10) Failure to comply with board order. Failure to comply with the terms of a board order or the terms of a settlement agreement or consent order, or other decision of the board imposing discipline.

14.3(11) Conviction of a crime. Conviction, in this state or any other jurisdiction, of any felony, or of any crime described in Iowa Code section 542.5(2). A copy of the record of conviction or plea of guilty shall be conclusive evidence. "Conviction" shall include any plea of guilty or nolo contendere, including Alford pleas, or finding of guilt whether or not judgment or sentence is deferred or suspended, and whether or not the conviction is on appeal. If such conviction is overturned or reversed by a court of last resort, discipline by the board based solely on the conviction shall be vacated.

14.3(12) Conduct discreditable to the accounting profession. Conduct discreditable to the accounting profession includes any act or practice that diminishes the public's confidence in the profession, impairs the credibility of the profession, or otherwise compromises the public's trust. While it is not possible to list all conduct that is discreditable to the accounting profession, the following list provides an illustrative range of acts or practices that are implicated:

- a. Dishonesty in business or financial affairs, or a pattern of fiscal irresponsibility.
- b. Placement on the sex offender registry.
- c. Securities fraud or violation of the Iowa consumer fraud Act.
- d. Willful or repeated failure to timely file tax returns or other tax documents.
- e. False testimony in a court or administrative proceeding, or affidavit, or otherwise under oath.
- f. Providing false or misleading information to a financial institution or governmental body or official.
- g. Stating or implying an ability to improperly influence a government agency or official, or attempting to do so through deception, bribery or other unlawful means.

h. Violation of a breach of fiduciary duty when acting in the capacity of a trustee, conservator, or other fiduciary, or as the professional advisor to a fiduciary.

i. Any violation of Iowa Code chapter 542 or administrative rules that involves dishonesty, bad faith, or unethical behavior.

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HUMAN SERVICES DEPARTMENT[441]

Rules transferred from Social Services Department[770] to Human Services Department[498],
see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.
Rules transferred from agency number [498] to [441] to conform with the reorganization
numbering scheme in general, IAC Supp. 2/11/87.

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INTELLECTUAL DISABILITIES, OR DEVELOPMENTAL DISABILITIES**

PREAMBLE

The mental health and disability services commission has adopted this set of standards to be met by all providers of services to people with mental illness, intellectual disabilities, or developmental disabilities. These standards apply to providers that are not required to be licensed by the department of inspections and appeals. These providers include community mental health centers, mental health services providers, case management providers, supported community living providers, and crisis response providers in accordance with Iowa Code chapter 225C.

The standards serve as the foundation of a performance-based review of those organizations for which the department holds accreditation responsibility, as set forth in Iowa Code chapters 225C and 230A. The mission of accreditation is to assure individuals using the services and the general public of organizational accountability for meeting best practices performance levels, for efficient and effective management, and for the provision of quality services that result in quality outcomes for individuals using the services.

The department's intent is to establish standards that are based on the principles of quality improvement and are designed to facilitate the provision of excellent quality services that lead to positive outcomes. The intent of these standards is to make organizations providing services responsible for effecting efficient and effective management and operational systems that enhance the involvement of individuals using the services and to establish a best practices level of performance by which to measure provider organizations.

[ARC 1660C, IAB 10/15/14, effective 12/1/14]

DIVISION I
SERVICES FOR INDIVIDUALS WITH DISABILITIES

PREAMBLE

This set of standards in this division has been established to be met by all providers of case management, day treatment, intensive psychiatric rehabilitation, supported community living, partial hospitalization, outpatient counseling and emergency services.

[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.1(225C) Definitions.

“*Accreditation*” means the decision made by the commission that the organization has met the applicable standards.

“*Advanced registered nurse practitioner*” means a nurse who has current licensure as a registered nurse in Iowa, or licensure in another state that is recognized in Iowa pursuant to Iowa Code chapter 152E, and who is also registered as certified in psychiatric mental health specialties pursuant to board of nursing rules in 655—Chapter 7.

“*Advisory board*” means the board that reviews and makes recommendations to the organization on the program being accredited. The advisory board shall meet at least three times a year and shall have at least three members, at least 51 percent of whom are not providers. The advisory board shall include representatives who have disabilities or family members of persons with disabilities. The advisory board’s duties include review and recommendation of policies, development and review of the organizational plan for the program being accredited, review and recommendation of the budget for the program being accredited, and review and recommendation of the performance improvement program of the program being accredited.

“*Anticipated discharge plan*” means the statement of the condition or circumstances by which the individual using the service would no longer need each of the specific services accredited under this chapter.

“Appropriate” means the degree to which the services or supports or activities provided or undertaken by the organization are suitable and desirable for the needs, situation, or problems of the individual using the service.

“Assessment” means the review of the current functioning of the individual using the service in regard to the individual’s situation, needs, strengths, abilities, desires and goals.

“Benchmarks” means the processes of an organization that lead to implementation of the indicators.

“Chronic mental illness” means the condition present in people aged 18 and over 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, 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.

“Commission” means the mental health and disability services commission (MH/DS commission) as established and defined in Iowa Code section 225C.5.

“Community” means a natural setting where people live, learn, work, and socialize.

“Community mental health center” means an organization providing mental health services that is established pursuant to Iowa Code chapters 225C and 230A.

“Crisis intervention plan” means a personalized, individualized plan developed with the individual using the service that identifies potential personal psychiatric, environmental, and medical emergencies. This plan shall also include those life situations identified as problematic and the identified strategies and natural supports developed with the individual using the service to enable the individual to self-manage, alleviate, or end the crisis. This plan shall also include how the individual can access emergency services that may be needed.

“Deemed status” means acceptance by the commission of accreditation or licensure of a program or service by another accrediting body in lieu of accreditation based on review and evaluation by the division.

“Department” means the Iowa 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.

A person from birth to the age of nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described above if the person, without services and supports, has a high probability of meeting those criteria later in life.

"Direct services" means services providing therapy, habilitation, or rehabilitation activities or support services such as transportation.

"Division" means the division of behavioral, developmental, and protective services for families, adults, and children of the department of human services.

"Doctor of medicine or osteopathic medicine" means a person who is licensed in the state of Iowa under Iowa Code chapter 148 as a physician and surgeon or under Iowa Code chapter 150A as an osteopathic physician and surgeon.

"Functional assessment" means the analysis of daily living skills. The functional assessment also takes into consideration the strengths, stated needs, and level and kind of disability of the individual using the service.

"Goal achieving" means to gain the required skills and supports to obtain the goal of choice. For purposes of this chapter, the definition and explanation are taken from the Psychiatric Rehabilitation Practitioner Tools, as developed by the Boston Center for Psychiatric Rehabilitation.

"Goal keeping" means assisting the individual using the service in maintaining successful and satisfying role performance to prevent the emergence of symptoms associated with role deterioration. For purposes of this chapter, the definition and explanation are taken from the Psychiatric Rehabilitation Practitioner Tools, as developed by the Boston Center for Psychiatric Rehabilitation.

"Incident," for the purposes of this chapter, means an occurrence involving the individual using the service that:

1. Results in a physical injury to or by the individual that requires a physician's treatment or admission to a hospital, or
2. Results in someone's death, or
3. Requires emergency mental health treatment for the individual, or
4. Requires the intervention of law enforcement, or
5. Results from any prescription medication error, or
6. Is reportable to protective services.

"Indicators" means conditions that will exist when the activity is done competently and benchmarks are achieved. Indicators also provide a means to assess the activity's effect on outcomes of services.

"Informed consent" refers to time-limited, voluntary consent. The individual using the service or the individual's legal guardian may withdraw consent at any time without risk of punitive action. "Informed consent" includes a description of the treatment and specific procedures to be followed, the intended outcome or anticipated benefits, the rationale for use, the risks of use and nonuse, and the less restrictive alternatives considered. The individual using the service or the legal guardian has the opportunity to ask questions and have them satisfactorily answered.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) under these rules which shall be made only when the onset of the person's condition was during the developmental period and shall be based on an assessment of the person's intellectual functioning and level of adaptive skills. A licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills shall make the diagnosis. A diagnosis of intellectual disability shall be made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"Intensive psychiatric rehabilitation practitioner" means a person who has at least 60 contact hours of training in intensive psychiatric rehabilitation and either:

1. Is certified as a psychiatric rehabilitation practitioner by the United States Psychiatric Rehabilitation Association; or

2. Holds a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and has at least one year of experience in the delivery of services to the population groups that the person is hired to serve.

"Leadership" means the governing board, the chief administrative officer or executive director, managers, supervisors, and clinical leaders who participate in developing and implementing organizational policies, plans and systems.

"Marital and family therapist" means a person who is licensed under Iowa Code chapter 154D in the application of counseling techniques in the assessment and resolution of emotional conditions. This includes the alteration and establishment of attitudes and patterns of interaction relative to marriage, family life, and interpersonal relationships.

"Mental health counselor" means a person who is licensed under Iowa Code chapter 154D in counseling services involving assessment, referral, consultation, and the application of counseling, human development principles, learning theory, group dynamics, and the etiology of maladjustment and dysfunctional behavior to individuals, families, and groups.

"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.

"Mental health service provider" means an organization whose services are established to specifically address mental health services to individuals or the administration of facilities in which these services are provided. Organizations included are:

1. Those contracting with a county board of supervisors to provide mental health services in lieu of that county's affiliation with a community mental health center (Iowa Code chapter 230A).

2. Those that may contract with a county board of supervisors for special services to the general public or special segments of the general public and that are not accredited by any other accrediting body.

These standards do not apply to individual practitioners or partnerships of practitioners covered under Iowa's professional licensure laws.

"Natural supports" means those services and supports an individual using the service identifies as wanted or needed that are provided at no cost by family, friends, neighbors, and others in the community, or by organizations or entities that serve the general public.

"New organization" means an entity that has never been accredited under 441—Chapter 24 or an accredited entity under 441—Chapter 24 that makes a significant change in its ownership, structure, management, or service delivery.

"Organization" means:

1. A governmental entity or an entity that meets Iowa Code requirements for a business organization as a for-profit or not-for-profit business. These entities include, but are not limited to, a business corporation under Iowa Code chapter 490 or a nonprofit corporation under Iowa Code chapter 504 that provides a service accredited pursuant to the rules in this chapter.

2. A county, consortium of counties, or the department of human services that provides or subcontracts for the provision of case management.

3. A division or unit of a larger entity, such as a unit within a hospital or parent organization.

“Organization” does not include: an individual for whom a license to engage in a profession is required under Iowa Code section 147.2, any person providing a service if the person is not organized as a corporation or other business entity recognized under the Iowa Code, or an entity that provides only financial, administrative, or employment services and that does not directly provide the services accredited under this chapter.

“Outcome” means the result of the performance or nonperformance of a function or process or activity.

“Policies” means the principles and statements of intent of the organization.

“Procedures” means the steps taken to implement the policies of the organization.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals for the population of a specified geographic area or for special target populations.

“*Psychiatric crisis intervention plan*” means a personalized, individualized plan developed with the individual using the service that identifies potential personal psychiatric emergencies. This plan shall also include those life situations identified as problematic and the identified strategies and natural supports developed with the individual using the service to enable the individual to self-manage, alleviate, or end the crisis. This plan shall also include how the individual can access emergency services that may be needed.

“*Psychiatric nurse*” means a person who meets the requirements of a certified psychiatric nurse, is eligible for certification by the American Nursing Association, and is licensed by the state of Iowa to practice nursing as defined in Iowa Code chapter 152.

“*Psychiatrist*” means a doctor of medicine or osteopathic medicine who is certified by the American Board of Psychiatry and Neurology or who is eligible for certification and who is fully licensed to practice medicine in the state of Iowa.

“*Psychologist*” means a person who:

1. Is licensed to practice psychology in the state of Iowa or meets the requirements of eligibility for a license to practice psychology in the state of Iowa as defined in Iowa Code chapter 154B; or
2. Is certified by the Iowa department of education as a school psychologist or is eligible for certification by the Iowa department of education.

“*Qualified case managers and supervisors*” means people who have the following qualifications:

1. A bachelor’s degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to the population groups that the person is hired as a case manager or case management supervisor to serve; or
2. An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.

People employed as case management supervisors on or before August 1, 1993, who do not meet these requirements shall be considered to meet these requirements as long as they are continuously employed by the same case management provider.

“*Readiness assessment*” means a process of involving the individual using the service in clarifying motivational readiness to participate in the recovery process. For purposes of this chapter, the definition and explanation are taken from the Psychiatric Rehabilitation Practitioner Tools, as developed by the Boston Center for Psychiatric Rehabilitation.

“*Readiness development*” means services designed to develop or increase an individual’s interest, motivation, and resolve to engage in the rehabilitation services process, as a means of enhancing independent functioning and quality of life. For purposes of this chapter, the definition and explanation are taken from the Psychiatric Rehabilitation Practitioner Tools, as developed by the Boston Center for Psychiatric Rehabilitation.

“*Registered nurse*” means a person who is licensed to practice nursing in the state of Iowa as defined in Iowa Code chapter 152.

“Rehabilitation services” means services designed to restore, improve, or maximize the individual’s optimal level of functioning, self-care, self-responsibility, independence and quality of life and to minimize impairments, disabilities and dysfunction caused by a serious and persistent mental or emotional disability.

“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 the individual using the service may share a residence.

“Serious emotional disturbance” means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer’s role or functioning in family, school, or community activities. “Serious emotional disturbance” shall not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as “other conditions that may be a focus of clinical attention,” unless those conditions co-occur with another diagnosable serious emotional disturbance.

“Service plan” means an individualized goal-oriented plan of services written in language understandable by the individual using the service and developed collaboratively by the individual and the organization.

“Staff” means people paid by the organization to perform duties and responsibilities defined in the organization’s policies and procedures.

[ARC 1660C, IAB 10/15/14, effective 12/1/14; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—24.2(225C) Standards for policy and procedures.

24.2(1) Performance benchmark. The organization has written policy direction for the organization and each service being accredited.

24.2(2) Performance indicators.

a. The organization has a policies and procedures manual with policy guidelines and administrative procedures for all organizational activities and services specific to its organization that addresses the standards in effect at the time of review.

b. The policies and procedures cover each benchmark and indicator in this chapter.

c. The policies and procedures manual is made available to all staff.

441—24.3(225C) Standards for organizational activities.

24.3(1) Performance improvement system.

a. *Performance benchmark.* The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance.

b. *Performance indicators.* The organization:

- (1) Annually measures and assesses organizational activities and services accredited in this chapter.
- (2) Gathers information from individuals using the services, from staff, and from family members.

(3) Implements an internal review of individual records for those services accredited under this chapter. For outpatient psychotherapy and counseling services, the organization:

1. Reviews the individual’s involvement in and with treatment.

2. Ensures that treatment activities are documented and are relevant to the diagnosis or presenting problem.

(4) Reviews the organization’s response to incidents reported under subrule 24.4(5) for necessity, appropriateness, effectiveness and prevention. This review includes analysis of incident data at least annually to identify any patterns of risk to the health and safety of consumers.

(5) Reviews the organization’s response to any situation that poses a danger or threat to staff or to individuals using the services for necessity, appropriateness, effectiveness, and prevention.

(6) Identifies areas in need of improvement.

(7) Has a plan to address the areas in need of improvement. Where applicable, the organization establishes a plan to resolve the problem of patients missing appointments.

(8) Implements the plan and documents the results.

24.3(2) Leadership.

a. *Performance benchmark.* Organization leaders provide the framework for the planning, designing, directing, coordination, provision and improvement of services that are responsive to the individuals using the services and the community served by the organization.

b. *Performance indicators.*

(1) There are clearly articulated mission and values statements that are reflected in the long-range organizational plans and in organization policies.

(2) The annual and long-range budgeting process involves appropriate governing and managing levels of leadership and reflects the organization's mission and values. An independent auditor or other person as provided by law performs an annual financial audit.

(3) Individuals using the services or family members of individuals using the services are represented on the organization's governing board or on an advisory board.

(4) The organization's decision-making process, including policy decisions affecting the organization, reflects involvement of the various levels of leadership and responsiveness to staff.

(5) Organization leaders solicit input from leaders of the various community groups representing individuals served by the organization in designing responsive service delivery systems.

(6) Organization leaders develop and implement a service system appropriate to the needs of the individuals served by the organization.

(7) Organization leaders make educational information, resources, and service consultation available to community groups.

24.3(3) Management information system.

a. *Performance benchmark.* Information is obtained, managed, and used in an efficient and effective method to document, enhance, and improve organizational performance and service delivery.

b. *Performance indicators.*

(1) The organization has a system in place to maintain current individual-specific information documenting the provision and outcomes of services and treatments provided.

(2) The organization has a system in place to maintain the confidentiality and security of information that identifies specific individuals using the services, including mail, correspondence, and electronic files.

24.3(4) Human resources.

a. *Performance benchmark.* The organization provides qualified staff to support the organization's mission and facilitate the provision of quality services.

b. *Performance indicators.* The organization:

(1) Has a job description in the personnel file of each staff member that clearly defines responsibilities and qualifications.

(2) Has a process to verify qualifications of staff, including degrees, licenses, medication management training, and certification as required by the position, within 90 days of the staff person's employment. For staff hired after July 1, 2006, personnel files contain evidence that verification of professional licenses and college degrees at the bachelor's level or higher, as required by the position, was obtained from the primary source.

(3) Evaluates staff annually.

(4) Includes a plan for staff development for each staff member in the annual evaluation.

(5) Provides training and education to all staff relevant to their positions.

(6) Provides for approved training on child and dependent adult abuse reporter requirements to all organization staff who are mandatory abuse reporters. The organization documents in personnel records training on child and dependent adult abuse reporter requirements.

(7) Has staff members sign a document indicating that they are aware of the organization's policy on confidentiality and maintains these documents in the personnel files.

(8) Provides an initial orientation to new staff and documents this orientation in the employee's personnel file.

(9) Has mechanisms in place that afford staff the right to express concerns about a particular care issue or to file a grievance concerning a specific employment situation.

(10) Completes criminal and abuse record checks and evaluations as required in Iowa Code section 135C.33(5) before employment for any employee who meets with individuals using the services in the individuals' homes.

(11) Establishes and implements a code of ethics for all staff addressing confidentiality, individual rights, and professional and legal issues in providing services and documents in the personnel records that the code of ethics in effect at the time of review has been reviewed with each staff member.

24.3(5) Organizational environment.

a. *Performance benchmark.* The organization provides services in an organizational environment that is safe and supportive for the individuals being served and the staff providing services.

b. *Performance indicators.*

(1) The environment enhances the self-image of the individual using the service and preserves the individual's dignity, privacy, and self-development.

(2) The environment is safe and accessible and meets all applicable local, state, and federal regulations.

(3) The processes that service and maintain the environment and the effectiveness of the environment are reviewed within the organization's monitoring and improvement system.

(4) The organization establishes intervention procedures for behavior that presents significant risk of harm to the individual using the service or others. The interventions also ensure that the individual's rights are protected and that due process is afforded.

(5) The organization meets state and federal regulations in the way it implements the safe storage, provision, administration, and disposal of medication when used within the service.

(6) All toys and other materials used by children are clean and safe.

441—24.4(225C) Standards for services. Providers for the services set forth in subrules 24.4(9) through 24.4(13) shall meet the standards in subrules 24.4(1) through 24.4(8) in addition to the standards for the specific service. Providers of outpatient psychotherapy and counseling services shall also meet standards in subrules 24.4(1), 24.4(2), 24.4(4), 24.4(6), 24.4(7), and 24.4(8). Providers of emergency services or evaluation services shall meet the benchmark for the services they provide.

24.4(1) Social history.

a. *Performance benchmark.* The organization completes a social history for each individual served.

b. *Performance indicators.*

(1) The organization collects and documents relevant historical information and organizes the information in one distinct document in a narrative format.

(2) The social history includes:

1. Relevant information regarding the onset of disability.
2. Family, physical, psychosocial, behavioral, cultural, environmental, and legal history.
3. Developmental history for children.

(4) Any history of substance abuse, domestic violence, or physical, emotional, or sexual abuse.

(3) Staff review and update the social history at least annually.

24.4(2) Assessment.

a. *Performance benchmark.* The organization develops a written assessment for each individual served. The assessment is the basis for the services provided to the individuals.

b. *Performance indicators.*

(1) The assessment includes information about the individual's current situation, diagnosis, needs, problems, wants, abilities and desired results, gathered with the individual's involvement.

(2) Staff solicit collateral provider information as appropriate to the individual situation in order to compile a comprehensive and full assessment.

- (3) Staff develop and complete the assessment in a narrative format.
- (4) Staff base decisions regarding the level, type and immediacy of services to be provided, or the need for further assessment or evaluation, upon the analysis of the information gathered in the assessment.
- (5) Staff complete an annual reassessment for each individual using the service and document the reassessment in a written format.
- (6) Documentation supporting the diagnosis is contained in the individual's record. A diagnosis of mental retardation is supported by a psychological evaluation conducted by a qualified professional. A diagnosis of developmental disability is supported by professional documentation. A determination of chronic mental illness is supported by a psychiatric or psychological evaluation conducted by a qualified professional.

24.4(3) Individual service plan.

a. *Performance benchmark.* Individualized, planned, and appropriate services are guided by an individual-specific service plan developed in collaboration with the individual using the service, staff, and significantly involved others as appropriate. Services are planned for and directed to where the individuals live, learn, work, and socialize.

b. *Performance indicators.*

- (1) The service plan is based on the current assessment.
- (2) The service plan identifies observable or measurable individual goals and action steps to meet the goals.
- (3) The service plan includes interventions and supports needed to meet those goals with incremental action steps, as appropriate.
- (4) The service plan includes the staff, people, or organizations responsible for carrying out the interventions or supports.
- (5) Services defined in the service plan are appropriate to the severity level of problems and specific needs or disabilities.
- (6) The plan reflects desired individual outcomes.
- (7) Activities identified in the service plan encourage the ability and right of the individual using the service to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.
- (8) Staff monitor the service plan with review occurring regularly. At least annually, staff assess and revise the service plan to determine achievement, continued need, or change in goals or intervention methods. The review includes the individual using the service, with the involvement of significant others as appropriate.
- (9) Staff develop a separate, individualized, anticipated discharge plan as part of the service plan that is specific to each service the individual receives.
- (10) The service plan includes documentation of any rights restrictions, why there is a need for the restriction, and a plan to restore those rights or a reason why a plan is not necessary or appropriate.

24.4(4) Documentation of service provision.

a. *Performance benchmark.* Individualized and appropriate intervention services and treatments are provided in ways that support the needs, desires, and goals identified in the service plan, and that respect the rights and choices of the individual using the service.

b. *Performance indicators.*

- (1) Staff document in the narrative the individual's participation in the treatment process.
- (2) Responsible staff document the individual's progress toward goals, the provision of staff intervention, and the individual's response to those interventions.
- (3) Documentation of service provision is in a written, legible, narrative format in accordance with organizational policies and procedures.

24.4(5) Incident reports.

a. *Performance benchmark.* The organization completes an incident report when organization staff first become aware that an incident has occurred.

b. *Performance indicators.*

- (1) The organization documents the following information:
 1. The name of the individual served who was involved in the incident.
 2. The date and time the incident occurred.
 3. A description of the incident.
 4. The names of all organization staff and others who were present or responded at the time of the incident. (For confidentiality reasons, other individuals who receive services should be identified by initials or some other accepted means.)
 5. The action the organization staff took to handle the situation.
 6. The resolution of or follow-up to the incident.
- (2) The staff who were directly involved at the time of the incident or who first became aware of the incident prepare and sign the incident report before forwarding it to the supervisor.
- (3) Staff file a copy of the completed incident report in a centralized location and make a notation in the individual's file.
- (4) Staff send a copy of the incident report to the individual's Medicaid targeted case manager or county case worker who is involved in funding the service and notify the individual's legal guardian within 72 hours of the incident.

24.4(6) Confidentiality and legal status.

- a. *Performance benchmark.* Staff release medical and mental health information only when properly authorized.

b. Performance indicators.

- (1) The organization obtains voluntary written authorization from the individual using the service, the individual's legal guardian, or other people authorized by law before releasing personal identifying information, medical records, mental health records, or any other confidential information.

- (2) Staff complete voluntary written authorization forms in accordance with existing federal and state laws, rules, and regulations and maintain them in each individual file.

- (3) Documentation regarding restrictions on the individual, such as guardianship, power of attorney, conservatorship, mental health commitments, or other court orders, is placed in the individual's record, if applicable.

24.4(7) Service systems.

- a. *Performance benchmark.* The organization develops a clear description of each of the services offered. The organization develops an admission and discharge system of services. Staff coordinate services with other settings and providers.

b. Performance indicators.

- (1) The organization has established and documented the necessary admission information to determine each individual's eligibility for participation in the service.

- (2) Staff include verification in each individual's file that a service description was provided to the individual using the service and, when appropriate, to family or significant others.

- (3) Continuity of services occurs through coordination among the staff and professionals providing services. Coordination of services through linkages with other settings and providers has occurred, as appropriate.

- (4) Staff include a written discharge summary in each individual record at the time of discharge.

24.4(8) Respect for individual rights.

- a. *Performance benchmark.* Each individual using the service is recognized and respected in the provision of services, in accordance with basic human, civil, and statutory rights.

b. Performance indicators.

- (1) Staff provide services in ways that respect and enhance the individual's sense of autonomy, privacy, dignity, self-esteem, and involvement in the individual's own treatment. Staff take language barriers, cultural differences, and cognitive deficits into consideration and make provisions to facilitate meaningful individual participation.

- (2) Staff inform individuals using the service and, when appropriate, family and significant others of their rights, choices, and responsibilities.

(3) The organization has a procedure established to protect the individuals using the service during any activities, procedure or research that requires informed consent.

(4) The organization verifies that individuals using the service and their guardians are informed of the process to express questions, concerns, complaints, or grievances about any aspect of the individual's service, including the appeal process.

(5) The organization provides the individuals and their guardians the right to appeal the application of policies, procedures, or any staff action that affects the individual using the service. The organization has established written appeal procedures and a method to ensure that the procedures and appeal process are available to individuals using the service.

(6) All individuals using the service, their legal representatives, and other people authorized by law have access to the records of the individual using the service in accordance with state and federal laws and regulations.

24.4(9) Case management services. "Case management services" means those services established pursuant to Iowa Code section 225C.20.

a. *Performance benchmark.* Case management services link individuals using the service to service agencies and support systems responsible for providing the necessary direct service activities and coordinate and monitor those services.

b. *Performance indicators.*

(1) Staff clearly define the need for case management and document it annually.

(2) At a minimum, the team is composed of the individual using the service, the case manager, and providers or natural supports relevant to the individual's service needs. The team may also include family members, at the discretion of the individual using the service.

(3) The team works with the individual using the service to establish the service plan that guides and coordinates the delivery of the services.

(4) The case manager advocates for the individual using the service.

(5) The case manager coordinates and monitors the services provided to the individual using the service.

(6) Documentation of contacts includes the date, the name of the individual using the service, the name of the case manager, and the place of service.

(7) The case manager holds individual face-to-face meetings at least quarterly with the individual using the service.

(8) Case managers do not provide direct services. Individuals using the service are linked to appropriate resources, which provide necessary direct services and natural supports.

(9) Individuals using the service participate in developing an individualized crisis intervention plan that includes natural supports and self-help methods.

(10) Documentation shows that individuals using the service are informed about their choice of providers as provided in the county management plan.

(11) Within an accredited case management program, the average caseload is no more than 45 individuals per each full-time case manager. The average caseload of children with serious emotional disturbance is no more than 15 children per full-time case manager.

(12) The case manager communicates with the team and then documents in the individual's file a quarterly review of the individual's progress toward achieving the goals.

24.4(10) Day treatment services. "Day treatment" means an individualized service emphasizing mental health treatment and intensive psychosocial rehabilitation activities designed to increase the individual's ability to function independently or facilitate transition from residential placement. Staff use individual and group treatment and rehabilitation services based on individual needs and identified behavioral or mental health issues.

a. *Performance benchmark.* Individuals using the service who are experiencing a significantly reduced ability to function in the community are stabilized and improved by the receipt of psychosocial rehabilitation, mental health treatment services, and in-home support services, and the need for residential or inpatient placement is alleviated.

b. *Performance indicators.*

- (1) Individuals using the service participate with the organizational staff in identifying the problem areas to be addressed and the goals to be achieved that are based on the individual's need for services.
- (2) Individuals using the service receive individualized services designed to focus on those identified mental health or behavioral issues that are causing significant impairment in their day-to-day functioning.
- (3) Individuals who receive intensive outpatient and day treatment services receive a comprehensive and integrated schedule of recognized individual and group treatment and rehabilitation services.
- (4) Individuals using the service and staff review their progress in resolving problems and achieving goals on a frequent and regular basis.
- (5) Individuals using the service receive services appropriate to defined needs and current risk factors.
- (6) Individuals using the service receive services from staff who are appropriately qualified and trained to provide the range and intensity of services required by the individual's specific problems or disabilities. A mental health professional provides or directly supervises the provision of treatment services.
- (7) Individuals using the service participate in discharge planning that focuses on coordinating and integrating individual, family, and community and organization resources.
- (8) Family members of individuals using the service are involved in the planning and provision of services, as appropriate and as desired by the individual.
- (9) Individuals using the service participate in developing a detailed psychiatric crisis intervention plan that includes natural supports and self-help methods.

24.4(11) Intensive psychiatric rehabilitation services. "Intensive psychiatric rehabilitation services" means services designed to restore, improve, or maximize level of functioning, self-care, responsibility, independence, and quality of life; to minimize impairments, disabilities, and disadvantages of people who have a disabling mental illness; and to prevent or reduce the need for services in a hospital or residential setting. Services focus on improving personal capabilities while reducing the harmful effects of psychiatric disability, resulting in an individual's recovering the ability to perform a valued role in society.

- a. *Performance benchmark.* Individuals using the service who are experiencing a significantly reduced ability to function in the community due to a disability are stabilized and experience role recovery by the receipt of intensive psychiatric rehabilitation services.
- b. *Performance indicators.*
 - (1) Individuals using the service receive services from staff who meet the definition of intensive psychiatric rehabilitation practitioner. The intensive psychiatric rehabilitation supervisor has at least a bachelor's degree in a human services field and 60 hours of training in intensive psychiatric rehabilitation.
 - (2) Individuals using the service receive four to ten hours per week of recognized psychiatric rehabilitation services. All services are provided for an identified period.
 - (3) Whenever possible, intensive psychiatric rehabilitative services are provided in natural settings where individuals using the service live, learn, work, and socialize.
 - (4) Significantly involved others participate in the planning and provision of services as appropriate and as desired by the individual using the service.
 - (5) Individuals using the service participate in developing a detailed psychiatric crisis intervention plan that includes natural supports and self-help methods.
 - (6) A readiness assessment is initially completed with staff to assist the individual in choosing a valued role and environment. The readiness assessment culminates in a score that documents the individual's motivational readiness.
 - (7) During the readiness development phase, staff document monthly in the individual's file changes in the individual's motivational readiness to choose valued roles and environments.
 - (8) During the goal-choosing phase, staff and the individual identify personal criteria, describe alternative environments, and choose the goal. These activities are documented in the individual's file.

(9) During the goal-achieving phase, the functional assessment and resource assessment are completed. Skill programming or skill teaching takes place. These activities are documented in the individual's file.

(10) During goal keeping, individuals using the service participate in discharge planning that focuses on coordinating and integrating individual, family, community, and organization resources for successful community tenure and the anticipated end of psychiatric rehabilitation services. Staff document increases in skill acquisition and skill competency.

(11) Staff document any positive changes in environmental status, such as moving to a more independent living arrangement, enrolling in an education program, getting a job, or joining a community group.

(12) On an ongoing basis and at discharge, staff or the individual using the service documents the level of individual satisfaction with intensive psychiatric rehabilitation services in each individual's file.

24.4(12) *Supported community living services.* "Supported community living services" means those services provided to individuals with a mental illness, mental retardation, or developmental disability to enable them to develop supports and learn skills that will allow them to live, learn, work and socialize in the community. Services are individualized, need- and abilities-focused, and organized according to the following components: outreach to appropriate support or treatment services; assistance and referral in meeting basic human needs; assistance in housing and living arrangements; crisis intervention and assistance; social and vocational assistance; the provision of or arrangement for personal, environmental, family, and community supports; facilitation of the individual's identification and development of natural support systems; support, assistance, and education to the individual's family and to the community; protection and advocacy; and service coordination.

These services are to be provided by organizational staff or through linkages with other resources and are intended to be provided in the individual's home or other natural community environment where the skills are learned or used. Supported community living is not part of an organized mental health support or treatment group, drop-in center, or clubhouse. Skill training groups may be one of the activities in the service plan and part of supported community living. Skill training groups cannot stand alone as a supported community living service.

a. *Performance benchmark.* Individuals using the service live, learn, work, and socialize in the community.

b. *Performance indicators.*

(1) Individuals receive services within their home and community setting where the skills are learned or used.

(2) At intake, the individuals using the service participate in a functional assessment to assist in defining areas of service need and establishing a service plan. Staff summarize the findings of the functional assessment in a narrative that describes the individual's current level of functioning in the areas of living, learning, working, and socialization. Staff review functional assessments on a regular basis to determine progress.

(3) Individuals using the service receive skill training and support services directed to enabling them to regain or attain higher levels of functioning or to maximize functioning in the current goal areas.

(4) Services are delivered on an individualized basis in the place where the individual using the service lives or works.

(5) Documentation that steps have been taken to encourage the use of natural supports and develop new ones is in the individual file.

(6) Individuals using the service participate in developing a detailed individualized crisis intervention plan that includes natural supports and self-help methods.

24.4(13) *Partial hospitalization services.* "Partial hospitalization services" means an active treatment program providing intensive group and individual clinical services within a structured therapeutic environment for individuals who are exhibiting psychiatric symptoms of sufficient severity to cause significant impairment in day-to-day functioning. Short-term outpatient crisis stabilization and rehabilitation services are provided to avert hospitalization or to transition from an acute care setting.

Services are supervised and managed by a mental health professional, and psychiatric consultation is routinely available. Clinical services are provided by a mental health professional.

a. *Performance benchmark.* Individuals who are experiencing serious impairment in day-to-day functioning due to severe psychiatric distress are enabled to remain in their community living situation through the receipt of therapeutically intensive milieu services.

b. *Performance indicators.*

(1) Individuals using the service and staff mutually develop an individualized service plan that focuses on the behavioral and mental health issues and problems identified at admission. Goals are based on the individual's need for services.

(2) Individuals using the service receive clinical services that are provided and supervised by mental health professionals. A licensed and qualified psychiatrist provides psychiatric consultation and medication services.

(3) Individuals using the service receive a comprehensive schedule of active, planned, and integrated psychotherapeutic and rehabilitation services provided by qualified professional staff.

(4) Individuals using the service receive group and individual treatment services that are designed to increase their ability to function independently.

(5) Individuals using the service are involved in the development of an anticipated discharge plan that includes linkages to family, provider, and community resources and services.

(6) Individuals using the service have sufficient staff available to ensure their safety, to be responsive to crisis or individual need, and to provide active treatment services.

(7) Individuals using the service receive services commensurate with current identified risk and need factors.

(8) Support systems identified by individuals using the service are involved in the planning and provision of services and treatments as appropriate and desired by the individual using the service.

(9) Individuals using the service participate in developing a detailed psychiatric crisis intervention plan that includes natural supports and self-help methods.

24.4(14) Outpatient psychotherapy and counseling services. "Outpatient psychotherapy and counseling services" means a dynamic process in which the therapist uses professional skills, knowledge and training to enable individuals using the service to realize and mobilize their strengths and abilities, take charge of their lives, and resolve their issues and problems. Psychotherapy services may be individual, group, or family, and are provided by a person meeting the criteria of a mental health professional or by a person with a master's degree or an intern working on a master's degree in a mental health field who is directly supervised by a mental health professional.

a. *Performance benchmark.* Individuals using the service realize and mobilize their own strengths and abilities to take control of their lives in the areas where they live, learn, work, and socialize.

b. *Performance indicators.*

(1) Individuals using the service are prepared for their role as partners in the therapeutic process at intake where they define their situations and evaluate those factors that affect their situations.

(2) Individuals using the service establish desired problem resolution at intake during the initial assessment.

(3) Psychiatric services other than psychopharmacological services are available from the organization as needed by the individual using the service.

(4) Psychopharmacological services are available from the organization as needed.

(5) Staff document mutually agreed-upon treatment goals during or after each session. A distinct service plan document is not required.

(6) Staff document mutually agreed-upon supports and interventions during or after each session. A distinct service plan document is not required.

(7) Staff document in the progress notes the individual's status at each visit and the reasons for continuing or discontinuing services. A distinct discharge summary document is not required.

(8) Any assignment of activities to occur between sessions is documented in the following session's documentation.

(9) Individuals using the service who have a chronic mental illness participate in developing a detailed psychiatric crisis intervention plan that includes natural supports and self-help methods.

(10) The record documents that the organization follows up on individuals who miss appointments.

24.4(15) Emergency services. “Emergency services” means crisis services that provide a focused assessment and rapid stabilization of acute symptoms of mental illness or emotional distress and are available and accessible, by telephone or face-to-face, on a 24-hour basis. The clinical assessment and psychotherapeutic services are provided by a person who has training in emergency services and who is a mental health professional or has access to a mental health professional, at least by telephone.

Services may be provided by a person who holds a master’s degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing, psychiatric rehabilitation, or social work; or a person who holds a bachelor’s degree in a human service discipline with five years’ experience providing mental health services or human services; or a psychiatric nurse who has three years of clinical experience in mental health. A comprehensive social history is not required for this treatment.

a. *Performance benchmark.* Individuals using the service receive emergency services when needed that provide a focused assessment and rapid stabilization of acute symptoms of mental illness or emotional distress.

b. *Performance indicators.*

(1) Individuals using the service can access 24-hour emergency services by telephone or in person.

(2) Information about how to access emergency services is publicized to facilitate availability of services to individuals using the service, family members, and the public.

(3) Individuals using the service receive assessments and services from either a mental health professional or from personnel who meet the requirements above and are supervised by a mental health professional. Psychiatric consultation is available, if needed.

(4) Individuals using the service receive intervention commensurate with current identified risk factors.

(5) Significantly involved others are involved as necessary and appropriate to the situation and as desired by the individual using the service.

(6) Individuals using the service are involved in the development of postemergency service planning and resource identification and coordination.

(7) Staff document contacts in a narrative format and maintain them in a central location that will allow timely response to the problems presented by the individual using the service.

(8) Timely coordination of contacts with relevant professionals is made.

24.4(16) Evaluation services. “Evaluation services” means screening, diagnosis and assessment of individual and family functioning needs, abilities, and disabilities, and determining current status and functioning in the areas of living, learning, working, and socializing.

a. *Performance benchmark.* Individuals using the service receive comprehensive evaluation services that include screening, diagnosis, and assessment of individual or family functioning, needs and disabilities.

b. *Performance indicators.*

(1) Evaluations include screening, diagnosis, and assessment of individual or family functioning, needs, abilities, and disabilities.

(2) Evaluations consider the emotional, behavioral, cognitive, psychosocial, and physical information as appropriate and necessary.

(3) Evaluations includes recommendations for services and need for further evaluations.

(4) Mental health evaluations are completed by a person who meets the criteria of a mental health professional, or a person with a master’s degree who is license-eligible and supervised by a mental health professional, or an intern of a master’s or doctorate program who is supervised by a mental health professional.

441—24.5(225C) Accreditation. The commission shall make all decisions involving issuance, denial, or revocation of accreditation. This accreditation shall delineate all categories of service the organization

is accredited to provide. Although an organization may have more than one facility or service site, the commission shall issue only one accreditation notice to the organization, except as provided in paragraph 24.5(5) "f."

24.5(1) Organizations eligible for accreditation. The commission accredits the following organizations:

- a. Case management providers.
- b. Community mental health centers.
- c. Supported community living providers.
- d. Mental health service providers.

24.5(2) Application and renewal procedures. An applicant for accreditation shall submit Form 470-3005, Application for Accreditation, to the Division of Behavioral, Developmental, and Protective Services, Department of Human Services, Fifth Floor, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

a. The application shall be signed by the organization's chief executive officer and the chairperson of the governing body and shall include the following information:

- (1) The name and address of the applicant organization.
- (2) The name and address of the chief executive officer of the applicant organization.
- (3) The type of organization and specific services for which the organization is applying for accreditation.
- (4) The targeted population groups for which services are to be provided, as applicable.
- (5) The number of individuals in each of the targeted population groups to be served, as applicable.
- (6) Other information related to the standards as requested by division staff.

b. Organizations that have received an initial 270-day accreditation and have not provided services by the end of the 270 days shall have their accreditation lapse for that specific service. This lapse of accreditation shall not be considered a denial. New applications may be submitted that include the waiting list of individuals to be served along with specific timelines of when the services will begin.

c. An organization in good standing may apply for an add-on service.

24.5(3) Application review. Upon receipt of an application, Form 470-3005, the division shall review the materials submitted to determine whether the application is complete and request any additional material as needed. Survey reviews shall commence only after the organization has submitted all application material.

a. For a new organization, staff may initially conduct a desk audit or on-site visit to review the organization's mission, policies, procedures, staff credentials, and program descriptions.

b. The division shall review organizational services and activities as determined by the accreditation category. This review may include audits of case records, administrative procedures, clinical practices, personnel records, performance improvement systems and documentation, and interviews with staff, individuals, boards of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

c. A team shall make an on-site visit to the organization. The division shall not be required to provide advance notice to the provider of the on-site visit for accreditation.

d. The on-site team shall consist of designated members of the division staff. At the division's discretion, the team may include provider staff of other providers, individuals, and others deemed appropriate.

e. The team shall survey the organization and the services indicated on the accreditation application in order to verify information contained in the application and ensure compliance with all applicable laws, rules, and regulations. At the time of a one-year recertification visit, the team shall review the services that did not receive three-year accreditation.

f. The team shall review case records and personnel records to see how the organization implements each of the indicators in the standards. If the documentation is not found in the records, the organization shall show, at the time the division staff is on site, documentation of how the indicator was accomplished.

g. When an organization subcontracts with agencies to provide services, on-site reviews shall be done at each subcontracting agency to determine if each agency meets all the requirements in this chapter. The accreditation is issued to the organization.

h. At the end of the survey, the team leader shall lend an exit review. Before the close of the on-site review, the organization must provide the team leader any documentation that demonstrates how the organization has met these standards for services.

i. The accreditation team leader shall send a written report of the findings to the organization within 30 working days after completion of the accreditation survey.

j. Organizations required to develop a corrective action and improvement plan pursuant to subrule 24.5(4) "a" shall submit the plan to the division within 30 working days after the receipt of a report issued as a result of the division's survey review. The action plan shall include specific problem areas cited, corrective actions to be implemented by the organization, dates by which each corrective measure shall be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

k. Quality assurance staff shall review and approve the corrective action and improvement plan before making an accreditation recommendation to the commission.

l. The division shall offer technical assistance to organizations applying for first-time accreditation. Following accreditation, any organization may request technical assistance from the division to bring into conformity those areas found in noncompliance with this chapter's requirements. If multiple deficiencies are noted during a survey, the commission may also require that technical assistance be provided to an organization, as staff time permits, to assist in implementation of an organization's corrective action plan. Renewal applicants may be provided technical assistance as needed, if staff time permits.

24.5(4) Performance outcome determinations. There are three major areas addressed in these standards: policies and procedures, organizational activities, and services, as set forth in rules 441—24.2(225C), 24.3(225C), and 24.4(225C). Each rule contains standards, with a performance benchmark and performance indicators for each standard. Each of the applicable standards for the three areas (policy and procedures, organizational activities, and services) shall be reviewed.

a. Quality assurance staff shall determine a performance compliance level based on the number of indicators found to be in compliance.

(1) For service indicators, if 25 percent or more of the files reviewed do not comply with the requirements for a performance indicator, then that indicator is considered out of compliance and corrective action is required.

(2) Corrective action is required when any indicator under policies and procedures or organizational activities is not met.

b. In the overall rating, the performance rating for policy and procedures shall count as 15 percent of the total, organizational activities as 15 percent of the total, and services as 70 percent of the total.

(1) Each of the three indicators for policy and procedures has a value of 5 out of a possible score of 15.

(2) Each of the 34 indicators for organizational activities has a value of .44 out of a possible score of 15.

(3) Each service has a separate weighting according to the total number of indicators applicable for that service, with a possible score of 70, as follows:

<u>Service</u>	<u>Number of indicators</u>	<u>Value of each indicator</u>
Case management	51	1.37
Day treatment	48	1.46
Intensive psychiatric rehabilitation	51	1.37
Supported community living	45	1.55
Partial hospitalization	48	1.46
Outpatient psychotherapy and counseling	35	2.00
Emergency	8	8.75
Evaluation	4	17.50

c. Quality assurance staff shall determine a separate score for each service to be accredited. When an organization offers more than one service under this chapter, there shall be one accreditation award for all the services based upon the lowest score of the services surveyed.

24.5(5) Accreditation decisions. The division shall prepare all documents with a final recommendation regarding accreditation to be presented at the commission meeting. The division shall mail to all commission members summary reports of the on-site service review or desk review and a final recommendation concerning accreditation on each application to be processed at the next commission meeting.

If the commission approves accreditation, Form 470-3006, Notice of Action-Approval, shall be issued which states the duration of the accreditation and the services that the organization is accredited to provide. If the commission denies or revokes accreditation, Form 470-3008, Notice of Action-Denial, shall be issued which states the reasons for the denial.

a. *Initial 270-day accreditation.* This type of accreditation may be granted to a new organization. The commission shall base the accreditation decision on a report by the division that:

- (1) The organization has an approved policies and procedures manual that includes job descriptions.
- (2) Staff assigned to the positions meet the qualifications in the standards and the policies and procedures of the organization.

b. *Three-year accreditation.* An organization or service is eligible for this type of accreditation if it has achieved an 80 percent or higher performance compliance level. The organization may be required to develop and submit a plan of corrective action and improvement that may be monitored either by written report or an on-site review.

c. *One-year accreditation.* An organization is eligible for this type of accreditation when multiple and substantial deficiencies exist in specific areas causing compliance levels with performance benchmarks and indicators to fall between 70 percent and 79 percent, or when previously required corrective action plans have not been implemented or completed. The organization must submit a corrective action plan to correct and improve specific deficiencies and overall levels of functioning. Quality assurance staff shall monitor this plan through on-site reviews, written reports and the provision of technical assistance.

d. *Probational 180-day accreditation.* An organization is eligible for probational 180-day accreditation instead of denial when the overall compliance level is from 60 to 69 percent, and pervasive and serious deficiencies exist; or when corrective action plans previously required as a result of a one-year accreditation have not been implemented or completed. The commission may downgrade organizations with a one-year or three-year accreditation to the probational 180-day accreditation when one or more complaints are founded.

All deficiencies must be corrected by the time of the follow-up on-site survey at the conclusion of the provisional period. After this survey, the organization shall meet the standards for accreditation for a one-year accreditation, or the commission shall deny accreditation.

e. *Add-on service accreditation.* When the on-site review of the add-on service results in a score comparable to the overall organization's score at the time of the most recent accreditation, the organization shall have the add-on accreditation date coincide with the overall accreditation date of the organization. If the add-on service on-site review results in a lower score and lower accreditation

decision, division staff shall conduct another on-site review for that add-on service when the add-on service accreditation expires.

f. Special terms.

(1) When an organization subcontracts with more than one agency, the length of accreditation shall be determined individually.

(2) The accreditation period for services that have deemed status according to rule 24.6(225C) shall coincide with the period awarded by the national accrediting body or the certification for home-and community-based services.

(3) New or add-on services that meet the requirements for accreditation shall receive an initial 270-day accreditation for that individual service. The term of accreditation shall be determined individually. At the time of recertification of the new add-on service, recommendation may be made to coincide with the term of accreditation for the other services of that organization that are accredited by the commission.

(4) An organization must notify the division when there are changes in its ownership, structure, management, or service delivery.

g. Extensions. The division may grant an extension to the period of accreditation if there has been a delay in the accreditation process that is beyond the control of the organization, the division, or the commission; or the organization has requested an extension to permit the organization to prepare and obtain approval of a corrective action plan. The division shall establish the length of the extension on a case-by-case basis.

h. Denial of accreditation. An emergency commission meeting may be called to consider denial or revocation of accreditation.

(1) Accreditation shall be denied when there are pervasive and serious deficiencies that put individuals at immediate risk or when the overall compliance level falls to 59 percent or below. Under such circumstances no corrective action report shall be required.

(2) When one or more complaints are received, quality assurance staff shall complete an investigation and submit a report to the commission. If any of the complaints are substantiated and the commission determines that there is a pervasive or serious deficiency, the commission may deny accreditation.

(3) An organization whose accreditation has been denied or revoked shall not be approved for any service for at least six months from the notice of decision denying or revoking accreditation.

(4) If the organization disagrees with any action or failure to act in regard to the notice of decision to deny accreditation to the organization, the organization has the right to appeal in accordance with 441—Chapter 7.

24.5(6) Nonassignability. Accreditation shall not be assignable to any other organization or provider. Any person or other legal entity acquiring an accredited facility for the purpose of operating a service shall make an application as provided in subrule 24.5(2) for a new certificate of accreditation. Similarly, any organization having acquired accreditation and desiring to alter the service philosophy or transfer operations to different premises must notify the division in writing 30 calendar days before taking action in order for the division to review the change.

24.5(7) Discontinuation.

a. Discontinued organization. A discontinued organization is one that has terminated all of the services for which it has been accredited. Accreditation is not transferable between organizations.

(1) An organization shall notify the division in writing of any sale, change in business status, closure, or transfer of ownership of the business at least 30 calendar days before the action.

(2) The organization shall be responsible for the referral and placement of individuals using the services, as appropriate, and for the preservation of all records.

b. Discontinued service. An organization shall notify the division in writing of the discontinuation of an accredited or certified service at least 30 calendar days before the service is discontinued.

(1) Notice of discontinuation of a service shall not be initiated during the 30 days before the start of a survey. Once a survey has begun, all services shall be considered in determining the organization's accreditation score.

(2) The organization shall be responsible for the referral and placement of individuals using the services, as appropriate, and for the preservation of all records.

441—24.6(225C) Deemed status. The commission shall grant deemed status to organizations accredited by a recognized national, not-for-profit, accrediting body when the commission determines the accreditation is for similar services. The commission may also grant deemed status for supported community living services to organizations that are certified under the Medicaid home- and community-based services (HCBS) mental retardation waiver.

24.6(1) National accrediting bodies.

a. The national accrediting bodies currently recognized as meeting division criteria for possible deemings are:

1. Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
2. The Commission on Accreditation of Rehabilitation Facilities (CARF).
3. The Council on Quality and Leadership in Supports for People with Disabilities (The Council).
4. Council on Accreditation of Services for Families and Children (COA).

b. The accreditation credentials of these national bodies must specify the type of organization, programs, and services that these bodies accredit and include targeted population groups, if appropriate.

c. Deemed status means that the division is accepting an outside body's review, assessment, and accreditation of an organization's functioning and services. Therefore, the accrediting body doing the review must be assessing categories of organizations and types of programs and services corresponding to those described under this chapter. An organization that has deemed status must adhere to and be accountable for the rules in this chapter.

d. When an organization that is nationally accredited requests deemed status for services not covered by the national body's standards but covered under this chapter, the division shall accredit those services. Division staff shall provide technical assistance to organizations with deemed status as time permits.

24.6(2) Application for deemed status.

a. To apply for deemed status, the organization shall submit Form 470-3332, Application and Letter of Agreement, and copies of the latest survey report and accreditation certificate, documentation of specific programming policies and procedures for populations being served, and credentials for staff providing services to populations served.

b. The division shall not accept an application for deemed status once the division has begun an on-site visit. The organization shall complete the accreditation process.

24.6(3) Requirements for deemed status. To be eligible for deemed status, the organization shall:

a. Be currently accredited by a recognized national accrediting body for services as defined in subrule 24.6(1); or

b. Be currently accredited for supported community living under the Medicaid HCBS mental retardation waiver pursuant to 441—subrule 77.37(14). If individuals with mental illness are served, the organization must submit verification of the training and credentials of the staff to show that its staff can meet the needs of the individuals served.

c. Require the supported community living staff to have the same supervisor as the HCBS/MR program.

d. Require staff for the program being deemed to have the training and credentials needed to meet the needs of the person served.

e. Require staff to meet the incident reporting requirements in subrule 24.4(5).

24.6(4) Granting of deemed status. When the commission grants deemed status, the accreditation period shall coincide with the period awarded by the national accrediting body or the certification for home- and community-based services. However, under no circumstances shall the commission award accreditation for longer than three years.

24.6(5) Reservations. When deemed status is granted, the commission and the division reserve rights to the following:

- a. To have division staff conduct on-site reviews for those organizations applying for deemed status which the division has not previously accredited.
- b. To have division staff do joint site visits with the accrediting body, attend exit conferences, or conduct focused follow-behind visits as determined to be appropriate in consultation with the national accrediting organization and the provider organization.
- c. To be informed of and to investigate all complaints that fall under this chapter's jurisdiction according to the process in rule 441—24.7(225C). The division shall report findings to the national accrediting body.

d. To review and act upon deemed status when:

- (1) Complaints have been founded, or
- (2) The organization's national accreditation status expires without renewal, or
- (3) The national accrediting body downgrades or withdraws the organization's status.

24.6(6) Continuation of deemed status.

a. The organization shall send a copy of Form 470-3332, Application and Letter of Agreement, along with a copy of the application for renewal to the national accrediting body at the same time as application is made to a national accrediting body.

b. HCBS staff shall furnish to the division copies of the letter notifying a provider of a forthcoming recertification for organizations deemed for supported community living under the HCBS mental retardation waiver.

c. Following the on-site review by a national accrediting body, the organization shall send the division a copy of the cover sheet and the national accrediting body report within 30 calendar days from the date that the organization receives the documents. If a corrective action plan is required, the organization shall send the division a copy of all correspondence and documentation related to the corrective action.

d. HCBS staff shall furnish the division with copies of HCBS certification reports and any corrective action required by HCBS within 30 calendar days after HCBS staff complete the report or the organization completes required corrective action.

441—24.7(225C) Complaint process. The division shall receive and record complaints by individuals using the services, employees, any interested people, and the public relating to or alleging violations of applicable requirements of the Iowa Code or administrative rules.

24.7(1) Submittal of complaint. The complaint may be delivered personally or by mail to the Division of Behavioral, Developmental, and Protective Services, Department of Human Services, Hoover State Office Building, Fifth Floor, 1305 East Walnut, Des Moines, Iowa 50319-0114, or by telephone (515)281-5874.

a. The division shall assist individuals in making a complaint as needed or requested.

b. The information received should specifically state the basis of the complaint. The division shall keep the name of the complainant confidential to the extent allowed by law.

24.7(2) Review of complaint. Upon receipt of a complaint, the division shall make a preliminary desk review of the complaint to determine an appropriate response. That response may include notifying the person who submitted the complaint that there is no basis for a review, referring the complaint to another investigative body, or making a determination to do a full investigation.

24.7(3) Investigation of complaint. If the division concludes that the complaint is reasonable, has merit, and is based on a violation of rules in this chapter, it may make an investigation of the organization. The division may investigate complaints by an office audit or by an on-site investigation. The division shall give priority for on-site investigations to instances when individuals using the service are in immediate jeopardy.

a. If a decision is made to conduct an on-site investigation, the on-site review does not require advance notice to the organization. The division shall notify the chief executive officer and board chairperson of the organization involved before or at the commencement of the on-site investigation that the division has received a complaint.

b. The division shall give the organization an opportunity to informally present a position regarding allegations in the complaint. The organization may submit the position in writing within five working days following the on-site visit or present it in a personal conference with division staff.

c. The division shall submit a written report by certified mail to the chief administrative officer of the organization and the chairperson of the board of directors within 20 working days after completion of the investigation.

d. The report shall indicate whether the complaint was or was not substantiated, the basis for the substantiation or nonsubstantiation, the specific rules violated, and a recommendation for corrective action with time lines specified in the report.

e. The date of delivery shown by the certified mail stub shall constitute the date of official notice.

24.7(4) Review by commission. When individuals receiving services are in immediate jeopardy, the commission may call an emergency meeting to make a decision on possible revocation or denial of accreditation.

a. To the extent allowed by Iowa Code section 21.5, the commission may review the complaint and investigation report in a closed meeting. The action taken by the commission shall be voted upon in the reconvened public meeting and entered into the official record of commission minutes.

b. If the complaint is substantiated, the commission may take actions deemed appropriate, which may include shortening the term of accreditation, requiring a corrective action plan, or suspending or revoking an organization's accreditation, depending on the severity of the substantiated complaint.

c. The division shall inform the complainant and the organization by certified mail of the findings and actions taken by the commission. The date of delivery shown by the certified mail stub shall constitute the date of official notice.

24.7(5) Corrective action plan. When the commission acts to suspend or revoke accreditation, there will be no corrective action plan. In other instances, if the complaint is substantiated, the organization shall submit a corrective action plan to the division within 20 calendar days after receiving the commission's decision. This plan must respond to violations cited and commission requirements and include time lines, internal monitoring systems, and performance improvement planning.

Failure of the organization to respond within 20 calendar days with an acceptable corrective action plan that addresses the organization's plan of correction following a substantiated investigation or complaint may of itself constitute the basis for revocation or suspension of accreditation. The commission shall determine the appropriate action based on the information submitted. The division shall notify the organization of any action the commission takes.

441—24.8(225C) Appeal procedure. An appeal may be filed using the procedure identified in 441—Chapter 7. Notice of an appeal shall be sent to Appeals Section, Department of Human Services, Hoover State Office Building, Fifth Floor, 1305 East Walnut, Des Moines, Iowa 50319-0114, within 30 calendar days of the written decision from the commission.

441—24.9(225C) Exceptions to policy. Requests for exceptions to the policies in this chapter shall follow the policies and procedures in the department's general rule on exceptions to policy at 441—1.8(17A,217).

These rules are intended to implement Iowa Code chapter 225C.

441—24.10 to 24.19 Reserved.

**DIVISION II
CRISIS RESPONSE SERVICES**

PREAMBLE

The department of human services in consultation with the mental health and disability services commission has established this set of standards to be met by all providers of crisis response services.
[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.20(225C) Definitions.

“*Action plan*” means a written plan developed for discharge in collaboration with the individual receiving crisis response services to identify the problem, prevention strategies, and management tools for future crises.

“*Crisis assessment*” means a face-to-face clinical interview to ascertain an individual’s current and previous level of functioning, potential for dangerousness, physical health, and psychiatric and medical condition. The crisis assessment becomes part of the individual’s action plan.

“*Crisis incident*” means an occurrence leading to physical injury or death, or an occurrence resulting from a prescription medication error, or an occurrence triggering a report of child or dependent adult abuse.

“*Crisis response services*” means short-term individualized crisis stabilization services which follow a crisis screening or assessment and which are designed to restore the individual to a prior functional level.

“*Crisis response staff*” means a person trained to provide crisis response services in accordance with rule 441—24.24(225C).

“*Crisis screening*” means a process to determine what crisis response service is appropriate to effectively resolve the presenting crisis.

“*Crisis stabilization community-based services*” or “*CSCBS*” means short-term services designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis and provided where the individual lives, works or recreates.

“*Crisis stabilization residential services*” or “*CSRS*” means a short-term alternative living arrangement designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis and is provided in organization-arranged settings of no more than 16 beds.

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

“*Dispatch*” means the function within crisis line operations to coordinate access to crisis care.

“*Face-to-face*” means services provided in person or utilizing telehealth in conformance with the federal Health Insurance Portability and Accountability Act (HIPAA) privacy rules.

“*Family support peer specialist*” means the same as defined in rule 441—25.1(331).

“*Informed consent*” means the same as defined in rule 441—24.1(225C).

“*Mental health crisis*” means a behavioral, emotional, or psychiatric situation which results in a high level of stress or anxiety for the individual or persons providing care for the individual and which cannot be resolved without intervention.

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

“*Mobile response*” means a mental health service which provides on-site, face-to-face mental health crisis services for an individual experiencing a mental health crisis. Crisis response staff providing mobile response have the capacity to intervene wherever the crisis is occurring, including but not limited to the individual’s place of residence, an emergency room, police station, outpatient mental health setting, school, recovery center or any other location where the individual lives, works, attends school, or socializes.

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

“*Peer support specialist*” means the same as defined in rule 441—25.1(331).

“*Physical health*” means any chronic or acute health factors that need to be addressed during crisis delivery services.

“*Qualified prescriber*” means a practitioner or other staff following the instruction of a practitioner as defined in Iowa Code section 155A.3 and a physician assistant or advanced registered nurse practitioner operating under the prescribing authority granted in Iowa Code section 147.107.

“*Restraint*” means the application of physical force or the use of a chemical agent or mechanical device for the purpose of restraining the free movement of an individual’s body to protect the individual, or others, from immediate harm.

“Rights restriction” means limitations not imposed on the general public in the areas of communications, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, and place of residence.

“Self-administered medication” means the process where a trained staff member observes an individual inject, inhale, ingest or, by any other means, take medication following the instructions of a qualified prescriber.

“Stabilization plan” means a written short-term strategy used to stabilize a crisis and developed by a mental health professional, in collaboration with the crisis response staff and with the involvement and consent of the individual or the individual’s representative.

“Staff-administered medication” means the direct application of a prescription drug, whether by injection, inhalation, ingestion, or any other means, to the body of an individual by a qualified prescriber or authorized staff following instructions of a qualified prescriber.

“Telehealth” is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the Internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

“Treatment summary” means a written summarization of the treatment and action plan at the point of an individual’s discharge or transition to another service.

“Twenty-four-hour crisis line” means a crisis line providing information and referral, counseling, crisis service coordination, and linkages to crisis screening and mental health services 24 hours a day.

“Twenty-four-hour crisis response” means services are available 24 hours a day, 365 days a year, providing access to crisis screening and assessment and linkage to mental health services.

“Twenty-three-hour observation and holding” means a level of care provided for up to 23 hours in a secure and protected, medically staffed, psychiatrically supervised treatment environment.

“Warm line” means a telephone line staffed by individuals with lived experience who provide nonjudgmental, nondirective support to an individual who is experiencing a personal crisis.
[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.21(225C) Standards for crisis response services. An organization may be accredited to provide any one or all of the identified crisis response services. An organization seeking crisis response service accreditation shall comply with the general standards within this division and additional standards for each specific service.

[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.22(225C) Standards for policies and procedures. Policies and procedures manuals contain policy guidelines and administrative procedures for all activities and services and address the standards in rule 441—24.2(225C).

[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.23(225C) Standards for organizational activities. The organization shall meet the standards in subrules 24.3(1) through 24.3(5).

[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.24(225C) Standards for crisis response staff. All crisis response staff shall meet the qualifications described in this rule. Additional staff requirements are described in each service.

24.24(1) Performance benchmark. Qualified crisis response staff provide crisis response services.

24.24(2) Performance indicators.

a. One or more of the following qualifications are met:

(1) A mental health professional as defined in Iowa Code section 228.1.

(2) A bachelor’s degree with 30 semester hours or equivalent in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education) and at least one year of experience in behavioral or mental health services.

- (3) A law enforcement officer trained in crisis intervention including, but not limited to, mental health first aid and mental health in-service training.
 - (4) An emergency medical technician (EMT) trained in crisis intervention including, but not limited to, mental health first aid.
 - (5) A peer support specialist with a minimum certification of mental health first aid.
 - (6) A family support peer specialist with a minimum certification of mental health first aid.
 - (7) A registered nurse with two years of mental or behavioral health experience.
- b. Documentation in staff records to verify satisfactory completion of department-approved training including:
- (1) A minimum of 30 hours of department-approved crisis intervention and training.
 - (2) A posttraining assessment of competency is completed.

[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.25(225C) Standards for services.

24.25(1) Standard for eligibility. An eligible recipient is an individual experiencing a mental health crisis or emergency where a mental health crisis screening is needed to determine the appropriate level of care.

24.25(2) Confidentiality and legal status. Standards in subrule 24.4(6) are met.

24.25(3) Service systems. Standards in subparagraphs 24.4(7) "b" (1) to (3) are met.

24.25(4) Respect for individual rights. Standards in subrule 24.4(8) are met.

[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.26(225C) Accreditation. The administrator for the division of mental health and disability services shall determine whether to grant, deny or revoke the accreditation of the centers and services as determined in Iowa Code section 225C.6(1) "c."

24.26(1) The organization shall meet the standards of subrule 24.5(1), with the addition of crisis response service organizations.

24.26(2) The organization shall meet the standards in subrules 24.5(2) and 24.5(3).

24.26(3) Performance outcome determinations are as follows:

a. Quality assurance staff shall determine a performance compliance level based on the number of indicators found to be in compliance.

(1) For service indicators, if 25 percent or more of the files reviewed do not comply with the requirements for a performance indicator, that indicator is considered out of compliance and corrective action is required.

(2) Corrective action is required when any indicator under policies and procedures or activities is not met.

b. In the overall rating, the performance rating for policies and procedures shall count as 15 percent of the total, activities as 15 percent of the total, and services as 70 percent of the total.

(1) Each of the three indicators for policies and procedures has a value of 5.0 out of a possible score of 15.

(2) Each of the 34 indicators for activities has a value of .44 out of a possible score of 15.

(3) Each service has a separate weighting according to the total number of indicators applicable for that service, with a possible score of 70, as follows:

c. Quality assurance staff shall determine a separate score for each service to be accredited. When an organization offers more than one service under this chapter, there shall be one accreditation award for all the services based upon the lowest score of the services surveyed.

Service	Number of Indicators	Value of Each Indicator
24-hour crisis response	19	3.9
Crisis evaluation	20	3.5
24-hour crisis line	23	3.0
Warm line	20	3.5
Mobile response	18	3.9
23-hour observation and holding	44	1.6
Crisis stabilization, community-based	39	1.8
Crisis stabilization, residential	50	1.4

24.26(4) The organization shall meet the standards in subrules 24.5(5) to 24.5(7).
 [ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.27(225C) Deemed status. The department shall grant deemed status to organizations accredited by a recognized national, not-for-profit, accrediting body when the department determines the accreditation is for similar services. The organization shall fulfill the standards described in subrules 24.6(1) to 24.6(6). The national accrediting bodies currently recognized as meeting division criteria for possible deeming are:

1. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
2. The Commission on Accreditation of Rehabilitation Facilities (CARF).
3. The Council on Quality and Leadership in Supports for People with Disabilities (The Council).
4. The Council on Accreditation of Services for Families and Children (COA).
5. The American Association of Suicidology (AAS).
6. Contact USA.

[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.28(225C) Complaint process. The department shall receive and record complaints by individuals using services, employees, any interested people, and the public relating to or alleging violations of applicable requirements of the Iowa Code or administrative rules in accordance with the standards described in rule 441—24.7(225C).
 [ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.29(225C) Appeal procedure. The department shall receive appeals according to the process in rule 441—24.8(225C).
 [ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.30(225C) Exceptions to policy. The department shall receive exceptions to policy meeting the standards in rule 441—24.9(225C).
 [ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.31(225C) Standards for individual crisis response services. Crisis response services provided to children and youth include coordination with parents, guardians, family members, natural supports, and service providers and with other systems such as education, juvenile justice and child welfare.

Crisis response services for individuals who have co-occurring or multi-occurring diagnoses focus on the integration and coordination of treatment services, and supports necessary to stabilize the individual, without regard to which condition is primary. Crisis response services are not to be denied due to the presence of a co-occurring substance abuse condition or developmental or neurodevelopmental disability.
 [ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.32(225C) Crisis evaluation. Crisis evaluation consists of two components: crisis screening and crisis assessment.

24.32(1) Crisis screening. The purpose of crisis screening is to determine the presenting problem and appropriate level of care.

a. *Performance benchmark.* Crisis screening includes a brief assessment of suicide lethality, substance use, alcohol use and safety needs. Crisis screening can be provided through contact with crisis response staff and through communication with the individual.

b. *Performance indicators.*

- (1) Crisis response staff are trained in crisis screening.
- (2) A uniform process for crisis screening and referrals is outlined in policies and procedures.
- (3) Crisis screening records are kept in individual files.

24.32(2) Crisis assessment. The purpose of crisis assessment is to determine the precipitating factors of the crisis, the individual and family functioning needs, and the diagnosis if present and to initiate a stabilization plan and discharge plan. A licensed mental health professional conducts a crisis assessment within 24 hours of an individual's admission to a crisis response service.

a. *Assessment requirements.* The crisis assessment includes:

- (1) Action plan.
- (2) Active symptoms of psychosis.
- (3) Alcohol use.
- (4) Coping ability.
- (5) History of trauma.
- (6) Impulsivity or absence of protective factors.
- (7) Intensity and duration of depression.
- (8) Lethality assessment.
- (9) Level of external support available to the individual.
- (10) Medical history.
- (11) Physical health.
- (12) Prescription medication.
- (13) Crisis details.
- (14) Stress indicators and level of stress.
- (15) Substance use.

b. *Performance benchmark.* Individuals receive comprehensive assessment by a mental health professional to determine the appropriate level of care.

c. *Performance indicators.*

- (1) Written policies and procedures describe a uniform process for assessment, referrals and record documentation.
- (2) Mental health professionals as defined in Iowa Code section 228.1(6) will complete assessments.
- (3) Information collected is sufficient to determine the appropriate level of care.
- (4) Assessment results are explained to the individual and family or guardian when appropriate.
- (5) The individual's strengths, preferences and needs are included in an action plan. The family or guardian may receive a copy of an action plan with a signed release.

[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.33(225C) Twenty-four-hour crisis response. The purpose of 24-hour crisis response is to provide access to crisis screening and assessment to de-escalate and stabilize the crisis. When the assessment indicates, a stabilization plan is developed to support the individual's return to a prior level of functioning. Twenty-four-hour crisis response staff link the individual to appropriate services. Crisis response staff provide service to individuals of any age.

24.33(1) Performance benchmark. Individuals in crisis have the ability to access crisis response services, including, but not limited to, crisis screening, crisis assessment and stabilization in the least restrictive level of care appropriate.

24.33(2) Performance indicators.

- a. Information on how to access 24-hour crisis response is publicized to facilitate availability of services to individuals using the service, family members and the public.
- b. Individuals accessing the service receive crisis screening and crisis response services from appropriate crisis response staff.
- c. Crisis screening is available and accessible face-to-face, using telephone or Web-based options, 24 hours a day, 365 days a year.
- d. A mental health professional is available for crisis assessment and consultation 24 hours a day, 365 days a year. The mental health professional has access to a qualified prescriber for consultation.
- e. The staffing pattern and schedule is documented.
- f. The integration and coordination of care is documented in the individual's record.
- g. The discharge, action and follow-up plans are documented in the individual's record, and copies of the plans are provided to the individual. The family or guardian may receive a copy with a signed release.

[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.34(225C) Twenty-four-hour crisis line. A 24-hour crisis line provides counseling, crisis service coordination, information and referral, linkage to services and crisis screening. Crisis line staff are qualified to provide crisis stabilization services pursuant to subrule 24.24(2).

24.34(1) Performance benchmark. Crisis screening, counseling, crisis service coordination and referrals are provided to individuals in crisis.

24.34(2) Performance indicators.

- a. The crisis line service is available 24 hours a day, 365 days a year.
- b. Policies are in place regarding how the crisis line is answered live, when to utilize the hold feature, the use of queue systems and triage of calls.
- c. Policies and procedures govern the use of technology, including telephonic and Internet capability in the service delivery structure, quality assurance, data integrity and confidentiality.
- d. Procedures are in place for ensuring the quality of the crisis line, including monitoring calls and corrective action plans.
- e. The crisis line is an integrated component of the crisis response service system; the crisis line is answered in an organization setting by trained crisis response staff.
- f. Policies define collaborative efforts and triage procedure between the mobile outreach teams, law enforcement and emergency services.
- g. Policies are in place to ensure follow-up contacts are provided within 24 hours of a crisis call for all risk cases. The crisis line integrates follow-up into all crisis service contacts.
- h. The crisis line utilizes standardized call center software with the capability to track:
 - (1) Date and time of answered call, topic of call, crisis screening provided, referral made, hold time, and demographics of call.
 - (2) Number of contacts, including terminated and lost calls.
- i. Policies and procedures describe a uniform process of crisis screening and training for crisis line staff.
- j. Training includes crisis screening tools, lethality assessment, crisis counseling, cultural competence, crisis service coordination, and information and referral.
- k. Twenty-four-hour access to a mental health professional is required.

[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.35(225C) Warm line. A peer-operated warm line is a service individuals can access to talk with someone with lived experience with mental, behavioral health and trauma issues. The line provides a resource for individuals experiencing emotional distress.

24.35(1) Performance benchmark. A warm line provides nonjudgmental listening, nondirective assistance, information, referral, and triage when appropriate.

24.35(2) Performance indicators.

- a. Policies are in place regarding how the warm line is answered live, placing callers on hold and when appropriate to use a queue system.
- b. Policies and procedures are in place for standard collection of demographics, the presented reason for calling and outcome of call.
- c. Policies and procedures are in place for crisis screening and when to triage a caller to a higher level of service.
- d. Data collection includes call answer times, duration of calls, and number of calls dropped, lost or terminated.
- e. Policies and procedures describe the staffing pattern and schedule.
- f. Warm-line staff can receive calls remotely through telephones or computers or within an organization.
- g. Staff qualifications and training for peer support specialists and family support peer specialists are required.
- h. Twenty-four-hour access to a mental health professional is required.

[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.36(225C) Mobile response. Crisis response staff provide on-site, in-person intervention for individuals experiencing a mental health crisis. The mobile response staff provide crisis response services in the individual's home or at locations in the community. Staff work in pairs to ensure staff safety and the safety of the individual served. A single staff member may respond if another person who meets one of the criteria listed in paragraph 24.24(2) "a" will be available on site. Twenty-four-hour access to a mental health professional is required.

24.36(1) Performance benchmark. Mobile response services are delivered to individuals in crisis in a timely manner.

24.36(2) Performance indicators.

- a. Mobile response staff are dispatched immediately after crisis screening has determined the appropriate level of care. If the mobile response staff already are responding to another call, staff explain to the caller that there may be a delay in receiving a mobile response and offer an alternative response.
- b. Mobile response staff have face-to-face contact with the individual in crisis within 60 minutes from dispatch. If the mobile response staff are responding to another request, there may be a delay in receiving mobile response and an alternative response should be provided.
- c. Data is collected to track and trend response time from initial dispatch, the time to respond to dispatch when a team is already in response; diversion from or admission to hospitals, correctional facilities and other crisis response services. The data for each fiscal year is reported to the department within 60 days of the close of the fiscal year.
- d. When an action plan is developed, a copy is sent within 24 hours, with the individual's signed consent, to service providers, the individual and others as appropriate.
- e. The following information is documented in the individual's service record:
 - (1) Triage and referral information.
 - (2) Reduction in the level of risk present in the crisis situation.
 - (3) Coordination with other mental health resources.
 - (4) Names and affiliation of all individuals participating in the mobile response.
- f. A follow-up appointment with the individual's preferred provider will be made, and mobile response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place.

[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.37(225C) Twenty-three-hour crisis observation and holding. Twenty-three-hour crisis observation and holding services may be a stand-alone service or embedded within a crisis stabilization residential service. Twenty-three-hour crisis observation and holding services are designed for individuals who need short-term crisis intervention in a safe environment less restrictive than hospitalization. This level of service is appropriate for individuals who require protection or when an

individual's ability to cope in the community is severely compromised and it is expected the crisis can be resolved in 23 hours. Twenty-three-hour crisis observation and holding services include, but are not limited to, treatment, medication administration, meeting with extended family or significant others, and referral to appropriate services. Twenty-three-hour crisis observation and holding chairs can be utilized.

24.37(1) Admission criteria. The services may be provided if any of the following admission criteria are met:

- a. There are indications the symptoms can be stabilized and an alternative treatment can be initiated within a 23-hour period.
- b. The presenting crisis cannot be safely evaluated or managed in a less restrictive setting, or no such setting is available.
- c. The individual does not meet inpatient criteria, and it is determined a period of observation assists in the stabilization and prevention of symptom exacerbation.
- d. Further evaluation is necessary to determine the individual's service needs.
- e. There is an indication of actual or potential danger to self or others as evidenced by a current threat or ideation.
- f. There is a loss of impulse control leading to life-threatening behavior and other psychiatric symptoms requiring stabilization in a structured, monitored setting.
- g. The individual is experiencing a crisis demonstrated by an abrupt or substantial change in normal life functioning brought on by a specific cause, sudden event or severe stressor.

24.37(2) Staffing requirements.

- a. A designated medical director or administrator is responsible for the management and operation of the organization or facility.
- b. Registered nurse practitioners and physician assistants have at least two years of mental health experience.
- c. At least one mental health professional is available for consultation 24 hours a day, 365 days a year.
- d. A mental health professional as defined in Iowa Code section 228.1(6) provides mental health services appropriate to the individual's needs.
- e. Crisis response staff are on duty 24 hours a day.
- f. A registered nurse is available on site 24 hours a day.

24.37(3) Twenty-three-hour observation and holding safety.

a. *Performance benchmark.* An incident report is created when staff are notified an incident has occurred.

b. *Performance indicators.*

- (1) The incident report documents:
 1. The name of the individual or individuals who were involved in the incident.
 2. Date and time of occurrence of the incident.
 3. A description of the incident.
 4. Names and signatures of all staff present at the time of the incident.
 5. The action taken by the staff.
 6. The resolution or follow-up to the incident.
- (2) A copy of the incident report is kept in a centralized file and a copy is given to the individual, the mental health and disability services region, and the individual's parent or guardian when appropriate.

24.37(4) Service requirements.

a. *Performance benchmark.* A treatment summary is provided to the individual and the individual's treatment team when applicable.

b. *Performance indicators.* The minimum treatment summary requirements include:

- (1) Action plan.
- (2) Crisis assessment, including challenges and strengths.
- (3) Course and progress of the individual with regard to each identified challenge.
- (4) Evaluation of the individual's mental status to inform ongoing placement and support decisions.
- (5) Recommendations and arrangements for further service needs.

(6) Signature of the mental health professional.

(7) Treatment interventions.

c. *Performance benchmark.* The individual using this service is provided a safe, secure observation and holding service in a location meeting the needs of the individual and in the least restrictive setting.

d. *Performance indicators.*

(1) Individuals give informed consent.

(2) Treatment providers, family members and other natural supports as appropriate are contacted within 23 hours of the individual's admission.

(3) Written policies and procedures cover medication administration, storage and documentation.

(4) Individual records include, but are not limited to, a treatment summary and verification of individual choice.

(5) The 23-hour crisis observation and holding facility is a welcoming and comfortable environment conducive to recovery.

(6) The 23-hour crisis observation and holding is primarily used as a diversion from hospital level of care.

(7) Communication attempts and contact with the individual's team will be documented.

(8) A follow-up appointment with the individual's preferred provider will be made, and crisis response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place.

(9) There are written policies and procedures of how to document and track discharge locations.

(10) The actual number of individuals served within the 23-hour period is documented. Individual treatment records contain reasons why individuals stay beyond the 23-hour period.

(11) Readmission data and length of time between admissions are tracked for data trend reports.

e. *Performance benchmark.* Policies and procedures address the additional safety standards for 23-hour crisis and observation services.

f. *Performance indicators.*

(1) Service compliance is documented regarding state fire marshal rules and fire ordinances and applicable local health, fire, occupancy code, and safety regulations.

(2) Based on standards used for public facilities, all food and drink is clean, wholesome, free from spoilage, and stored and served in a manner safe for human consumption.

(3) Doors must not be locked from the inside. The use of door locks is as approved by the fire marshal and professional staff.

(4) Twenty-three-hour observation and holding services have an emergency preparedness plan to describe the process for an individual to continue receiving services during a disaster including, but not limited to, cases of severe weather or fire.

g. *Performance benchmark.* Policies and procedures address the cleanliness of the 23-hour observation and holding service.

h. *Performance indicators.*

(1) Services provide a safe, clean, well-ventilated, properly heated environment in good repair and free from vermin.

(2) An individual's resting or sleeping area includes:

1. A sturdily constructed bed or comfortable chair.

2. A sanitized mattress protected with a clean mattress pad, or sanitized chair.

3. Curtains or blinds are on bedroom windows.

4. Available clean linen.

5. Doors or partitions for privacy.

6. Right to privacy is respected.

(3) Bathrooms include items necessary for personal hygiene and personal privacy.

1. A safe supply of hot and cold running water which is potable.

2. Clean towels, electric hand dryers or paper towel dispensers, and an available supply of toilet paper and soap.

3. Natural or mechanical ventilation capable of removing odors.
4. Tubs or showers have slip-proof surfaces.
5. Partitions with doors which provide privacy if a bathroom has multiple toilet stools.
6. Toilets, wash basins, and other plumbing or sanitary facilities are maintained in good operating condition.
7. Privacy in bathrooms for male and female individuals.
 - i. *Performance benchmark.* Personal rights are acknowledged.
 - j. *Performance indicator.* The following are allowed:
 - (1) Areas in which an individual may be alone when appropriate.
 - (2) Areas for private conversations with others.
 - (3) Secure space for personal belongings.
 - (4) Personal clothing is allowed in accordance with organization policy.
 - k. *Performance benchmark.* Policies and procedures address health and safety standards.
 - l. *Performance indicators.*
 - (1) An emergency preparedness plan is designed to provide effective utilization of available resources during a disaster event including, but not limited to, cases of severe weather or fire.
 - (2) Services comply with rule 441—24.39(225C).
 - (3) There are written policies on safety.
 - (4) Seclusion is not used.
 - (5) Mechanical or chemical restraints are not used at any time.
 - (6) The smokefree air Act, Iowa Code chapter 142D, is followed.

[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.38(225C) Crisis stabilization community-based services (CSCBS). The goal of CSCBS is to stabilize the individual within the community. CSCBS is designed as a voluntary service for individuals in need of a safe, secure location that is less intensive and restrictive than an inpatient hospital. Individuals receive CSCBS services including, but not limited to, psychiatric services, medication, counseling, referrals, peer support and linkage to ongoing services. The duration for CSCBS is expected to be less than five days.

24.38(1) Eligibility. To be eligible, an individual must:

- a. Be determined appropriate for the service by mental health assessment; and
- b. Be determined not to need inpatient acute hospital psychiatric services.

24.38(2) Staffing requirements.

a. A designated director or administrator is responsible for the management and operation of the CSCBS.

b. At least one licensed nurse practitioner, physician assistant, or psychiatrist is available for consultation 24 hours a day, 365 days a year.

c. Mental health professionals with expertise appropriate to the individual's needs provide services.

d. Contact between the individual and a mental health professional occurs at least one time a day.

e. Additional services are provided by crisis response staff at a minimum of one hour per day, including, but not limited to, skill building, peer support or family support peer services. The goal of CSCBS is to stabilize the individual within the community. CSCBS is designed for voluntary services for individuals in need of a safe, secure location that is less intensive and restrictive than an inpatient hospital.

f. Crisis response staff must be awake and attentive 24 hours a day.

24.38(3) Performance benchmark. The individual using CSCBS is provided safe, secure and structured crisis stabilization services in the least restrictive location meeting the needs of the individual. The CSCBS can be for youth aged 18 and under or adults aged 18 and older.

24.38(4) Performance indicators.

a. The individual can provide consent for treatment providers, family members and other natural supports to be contacted within 24 hours of admission.

b. Daily crisis stabilization services include, at minimum, daily contact with a mental health professional and one hour of additional crisis stabilization services from crisis response staff.

c. The numbers of days an individual receives crisis stabilization services are documented. The documentation records specific reasons for the delivery of services beyond five days.

d. Individual records are maintained to document the following:

(1) Daily contact with a mental health professional.

(2) Additional services provided including, but not limited to, skill building, peer support or family support peer services.

(3) Medication record.

e. Individual choice is verified including, but not limited to, treatment participation and discharge plan options.

f. Readmission data is tracked, including an analysis of data trends looking at effectiveness, and appropriate corrective action taken. The information is documented in the performance improvement system files.

24.38(5) Crisis stabilization incident reporting.

a. *Performance benchmark.* An incident report is filed when staff are notified an incident has occurred.

b. *Performance indicators.*

(1) The incident report documents:

1. The name of the individual involved in the incident.

2. Date and time the incident occurred.

3. A description of the incident.

4. Names and signatures of all staff present at the time of the incident.

5. The action the staff took to handle the situation.

6. The resolution or follow-up to the incident.

(2) A copy of the incident report is kept in a centralized file and a copy given to the individual, the mental health and disability services region, and the parent or guardian when appropriate.

24.38(6) Service requirements.

a. *Stabilization plan.* The individual in crisis is involved collaboratively in all aspects of crisis stabilization services including, but not limited to, admission, treatment planning, intervention, and discharge. The involvement of family members and others is encouraged.

Within 24 hours of an individual's admission to crisis stabilization services, a written short-term stabilization plan is developed, with the involvement and consent of the individual, and is reviewed frequently to assess the need for the individual's continued placement in CSCBS. At a minimum, this plan includes:

(1) Criteria for discharge, including referrals and linkages to appropriate services and coordination with other systems.

(2) Description of any physical disability and any accommodations necessary to provide the same or equal services and benefits as those afforded nondisabled individuals.

(3) Evidence of input by the individual, including the individual's signature.

(4) Goal statement. Goals are consistent with the individual's needs and projected duration of service delivery and include objectives which build on strengths and are stated in terms allowing measurement of progress.

(5) Rights restrictions.

(6) Names of all other persons participating in the development of the plan.

(7) Specification of treatment responsibilities and methods.

b. *Performance benchmark.* A stabilization plan is completed within 24 hours of the individual's admittance.

c. *Performance indicators.*

(1) Individual records include a written short-term stabilization plan developed with the involvement and consent of the individual within 24 hours of admittance and reviewed frequently to assess the need for continued placement in CSCBS.

(2) Individual records indicate a crisis stabilization plan is completed within the 24-hour time frame.

(3) Reasons for crisis stabilization plans not meeting the criteria are documented.

(4) A follow-up appointment with the individual's preferred provider will be made, and crisis response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place.

24.38(7) Treatment summary. Prior to the individual's discharge from CSCBS, a treatment summary is completed. A copy of the summary is provided to the individual and shared with the individual's treatment team of providers, if applicable.

a. *Contents.* At a minimum, the treatment summary includes:

(1) Course and progress of the individual with regard to each identified problem.

(2) Documented note of a mental health professional contact one time daily.

(3) Evolution of the mental status to inform ongoing placement and support decisions.

(4) Final assessment, including general observations and significant findings of the individual's condition initially while services were being provided and at discharge.

(5) Recommendations and arrangements for further service needs.

(6) Signature of the mental health professional.

(7) Stabilization plan.

(8) Reasons for termination of service.

(9) Treatment interventions.

b. *Performance benchmark.* A treatment summary is completed during the length of stay in CSCBS.

c. *Performance indicators.*

(1) Records include a written treatment summary developed with the involvement of the individual. A copy of the summary is provided upon discharge.

(2) Incidents in which a treatment plan was not completed within the length of stay and any corrective action necessary to alleviate this issue are documented.

24.38(8) Health and safety.

a. *Performance benchmark.* Emergency preparedness policies and procedures include health and safety measures.

b. *Performance indicators.*

(1) Emergency preparedness plans are designed to provide effective utilization of available resources for care to continue during a disaster event including, but not limited to, cases of severe weather or fire.

(2) Crisis services comply with rule 441—24.39(225C).

[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.39(225C) Crisis stabilization residential services (CSRS). Crisis stabilization residential services are short-term services provided in facility-based settings of no more than 16 beds. The goal of CSRS is to stabilize and reintegrate the individual back into the community. Crisis stabilization residential services are designed for voluntary individuals who are in need of a safe, secure environment less intensive and restrictive than an inpatient hospital. Crisis stabilization residential services have the capacity to serve more than two individuals at a time. Crisis stabilization residential services can be for youth aged 18 and younger or adults aged 18 and older. Youth and adults cannot be housed in the same facility setting. Facilities licensed by the department of inspections and appeals for other services would have to comply with the provisions of Iowa Administrative Code rule 481—57.50(135C) for operating another business or activity in the facility.

24.39(1) Eligibility. To be eligible, an individual must:

a. Be an adult aged 18 or older or a youth aged 18 or under.

b. Be determined appropriate for the service by a mental health assessment; and

c. Be determined to not need inpatient acute hospital psychiatric services.

24.39(2) Staffing requirements.

- a. A designated director or administrator is responsible for the management and operation of the CSRS of no more than 16 beds.
- b. At least one licensed mental health professional is available for consultation 24 hours a day, 365 days a year.
- c. Crisis stabilization residential services are provided by a mental health professional with expertise appropriate to the individual's needs.
- d. Each individual has contact with a mental health professional at least one time a day.
- e. Each individual has a minimum of one hour per day of additional services provided by crisis response staff including, but not limited to, skill building, peer support or family support peer services; or other therapeutic programming.
- f. Awake and attentive staffing 24 hours a day, 365 days a year is provided.

24.39(3) Performance benchmark. The individual is provided safe, secure and structured crisis stabilization services in the least restrictive location meeting the individual's needs.

24.39(4) Performance indicators.

- a. Individual's consent is documented, and treatment providers, family members and other natural supports are contacted within 24 hours of admission.
- b. A comprehensive mental health assessment is completed within 24 hours of admission.
- c. Daily crisis stabilization includes, at minimum, daily contact with a mental health professional and one hour of additional crisis stabilization service.
- d. The length of stay is expected to be less than five days.
- e. The number of days an individual receives crisis stabilization services is documented. The documentation records specific reasons for lengths of stay beyond five days.
- f. Records include:
 - (1) Stabilization plan.
 - (2) Medication record.
 - (3) Treatment summary.
 - (4) Daily contact with a mental health professional.
- g. Additional services provided include, but are not limited to, skill building, peer support or family support peer services.
- h. Individual choice is verified including, but not limited to, treatment participation and discharge plan options.
 - i. Data of readmission is tracked including an analysis of data trends, looking at effectiveness, and appropriate corrective action. The information is documented in the performance improvement system.
 - j. Documentation tracks that the youth's education needs are met with educational services received in the CSRS, and an action plan is in place to return the youth to school upon discharge.

24.39(5) Crisis stabilization incident reporting.

- a. *Performance benchmark.* An incident report is completed when staff are notified an incident has occurred.
- b. *Performance indicators.*
 - (1) The incident report documents:
 - 1. The name of the individual who was involved in the incident.
 - 2. Date and time of occurrence of the incident.
 - 3. A description of the incident.
 - 4. Names and signatures of all staff present at the time of the incident.
 - 5. The action staff took to handle the situation.
 - 6. The resolution or follow-up to the incident.
 - (2) A copy of the incident report is maintained in a centralized file and a copy given to the individual, the mental health and disability services region, and the parent or guardian when appropriate.

24.39(6) Service requirements.

a. *Stabilization plan.* The individual is involved collaboratively in all aspects of crisis stabilization services including, but not limited to, admission, treatment planning, intervention, and discharge. The involvement of family members and others is encouraged.

Within 24 hours of admission to CSRS, a written short-term stabilization plan is developed, with the involvement and consent of the individual, and reviewed frequently to assess the need for continued placement in CSRS. At a minimum, this plan includes:

(1) Criteria for discharge, including referrals and linkages to appropriate services and coordination with other systems.

(2) Description of any physical disability and accommodations necessary to provide the same or equal services and benefits as those afforded nondisabled individuals.

(3) Evidence of input by the individual, including the individual's signature.

(4) Goal statement.

(5) Goals consistent with needs and projected length of stay.

(6) Objectives that are built on strengths and allow measurement of progress.

(7) Rights restrictions.

(8) Signatures of all participating in the development of the plan.

(9) Specification of treatment responsibilities and methods.

b. *Performance benchmark.* A stabilization plan is completed within 24 hours of admittance.

c. *Performance indicators.*

(1) Records include a written short-term stabilization plan developed with the involvement and consent of the individual within 24 hours of admission and is reviewed frequently to assess the need for continued placement in CSRS.

(2) Records indicating a stabilization plan has been completed within the 24-hour time frame are maintained.

(3) Reasons the stabilization plan does not meet the criteria is documented.

(4) A follow-up appointment with the individual's preferred provider will be made, and crisis response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place.

24.39(7) Treatment summary. Prior to discharge, a treatment summary is provided and a copy shared with the individual and treatment team as appropriate.

a. *Contents.* At a minimum, this treatment summary includes:

(1) Course and progress regarding each identified problem.

(2) Documentation of daily contact with a mental health professional.

(3) Impact on placement and support decisions.

(4) Assessment.

(5) Action plan.

(6) Stabilization plan.

(7) Treatment interventions.

(8) Reasons for termination of service.

(9) Signature of the mental health professional.

b. *Performance benchmark.* A treatment summary is completed during the individual's length of stay in CSRS.

c. *Performance indicators.*

(1) Records include a written treatment summary developed with the involvement and consent of the individual.

(2) An individual receives a copy of the treatment summary upon discharge.

(3) Corrective action steps are documented when treatment plans are not completed within the length of stay.

24.39(8) Health and safety.

a. *Performance benchmarks.*

(1) Emergency preparedness policies and procedures include health and safety measures.

- (2) Crisis stabilization services meet all applicable local, state and federal regulations.
- (3) Medication administration and documentation standards in rule 441—24.40(225C) are documented.
- b. Performance indicators.*
- (1) Health and fire safety inspections.
1. Documentation includes Iowa fire marshal rules and fire ordinances, local health, fire, occupancy code, and safety regulations.
 2. Standards for public facilities guide food and beverage safety, nutrition standards, and safe storage of all consumable products.
 3. Crisis stabilization residential services comply with rule 441—24.40(225C).
- (2) Emergency preparedness. Emergency preparedness policies are designed to provide effective utilization of available resources for continuation during a disaster event, including, but not limited to, cases of severe weather or fire.
- (3) The facility is safe, clean, well-ventilated, and a properly heated environment in good repair and free from vermin.
- (4) Bedrooms include:
1. A sturdily constructed bed.
 2. A sanitized mattress protected with a clean mattress pad.
 3. A designated space in proximity to the sleeping area for personal possessions including clothing.
 4. Curtains or window blinds on bedroom windows.
 5. Available clean linens.
- (5) Sleeping areas include:
1. Doors for privacy.
 2. Partitioning and placement of furniture to provide privacy.
 3. Rooms accommodate no more than two per room. Single room dimensions are at least 80 square feet not including closets. Dual occupancy rooms are at least 120 square feet not including closets.
 4. Personal belongings and personal touches in the rooms are defined within CSRS policy.
 5. Respect by staff for an individual's right to privacy.
- (6) Personal hygiene and privacy tools are provided:
1. A safe supply of hot and cold running water which is potable.
 2. Clean towels, electric hand dryers or paper towel dispensers, and an available supply of toilet paper and soap.
 3. Natural or mechanical ventilation capable of removing odors.
 4. Tubs or showers with slip-proof surfaces.
 5. Partitions with doors which provide privacy if a bathroom has multiple toilet stools.
 6. Toilets, wash basins, and other plumbing or sanitary facilities are in good operating condition.
 7. Privacy in bathrooms for male and female individuals.
- (7) Federal laws regarding smoking on property are recognized and followed.
- (8) The following is provided:
1. Areas in which an individual may be alone when appropriate.
 2. Areas for private conversations with others.
 3. A secure space for personal belongings.
- c. Housekeeping.* Maintenance of living quarters and day-to-day housekeeping activities are clearly defined in writing and a part of the orientation. Staff assistance and equipment are provided as needed.
- d. Clothing.*
- (1) Personal clothing is allowed in accordance with CSRS policy.
 - (2) Clothing may be washed with provided laundry mechanisms.
- e. Religion/culture.* Rights to religion and culture include:
- (1) The opportunity to participate in religious activities and services in accordance with the individual's faith or of a minor individual's parent(s) or guardian.
 - (2) Arrange for transportation to religious activities when appropriate per CSRS policy.

f. Smoking. The smokefree air Act, Iowa Code chapter 142D, is included in the CSRS policy.
[ARC 1660C, IAB 10/15/14, effective 12/1/14]

441—24.40(225C) Medication—administration, storage and documentation. This rule sets forth medication requirements for 23-hour crisis observation and holding, crisis stabilization community-based services, and crisis stabilization residential services.

24.40(1) Performance benchmark. Policies and procedures ensure prescription and over-the-counter drugs are administered or self-administered safely and properly in accordance with federal, state and local laws and regulations. Medication is administered by a qualified prescriber or an individual following the instructions of a qualified prescriber. Medication storage is maintained in accordance with the security requirements of federal, state and local laws. Case records include written policies and procedures regarding use of medication.

24.40(2) Performance indicators.

a. Administration of medication.

(1) Medication administration dose schedules and standardization of abbreviations are documented.

(2) Throughout the CSRS specific methods for control and accountability of medication products are established.

(3) Prescription and over-the-counter drugs are administered or self-administered safely and properly in accordance with federal, state and local laws and regulations.

(4) Medications are prescribed by a qualified prescriber under Iowa law.

(5) Prescription drugs are not administered or self-administered without a written order signed by a qualified prescriber.

b. Staff-administered medication.

(1) Only qualified and authorized staff administers medication, and a current, accurate list of staff is maintained.

(2) Qualified prescribers instruct how medications are administered and documented. The type and amount of medication, time and date of medication administered, and the name of staff administering the medication are transcribed in the medication record.

c. Self-administered medication.

(1) Policies and procedures document which staff have completed department-approved training on self-administration of prescription medication.

(2) Self-administration of prescription and over-the-counter medications are permitted only when the medication label is clear and complete.

d. Medication storage. Medication storage policies under the care and control of the administration include:

(1) All medication is maintained in locked storage, and controlled substances are maintained in a locked box within locked storage.

(2) Medications requiring refrigeration are kept in a refrigerator separated from food and other edible items.

(3) Disinfectants and medication for external use are stored separately from internal and injectable medications.

(4) Each medication is stored in original containers and labeled with the name.

(5) All potent poisonous or caustic medications are clearly labeled; stored separately from other medication, in a specific well-illuminated cabinet, closet, or storeroom; and made accessible only to authorized staff.

(6) Medication provided is dispensed from a licensed pharmacy in the state of Iowa in accordance with the Iowa Code. It can also be provided by a qualified prescriber from a licensed pharmacy in another state according to the laws of the state.

(7) Prescription medications prescribed for one individual are not administered or allowed in the possession of another.

e. *Medication labeling.* All prescribed medications are clearly labeled with the full name; prescriber's name; prescription number; name and strength of the medication; dosage; directions for use; date of issue; and name, address and telephone number of the pharmacy or prescriber issuing the medication. Medications are packaged and labeled according to state and federal guidelines.

f. *Monthly inspection.* The staff member in charge of medication provides monthly inspection of all storage units.

g. *Damaged labels.* Medication containers having soiled, damaged, illegible, or makeshift labels are returned to the issuing pharmacist, pharmacy, or qualified prescriber for relabeling or disposal.

h. *Unused medications.* Unused prescription drugs are destroyed by staff with a witness present, when an individual leaves the crisis service without medication. A notation is documented in the record. When an individual is discharged or leaves the crisis service, medications currently being administered are sent in their original containers with the individual or with a designated person, with the approval of the qualified prescriber.

i. *Medication brought by individual.* If the prescribed and over-the-counter medication the individual brings to the CSRS is not used, the medication is packaged, sealed and stored. The sealed packages of medications are returned to the individual or family at the time of discharge.

j. *Medication documentation.*

(1) Written policies and procedures are in place for the review, approval, and implementation of ethical, safe, human and efficient behavioral intervention procedures.

(2) Written policies and procedures are in place to inform the individual and the individual's legal guardian, when appropriate, about prohibitions on the use of medication as a restraint.

(3) Documentation is required in case records on adverse drug reactions when medications are administered and self-administered.

(4) All medication orders are documented in the case records and document the name of the medication, dose, route of administration, frequency of administration, name of the qualified prescriber prescribing the medication, and name of the staff administering or dispensing the medication.

(5) Medication records are documented by authorized staff administering the medication.

k. *Medication rights and responsibilities.*

(1) Medication is not used as a restraint. The use of psychopharmacological medication in excess of the standard plan of care is prohibited. Using medication as a restraint includes:

1. Drugs or medications used to control behavior or restrict freedom of movement.

2. Drugs or medications used in excessive amounts or in excessive frequency.

3. Neuroleptics, anxiolytics, antihistamines, and atypical neuroleptics, or other medication used for calming, rather than for the medication's indicated treatment.

(2) Drugs or medications used for standard treatment of the individual's medical or psychiatric condition are not considered to be used as a restraint.

These rules are intended to implement Iowa Code section 331.397 and 2014 Iowa Acts, House File 2379.

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effective 10/1/15]

¹ Effective date of definitions of “Administrator,” “Division” and “Persons with mental retardation” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 10, 1995.

CHAPTER 25 DISABILITY SERVICES MANAGEMENT

PREAMBLE

This chapter provides for definitions of regional core services, access and practice standards, reporting of regional expenditures, development and submission of regional management plans, data collection, applications for funding as they relate to regional service systems for individuals with mental illness, intellectual disabilities, developmental disabilities, or brain injury, and submission of data for Medicaid offset calculations.

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

DIVISION I REGIONAL CORE SERVICES

441—25.1(331) Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“Job development” means services that assist individuals in preparing for, securing and maintaining gainful, competitive employment. Employment shall be integrated into normalized work settings, shall provide pay of at least minimum wage, and shall be based on the individual’s skills, preferences, abilities, and talents. Services assist individuals seeking employment to develop or re-establish skills, attitudes, personal characteristics, interpersonal skills, work behaviors, and functional capacities to achieve positive employment outcomes.

“Medication management” means services provided directly to or on behalf of the individual by a licensed professional as authorized by Iowa law including, but not limited to, monitoring effectiveness of and compliance with a medication regimen; coordination with care providers; investigating potentially

negative or unintended psychopharmacologic or medical interactions; reviewing laboratory reports; and activities pursuant to licensed prescriber orders.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[ARC 1096C, IAB 10/16/13, effective 11/20/13]

441—25.2(331) Core service domains.

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

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

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

- a. Assessment and evaluation.
- b. Case management.
- c. Crisis evaluation.
- d. Day habilitation.
- e. Family support.
- f. Health homes.
- g. Home and vehicle modification.
- h. Home health aide.
- i. Job development.
- j. Medication prescribing and management.
- k. Mental health inpatient treatment.
- l. Mental health outpatient treatment.
- m. Peer support.
- n. Personal emergency response system.
- o. Prevocational services.
- p. Respite.
- q. Supported employment.
- r. Supportive community living.
- s. Twenty-four-hour access to crisis response.

Regions may fund or provide other services in addition to the required core services consistent with requirements set forth in subrules 25.2(4) and 25.2(5).

25.2(4) A regional service system shall consider the scope of services included in addition to the required core services. Each service included shall be described and projection of need and the funding necessary to meet the need shall be included.

25.2(5) A regional service system may provide funding for other appropriate services or other support. In considering whether to provide such funding, a region may consider the following criteria:

a. Applying a person-centered planning process to identify the need for the services or other support.

b. The efficacy of the services or other support is recognized as an evidence-based practice, is deemed to be an emerging and promising practice, or providing the services is part of a demonstration and will supply evidence as to the effectiveness of the services.

c. A determination that the services or other support provides an effective alternative to existing services that have been shown by the evidence base to be ineffective, to not yield the desired outcome, or to not support the principles outlined in *Olmstead v. L.C.*, 527 U.S. 581.

[ARC 1096C, IAB 10/16/13, effective 11/20/13]

441—25.3(331) Access standards. The region shall include:

25.3(1) A sufficient provider network which shall include:

a. A community mental health center or federally qualified health center that provides psychiatric and outpatient mental health services in the region.

b. A hospital with an inpatient psychiatric unit or state mental health institute located in or within reasonably close proximity that has the capacity to provide inpatient services to the applicant.

25.3(2) Crisis services shall be available 24 hours per day, seven days per week, 365 days per year for mental health and disability-related emergencies.

25.3(3) The region shall provide the following treatment services:

a. Outpatient.

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

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

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

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

b. Inpatient.

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

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

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

25.3(4) A region shall provide the following basic crisis response:

a. Twenty-four-hour access to crisis response, 24 hours per day, seven days per week, 365 days per year.

b. Crisis evaluation within 24 hours.

25.3(5) Support for community living. The first appointment shall occur within four weeks of the individual's request of support for community living.

25.3(6) Support for employment. The initial referral shall take place within 60 days of the individual's request of support for employment.

25.3(7) Recovery services. An individual receiving recovery services shall not have to travel more than 30 miles if residing in an urban area or 45 miles if residing in a rural area to receive services.

25.3(8) Service coordination:

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

b. An individual shall receive service coordination within 10 days of the initial request for such service or being discharged from an inpatient facility.

25.3(9) The following limitations apply to home and vehicle modification for an individual receiving mental health and disability services:

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

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

[ARC 1096C, IAB 10/16/13, effective 11/20/13]

441—25.4(331) Practices. A region shall ensure that access is available to providers of core services that demonstrate the following competencies:

25.4(1) Regions shall have service providers that are trained to provide effective services to individuals with two or more of the following co-occurring conditions:

- a. Mental illness.
- b. Intellectual disability.
- c. Developmental disability.
- d. Brain injury.
- e. Substance use disorder.

Training for serving individuals with co-occurring conditions provided by the region shall be training identified by the Substance Abuse and Mental Health Services Administration, the Dartmouth Psychiatric Research Center or other generally recognized professional organization specified in the regional service system management plan.

25.4(2) Regions shall have service providers that are trained to provide effective trauma-informed care. Trauma-informed care training provided by the region shall be recognized by the National Center for Trauma-Informed Care or other generally recognized professional organization specified in the regional service system management plan.

25.4(3) Regions must have evidence-based practices that the region has independently verified as meeting established fidelity to evidence-based service models including, but not limited to, assertive community treatment or strengths-based case management; integrated treatment of co-occurring substance abuse and mental health disorders; supported employment; family psychoeducation; illness management and recovery; and permanent supportive housing.

[ARC 1096C, IAB 10/16/13, effective 11/20/13]

These rules are intended to implement Iowa Code chapter 331 and 2012 Iowa Acts, chapter 1120, section 15.

441—25.5 to 25.10 Reserved.

DIVISION II
REGIONAL SERVICE SYSTEM

PREAMBLE

These rules define the standards for a regional service system. The mental health and disability services provided by counties operating as a region shall be delivered in accordance with a regional service system management plan approved by the region's governing board and implemented by the regional administrator (Iowa Code section 331.393). Iowa counties are encouraged to enter into a regional system when the regional approach is likely to increase the availability of services to residents of the state who need the services. It is the intent of the Iowa general assembly that the adult residents of this state should have access to needed mental health and disability services regardless of the location of their residence.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

441—25.11(331) Definitions.

“*Access point*” means a provider, public or private institution, advocacy organization, legal representative, or educational institution with staff trained to complete applications and guide individuals with a disability to needed services.

“Applicant” means an individual who applies to receive services and supports from the service system.

“Assessment and evaluation” means the same as defined in rule 441—25.1(331).

“Assistive technology account” means funds in contracts, savings, trust or other financial accounts, financial instruments, or other arrangements with a definite cash value that are set aside and designated for the purchase, lease, or acquisition of assistive technology, assistive technology services, or assistive technology devices. Assistive technology accounts must be held separately from other accounts. Funds must be used to purchase, lease, or otherwise acquire assistive technology services or devices for a working individual with a disability. Any withdrawal from an assistive technology account other than for the designated purpose becomes a countable resource.

“Authorized representative” means a person designated by the individual or by Iowa law to act on the individual’s behalf in specified affairs to the extent prescribed by law.

“Chief executive officer” means the person chosen and supervised by the governing board who serves as the single point of accountability for the mental health and disability services region and whose responsibilities include, but are not limited to, planning, budgeting, monitoring county and regional expenditures, and ensuring the delivery of quality services that achieve expected outcomes for the individuals served.

“Choice” means the individual or authorized representative chooses the services, supports, and goods needed to best meet the individual’s goals and accepts the responsibility and consequences of those choices.

“Clear lines of accountability” means the structure of the governing board’s organization makes it evident that the ultimate responsibility for the administration of the non-Medicaid-funded mental health and disability services lies with the governing board and that the governing board directly and solely supervises the organization’s chief executive officer.

“Community” means an integrated setting of an individual’s choice.

“Conflict-free case management” means there is no real or seeming incompatibility between the case manager’s other interests and the case manager’s duties to the individual served and includes case management separate from direct service provision; eligibility determination for services; establishment of funding levels for the individual’s services; and requirements that prohibit the case manager from performing evaluations, assessments, and plans of care if the case manager is related by blood or marriage to the individual or any of the individual’s paid caregivers or persons financially responsible for the individual or empowered to make financial or health-related decisions on behalf of the individual.

“Coordinator of disability services” means the same as defined in Iowa Code section 331.390(3) “b.”

“Countable resource” means real or personal property that has a cash value that is available to the owner upon disposition and is capable of being liquidated.

“Countable value” means the equity value of a resource, which is the current fair market value minus any legal debt on the item.

“County of residence” means the same as defined in Iowa Code section 331.394.

“Department” means the department of human services.

“Director” means the director of human services.

“Disability services” means the same as defined in Iowa Code section 225C.2.

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

“Empowerment” means that the service system ensures the rights, dignity, and ability of individuals and their families to exercise choices, take risks, provide input, and accept responsibility.

“Exempt resource” means a resource that is disregarded in the determination of eligibility for public funding assistance and in the calculation of client participation amounts.

“Homeless person” means the same as defined in Iowa Code section 48A.2.

“Household” means, for an individual who is 18 years of age or over, the individual, the individual’s spouse or domestic partner, and any children, stepchildren, or wards under the age of 18 who reside with the individual. For an individual under the age of 18, “household” means the individual, the individual’s parents (or parent and domestic partner), stepparents or guardians, and any children, stepchildren, or

wards under the age of 18 of the individual's parents (or parent and domestic partner), stepparents, or guardians who reside with the individual.

"Income" means all gross income received by the individual's household, including but not limited to wages, income from self-employment, retirement benefits, disability benefits, dividends, annuities, public assistance, unemployment compensation, alimony, child support, investment income, rental income, and income from trust funds.

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

"Individualized services" means services and supports that are tailored to meet the personalized needs of the individual.

"Liquid assets" means assets that can be converted to cash in 20 days. Liquid assets include but are not limited to cash on hand, checking accounts, savings accounts, stocks, bonds, cash value of life insurance, individual retirement accounts, certificates of deposit, and other investments.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors: achieving high-quality outcomes for participants, coordinating access, and containing costs.

"Managed system" means a system that integrates planning, administration, financing, and service delivery. The system consists of the financing or governing organization, the entity responsible for care management, and the network of service providers.

"Management organization" means an organization contracted to manage part or all of the service system for a region.

"Medical savings account" means an account that is exempt from federal income taxation pursuant to Section 220 of the U.S. Internal Revenue Code (26 U.S.C. §220) as supported by documentation provided by the bank or other financial institution. Any withdrawal from a medical savings account other than for the designated purpose becomes a countable resource.

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

"Non-liquid assets" means assets that cannot be converted to cash in 20 days. Non-liquid assets include, but are not limited to, real estate, motor vehicles, motor vessels, livestock, tools, machinery, and personal property.

"Population" means the same as defined in Iowa Code section 331.388.

"Provider" means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance, is accredited under 441—Chapter 24, holds a professional license to provide the service, is accredited by a national insurance panel, or holds other national accreditation or certification.

"Regional administrator" or *"regional administrative entity"* means the administrative office or organization formed by agreement of the counties participating in a mental health and disability services region to function on behalf of those counties.

"Regional services fund" means the mental health and disability regional services fund created in Iowa Code section 225C.7A.

"Regional service system management plan" means the regional service system plan developed pursuant to Iowa Code section 331.393 for the funding and administration of non-Medicaid-funded mental health and disability services and includes an annual service and budget plan, a policies and procedures manual, and an annual report and how the region will coordinate with the department in the provision of mental health and disability services funded under the medical assistance program.

"Resources" means all liquid and non-liquid assets that are owned in part or in whole by the individual household, that could be converted to cash to use for support and maintenance, and that the individual household is not legally restricted from using for support and maintenance.

"Retirement account" means any retirement or pension fund or account listed in Iowa Code section 627.6(8)"f."

"Retirement account in the accumulation stage" means a retirement account into which a deposit was made in the previous tax year. Any withdrawal from a retirement account becomes a countable resource.

“Service system” refers to the mental health and disability services and supports administered by the regional administrative entity and paid from the regional services fund.

“State case status” means the standing of an individual who has no county of residence.

“State commission” means the same as defined in Iowa Code section 225C.5.

“System of care” means the coordination of a system of services and supports to individuals and their families that ensures they optimally live, work, and recreate in integrated communities of their choice.

“System principles” means practices that include individual choice, community and empowerment.
[ARC 1173C, IAB 11/13/13, effective 1/1/14]

441—25.12(331) Regional governance structure. The counties comprising a mental health and disability services region shall enter into an agreement to form a regional administrator under the control of a governing board to function on behalf of those counties as defined in Iowa Code chapter 28E and sections 331.388, 331.390 and 331.392 and 2013 Iowa Acts, House File 648, section 14.

25.12(1) Governing board. The governing board shall comply with the following requirements:

a. The governing board shall comply with the membership requirements as outlined in Iowa Code section 331.390 and follow the requirements in Iowa Code chapter 69 and other applicable laws relating to boards and commissions.

b. A regional advisory committee shall be created and shall designate members to the governing board as defined in Iowa Code section 331.390(2).

c. The governing board shall appoint and evaluate the performance of the chief executive officer of the regional administrative entity who will serve as the single point of accountability for the region.

25.12(2) Regional administrator. The formation of the regional administrator shall be as defined in Iowa Code sections 331.388 and 331.390.

a. The regional administrative entity is under the control of the governing board.

b. The regional administrative entity shall enter into and manage performance-based contracts in accordance with Iowa Code section 225C.4(1) “u.”

c. The regional administrative entity structure shall have clear lines of accountability.

d. The regional administrative entity functions as a lead agency utilizing shared county or regional staff or other means of limiting administrative costs.

e. The regional administrative entity staff shall include one or more coordinators of disability services.

25.12(3) Regional service system management. The region may either directly implement a system of service management and contract with service providers, or contract with a private entity to manage the regional service system, provided all requirements of Iowa Code section 331.393 are met by the private entity.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

441—25.13(331) Regional finances.

25.13(1) Funding. Non-Medicaid mental health and disability services funding is under the control of the governing board and shall:

a. Be maintained to limit administrative burden and provide public transparency regarding financial processes.

b. Be maintained in one of three ways:

(1) In a combined account.

(2) In separate county accounts that are under the control of the governing board.

(3) In other arrangements authorized by law.

25.13(2) Accounting system and financial reporting. The accounting system and financial reporting to the department shall conform to Iowa Code section 331.391 and include all non-Medicaid mental health and disability expenditures. Information shall be separated and identified in a uniform chart of accounts, including but not limited to the following: expenses for administration; purchase of services; and enterprise costs for which the region is a service provider or is directly billing and collecting payments.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

441—25.14(331) Regional governance agreement. The expectations for regional governance agreements entered into by the counties comprising a mental health and disability services region are defined in Iowa Code sections 28E.1, 331.388, 331.390 and 331.392.

25.14(1) Organizational provisions. The organizational provisions of the regional governance agreement shall include the following:

- a. A statement of purpose, goals, and objective of entering into the agreement.
- b. Identification of the governing board membership and the terms, methods of appointment, and voting procedures, including whether or not voting will be weighted.
- c. The identification of the process for selecting the executive staff, including but not limited to the chief executive officer of the regional administrative entity.
- d. Identification of the counties participating in the agreement.
- e. The time period of the agreement and terms for termination or renewal of the agreement.
- f. Provisions for joining a region. Additional counties may join the region. The agreement shall not prohibit a county from being assigned by the department to a region according to Iowa Code section 331.389(4) "c."
- g. Methods for dispute resolution and mediation.
- h. Methods for termination of a county's participation in the region.
- i. Provision for formation and assigned responsibilities for one or more advisory committees consisting of:
 - (1) Individuals who utilize services or the actively involved relatives of such individuals.
 - (2) Service providers.
 - (3) Governing board members.
 - (4) Other interests identified in the agreement.

25.14(2) Administrative provisions. The administrative provisions of the regional governance agreement shall include all of the following:

- a. Identification of whether the region will either directly implement a system of service management or contract with a private entity to manage the regional service system as defined in Iowa Code section 331.393(7).
- b. Responsibility of the governing board in appointing and evaluating the performance of the chief executive officer of the regional administrative entity.
- c. A general list of the functions and responsibilities of the regional administrative entity's chief executive officer and other staff including but not limited to coordinators of disability services.
- d. Specification of the functions to be carried out by each party to the agreement and by any subcontractor of a party to the agreement.

25.14(3) Financial provisions. The financial provisions of the regional governance agreement shall include all of the following:

- a. Methods for pooling, managing and expending funds under control of the regional administrative entity. If the agreement does not provide for pooling of the participating county moneys in a single fund, the agreement shall specify how the participating county moneys will be subject to the control of the regional administrative entity.
- b. Methods for allocating administrative funding and resources.
- c. Methods for contributing initial funds to the region.
- d. Methods for acquiring or disposing of real property.
- e. The process for how to use savings achieved for reinvestment.
- f. A process for performance of an annual independent audit of the regional administrator.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

441—25.15(331) Eligibility, diagnosis, and functional assessment criteria.

25.15(1) Eligibility for mental health services. An individual must comply with all of the following requirements to be eligible for mental health services under the regional service system:

- a. The individual complies with the financial eligibility requirements in rule 441—25.16(331).
- b. The individual is at least 18 years of age.

c. The individual is a resident of this state.

d. The individual has had at any time during the preceding 12-month period a mental health, behavioral, or emotional disorder or, in the opinion of a mental health professional, may now have such a diagnosable disorder. The diagnosis shall be made in accordance with the criteria provided in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and shall not include the manual's "V" codes identifying conditions other than a disease or injury. The diagnosis shall also not include substance-related disorders, dementia, antisocial personality, or developmental disabilities, unless co-occurring with another diagnosable mental illness.

e. The results of a standardized functional assessment support the need for mental health services of the type and frequency identified in the individual's case plan. The standardized functional assessment methodology shall be designated for mental health services by the director of human services in consultation with the state commission. A functional assessment must be completed within 90 days of application for services.

25.15(2) Other conditions of eligibility for mental health services.

a. An individual who is 17 years of age, is a resident of this state, and is receiving publicly funded children's services may be considered eligible for services through the regional service system during the three-month period preceding the individual's eighteenth birthday in order to provide a smooth transition from children's to adult services.

b. An individual less than 18 years of age and a resident of the state may be considered eligible for those mental health services made available to all or a portion of the residents of the region of the same age and eligibility class under the county management plan of one or more counties of the region applicable prior to formation of the region. Eligibility for services under this paragraph is limited to availability of regional service system funds without limiting or reducing core services, and if part of the approved regional service system management plan.

25.15(3) Eligibility for intellectual disability services. An individual must comply with all of the following requirements to be eligible for intellectual disability services under the regional service system:

- a. The individual complies with the financial eligibility requirements in rule 441—25.16(331).
- b. The individual is at least 18 years of age.
- c. The individual is a resident of this state.
- d. The individual has a diagnosis of intellectual disability as defined by Iowa Code section 4.1(9A).
- e. The results of a standardized functional assessment support the need for intellectual disability services of the type and frequency identified in the individual's case plan. The standardized functional assessment methodology shall be designated for intellectual services by the director of human services in consultation with the state commission. A functional assessment must be completed within 90 days of application for services.

25.15(4) Other conditions of eligibility for intellectual disability services.

a. An individual who is 17 years of age, is a resident of this state, and is receiving publicly funded children's services may be considered eligible for services through the regional service system during the three-month period preceding the individual's eighteenth birthday in order to provide a smooth transition from children's to adult services.

b. An individual less than 18 years of age and a resident of the state may be considered eligible for those intellectual disability services made available to all or a portion of the residents of the region of the same age and eligibility class under the county management plan of one or more counties of the region applicable prior to formation of the region. Eligibility for services under this paragraph is limited to availability of regional service system funds without limiting or reducing core services, and if part of the approved regional service system management plan.

25.15(5) Eligibility for brain injury services. An individual must comply with all of the following requirements to be eligible for brain injury services under the regional service system, if such services were provided to the same class of individuals by a county in the region prior to regional formation and if funds are available to continue such services without limiting or reducing core services.

- a. The individual complies with the financial eligibility requirements in rule 441—25.16(331).
- b. The individual is at least 18 years of age.

- c. The individual is a resident of this state.
- d. The individual has a diagnosis of brain injury as defined in rule 441—83.81(249A).
- e. The results of a standardized functional assessment support the need for brain injury services of the type and frequency identified in the individual's case plan. The standardized functional assessment methodology used is the methodology approved for brain injury services by the director of human services in consultation with the state commission. A functional assessment must be completed within 90 days of application for services.

25.15(6) Other conditions of eligibility for brain injury services. An individual who is 17 years of age, is a resident of this state, and is receiving publicly funded children's services may be considered eligible for services through the regional service system during the three-month period preceding the individual's eighteenth birthday in order to provide a smooth transition from children's to adult services.

25.15(7) Eligibility for developmental disability services.

a. Until funding is designated for other service populations, eligibility for the core service domains shall be as identified in Iowa Code section 331.397(1) "b."

b. If a county in a region was providing services to an eligibility class of individuals with a developmental disability other than intellectual disability prior to formation of the region, the class of individuals shall remain eligible for the services provided when the region is formed, providing that funds are available to continue such services without limiting or reducing core services. The individual must also meet the requirements in paragraphs 25.15(7) "c," "d," "e" and "f."

c. The individual complies with the financial eligibility requirements in rule 441—25.16(331).

d. The individual is at least 18 years of age.

e. The individual is a resident of this state.

f. The individual has a diagnosis of a developmental disability other than an intellectual disability as defined in rule 441—24.1(225C).

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

441—25.16(331) Financial eligibility requirements. The regional service system management plan shall identify basic financial eligibility standards for disability services as defined in Iowa Code section 331.395.

25.16(1) Income requirements. Income requirements shall be as defined in Iowa Code section 331.395(1).

25.16(2) Resource requirements. An individual must have resources that are equal to or less than \$2,000 in countable value for a single-person household or \$3,000 in countable value for a multiperson household or follow the most recent federal supplemental security income guidelines.

a. The countable value of all countable resources, both liquid and non-liquid, shall be included in the eligibility determination except as exempted in this subrule.

b. A transfer of property or other assets within five years of the time of application with the result of, or intent to, qualify for assistance may result in denial or discontinuation of funding.

c. The following resources shall be exempt:

(1) The homestead, including equity in a family home or farm that is used as the individual household's principal place of residence. The homestead shall include all land that is contiguous to the home and the buildings located on the land.

(2) One automobile used for transportation.

(3) Tools of an actively pursued trade.

(4) General household furnishings and personal items.

(5) Burial account or trust limited in value as to that allowed in the medical assistance program.

(6) Cash surrender value of life insurance with a face value of less than \$1,500 on any one person.

(7) Any resource determined excludable by the Social Security Administration as a result of an approved Social Security Administration work incentive.

d. If an individual does not qualify for federally funded or state-funded services or other support but meets all income, resource, and functional eligibility requirements of this chapter, the following types of resources shall additionally be considered exempt from consideration in eligibility determination:

- (1) A retirement account that is in the accumulation stage.
- (2) A medical savings account.
- (3) An assistive technology account.
- (4) A burial account or trust limited in value as to that allowed in the medical assistance program.
 - e. An individual who is eligible for federally funded services and other support must apply for and accept such funding and support.

25.16(3) Copayment standards. A regional administrative entity must comply with copayment standards as defined in Iowa Code section 331.395.

a. Copayments are allowed for individuals with income above 150 percent of the federal poverty level.

b. Copayments in this rule are related to core services as defined in Iowa Code section 331.397.

25.16(4) Copayment standards required by any federal, state, regional, or municipal program. Any copayments or other client participation required by any federal, state, regional or municipal program in which the individual participates shall be required by the regional administrative entity. Such copayments include, but are not limited to:

a. Client participation for maintenance in a residential care facility through the state supplementary assistance program.

b. The financial liability for institutional services paid by counties as provided in Iowa Code section 230.15.

c. The financial liability for attorney fees related to commitment as provided by Iowa Code section 229.8.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

441—25.17(331) Exempted counties. If a county has been exempted pursuant to Iowa Code section 331.389 from the requirement to enter into a regional service system, the county and the county's board of supervisors shall fulfill all the requirements of this chapter for a regional service system management plan.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

441—25.18(331) Annual service and budget plan. The annual service and budget plan shall describe the services to be provided and the cost of those services for the ensuing year.

25.18(1) The annual service and budget plan is due on April 1 prior to the July 1 implementation of the annual plan and shall be approved by the region's governing board prior to submittal to the department. The initial plan is due on April 1, 2014.

25.18(2) The annual service and budget plan shall include but not be limited to:

a. The locations of the local access points for services. This shall include the name of the access points including the physical locations and contact information.

b. Targeted case management. The targeted case management agencies for the region, including the physical location and contact information for those agencies, shall be included.

c. Crisis planning. The plan for ensuring effective crisis prevention, response and resolution, including contact information for the agencies responsible, shall be included.

d. Scope of services. A description of the scope of services to be provided, a projection of need for the service, and the funding necessary to meet the need shall be included.

(1) The scope shall include the regional core services as defined in rule 441—25.1(331).

(2) The scope shall also include services in addition to the required core services.

e. Budget and financing provisions for the next year. The provisions shall address how county, regional, state and other funding sources will be used to meet the service needs within the region.

f. Financial forecasting measures. The plan shall describe the financial forecasting measures used in the identification of service need and funding necessary for services.

g. The provider reimbursement provisions. The plan shall describe the types of reimbursement methods that will be used, including fee for service, compensating providers for a "system of care" approach, and use of nontraditional providers. A region also shall provide funding approaches that

identify and incorporate all services and sources of funding used by the individuals receiving services, including the medical assistance program.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

441—25.19(331) Annual service and budget plan approval. The annual service and budget plan shall be submitted by April 1, 2014, as a part of the region's management plan for the fiscal year beginning July 1, 2014. The director shall review all regional annual service and budget plans submitted by the dates specified. If the director finds the regional annual service and budget plan in compliance with these rules and state and federal laws, the director may approve the plan. A plan approved by the director for the fiscal year beginning July 1, 2014, shall remain in effect until June 30, 2015, subject to amendment.

25.19(1) Criteria for acceptance. The director shall determine a plan is acceptable when it contains all the required information, meets the criteria described in this division, and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the plan contains all the required information and meets criteria described in this division.

25.19(2) Notification. Except as specified in subrule 25.19(3), the director shall notify the region in writing of the decision on the plan by June 1, 2014. The decision shall specify that either:

a. The annual service and budget plan is approved as it was submitted, either with or without supplemental information already requested and received.

b. The annual service and budget plan will not be approved until revisions are made. The letter will specify the nature of the revisions requested and the time frames for their submission.

25.19(3) Review of late submittals. The director may review plans not submitted by April 1, 2014, after all plans submitted by that date have been reviewed. The director will proceed with the late submittals in a timely manner.

25.19(4) Amendments. An amendment to the annual service and budget plan shall be approved by the regional governance board and submitted to the department at least 45 days before the date of implementation. Before implementation of any amendment to the plan, the director must approve the amendment.

a. *Criteria for acceptance.* The director shall determine an amendment is acceptable when it contains all the required information and meets the criteria described in this division for the applicable part of the annual service and budget plan and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the amendment contains all the required information and meets criteria described in this division.

b. *Notification.* The director shall notify the region, in writing, of the decision on the amendment within 45 days of receipt of the amendment. The decision shall specify either that:

(1) The amendment is approved as it was submitted, either with or without supplemental information already requested and received.

(2) The amendment is not approved. The notification will include why the amendment is not approved.

25.19(5) Reconsideration. Regions dissatisfied with the director's decision on a plan or an amendment may file a letter with the director requesting reconsideration. The letter requesting reconsideration must be received within 30 working days of the date of the notice of decision and shall include a request for the director to review the decision and the reasons for dissatisfaction. Within 30 working days of the receipt of the letter requesting reconsideration, the director will review both the reconsideration request and evidence provided. The director shall issue a final decision in writing.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

441—25.20(331) Annual report. The annual report shall describe the services provided, the cost of those services, the number of individuals served, and the outcomes achieved for the previous fiscal year. The annual report is due on December 1 following a completed fiscal year of implementing the annual service and budget plan. The initial report is due on December 1, 2015. The annual report shall include but not be limited to:

1. Services actually provided.
2. Actual numbers of individuals served.

3. Moneys expended.

4. Outcomes achieved.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

441—25.21(331) Policies and procedures manual for the regional service system. The policies and procedures manual shall describe the policies and process developed to direct the management and administration of the regional service system. The initial manual is due on April 1, 2014, and will remain in effect subject to amendment.

25.21(1) Content. The manual shall include but not be limited to:

a. Financing and delivery of services and supports. A description of the region's process used to develop and ensure the ongoing financial accountability and delivery of services outlined in the region's annual service and budget plan shall be included.

b. Enrollment. The application and enrollment process that is readily accessible to applicants and their families or authorized representatives shall be included. This procedure shall identify regional access points and where applicants can apply for services and how and when the applications will reach the regional administrative entity's designated staff for processing.

c. Eligibility. The process utilized to determine eligibility shall be included in the manual and shall include but not be limited to:

(1) The criteria used to authorize or deny funding for services and supports. This shall include guidelines for who is eligible to receive services and supports by eligibility group, and type of service or support.

(2) Financial eligibility and copayment criteria, which shall meet the requirements of rule 441—25.16(331).

(3) The time frames for conducting eligibility determination that provide for timely access to services, including necessary and immediate services not to exceed ten days.

(4) The process for development of a written notice of decision. The time frame for sending a written notice of decision to the individual and guardian (if applicable) and the service providers identified in the notice shall be included. The notice of decision shall:

1. Explain the action taken on the application and the reasons for that action.

2. State what services are approved and name the service providers.

3. Outline the applicant's right to appeal.

4. Describe the appeal process.

d. Utilization of and access to services. The process for managing utilization of and access to services and other assistance shall be included. The process shall describe how coordination between the services included in the annual service and budget plan and the disability services administered by the state and others will be managed.

e. Quality management and improvement process. The quality management and improvement process shall at a minimum meet the requirements of the department's outcome and performance measures process as outlined in Iowa Code sections 225C.4(1)"j" and 225C.6A.

f. Risk management and fiscal viability. If the region contracts with a private entity, the manual must include risk management provisions and fiscal viability of the annual services and budget plan.

g. Targeted case management.

(1) Designation of targeted case management providers. The process used to identify and designate targeted case management providers for the region shall be described. This process shall include the requirement for the implementation of evidence-based practice models of case management within the region. Requirements of this practice include:

1. Providing the individual receiving the case management with a choice of providers.

2. Allowing a service provider to be the case manager but prohibiting the provider from referring that individual only to services administered by the provider.

3. Provisions to ensure compliance with, but not exceed, federal requirements for conflict-free case management.

(2) Qualifications of targeted case managers. A region's manual shall require that any targeted case managers or other persons providing service coordination while working for the designated provider meet the qualifications of qualified case managers and supervisors as defined in rule 441—24.1(225C).

(3) Targeted case management and service coordination services. Targeted case management and service coordination services utilized in a regional service system shall include but are not limited to the following as defined in Iowa Code section 331.393(4) "g":

1. Performance and outcome measures relating to the health, safety, work performance, and community residency of the individuals receiving the services.

2. Standards for delivery of the services, including but not limited to the social history, assessment, service planning, incident reporting, crisis planning, coordination, and monitoring for individuals receiving the services.

3. Methodologies for complying with the requirements of paragraph 25.21(1) "g." Methodologies may include the use of electronic record keeping and remote or Internet-based training.

h. System of care approach plan.

i. Decentralized service provision. Measures to provide services in a dispersed manner that meet the minimum access standards of core services and that utilize the strengths and assets of the service providers within and available to the region shall be included.

j. Provider network formation and management. The manual shall require that providers that are subject to license, accreditation or approval meet established standards. The manual shall detail the approval process, including criteria, developed to select providers that are not currently subject to license, accreditation or approval standards. The manual shall identify the process the regional administrative entity will use to contract with providers and manage the provider network to ensure it meets the needs of the individuals in the region. The provider network will include but is not limited to the following:

(1) A contract with a community mental health center that provides services in the individual's region or with a federally qualified health center that provides psychiatric and outpatient mental health services in the individual's region.

(2) Contracts with licensed and accredited providers to provide each service in the required core service domains.

(3) Adequate numbers of licensed and accredited providers to ensure availability of core services so that there is no waiting list for services due to lack of available providers.

(4) A contract with an inpatient psychiatric hospital unit or state mental health institute within reasonably close proximity.

k. Service provider payment provisions. A policy for payment of service providers which describes the method and process of paying for services and supports delivered to the region shall be included.

l. Grievance processes. The manual shall develop and implement processes for appealing the decisions of the regional administrative entity in the following circumstances:

(1) Nonexpedited appeal process. The appeal process shall be based on objective criteria, specify time frames, provide for notification in accessible formats of the decisions to all parties, and provide some assistance to individuals with disabilities using the process. Responsibility for the final step in the appeal process shall be a state administrative law judge in nonexpedited appeals.

(2) Expedited appeal process. This appeal process is to be used when the decision of the regional administrative entity concerning an individual varies from the type and amount of service identified to be necessary for the individual in a clinical determination made by a mental health professional and the mental health professional believes that the failure to provide the type and amount of service identified could cause an immediate danger to an individual's health or safety. This appeal process shall be performed by a mental health professional who is either the administrator of the division of mental health and disability services of the department of human services or the administrator's designee.

1. The appeal shall be filed within five days of receipt of the notice of decision by the regional administrative entity.

2. The expedited review by the division administrator or designee shall take place within two days of receipt of the request, unless more information is needed. There is an extension of two days from the time the new information is received.

3. The administrator shall issue an order, including a brief statement of findings of fact, conclusions of law, and policy reasons for the order, to justify the decision made concerning the expedited review. If the decision concurs with the contention that there is an immediate danger to the individual's health or safety, the order shall identify the type and amount of service which shall be provided for the individual. The administrator or designee shall give such notice as is practicable to individuals who are required to comply with the order. The order is effective when issued.

4. The decision of the administrator or designee shall be considered a final agency action and is subject to judicial review in accordance with Iowa Code section 17A.19.

m. Implementation of interagency and multisystem collaboration and care coordination. The policies and procedures manual shall describe how the region will collaborate with other funders, other regional service systems, service providers, case management, individuals and their families or authorized representatives, and advocates to ensure that authorized services and supports are responsive to individuals' needs, consistent with system principles, and cost-efficient. The manual shall describe the process for collaboration with the court to ensure alternatives to commitment and to coordinate funding for services to individuals who are under court-ordered commitment services pursuant to Iowa Code chapter 229.

n. Addressing multioccurring needs. The policies and procedures manual shall include criteria and measures to be used to address the needs of individuals who have two or more co-occurring mental health, intellectual or other developmental disability, brain injury, or substance-related disorders. The manual shall also include criteria and measures to be used to address the needs of individuals with specialized needs.

o. Service management and functional assessment. The policies and procedures manual shall describe how functional assessments and service management will be incorporated in accordance with applicable requirements.

p. Service system management. The policies and procedures manual shall identify whether the region will be directly implementing a system of service management or will contract with a private entity to manage the regional service system. If the region contracts with a private entity, the region will ensure that all requirements of Iowa Code section 331.393 and these administrative rules are fulfilled.

q. Assistance to other than core service populations. The policies and procedures manual shall specify the services populations, other than core service populations, to whom the region will provide assistance if funding is available.

r. Waiting list criteria. The policies and procedures manual shall specify whether the region will use waiting lists. If the policy and procedures manual specifies the use of waiting lists for funding services and supports, it shall specify criteria for the use and review of each waiting list, including the criteria to be used to determine how and when an individual will be placed on a waiting list. The criteria will include how core services and additional core services will be impacted the least by budgetary limitations. The manual shall specify how waiting list data will be used in future planning.

25.21(2) Approval. The manual shall be submitted by April 1, 2014, as a part of the region's management plan for the fiscal year beginning July 1, 2014. The manual shall be approved by the region's governing board and is subject to approval by the director of human services. The director shall review all regional annual service and budget plans submitted by the dates specified. If the director finds the manual in compliance with these rules and state and federal laws, the director may approve the plan. A plan approved by the director for the fiscal year beginning July 1, 2014, shall remain in effect subject to amendment.

a. *Criteria for acceptance.* The director shall determine a plan is acceptable when it contains all the required information, meets the criteria described in this division, and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the plan contains all the required information and meets criteria described in this division.

b. *Notification.*

(1) Except as specified in subparagraph 25.21(2) "b" (2), the director shall notify the region in writing of the decision on the plan by June 1, 2014. The decision shall specify that either:

1. The policies and procedures manual is approved as it was submitted, either with or without supplemental information already requested and received.

2. The policies and procedures manual will not be approved until revisions are made. The letter will specify the nature of the revisions requested and the time frames for their submission.

(2) Review of late submittals. The director may review manuals not submitted by April 1, 2014, after all manuals submitted by that date have been reviewed. The director will proceed with the late submittals in a timely manner.

25.21(3) Amendments. An amendment to the policy and procedures manual shall be approved by the regional governance board and submitted to the department at least 45 days before the date of implementation. Before implementation of any amendment to the manual, the director must approve the amendment.

a. *Criteria for acceptance.* The director, in consultation with the state commission, shall determine an amendment is acceptable when it contains all the required information and meets the criteria described in this division for the applicable part of the policy and procedures manual and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the amendment contains all the required information and meets criteria described in this division.

b. *Notification.* The director shall notify the region, in writing, of the decision on the amendment within 45 days of receipt of the amendment. The decision shall specify either that:

(1) The amendment is approved as it was submitted, either with or without supplemental information already requested and received.

(2) The amendment is not approved. The notification will explain why the amendment is not approved.

25.21(4) Reconsideration. Regions dissatisfied with the director's decision on a manual or an amendment may file a letter with the director requesting reconsideration. The letter of reconsideration must be received within 30 working days of the date of the notice of decision and shall include a request for the director to review the decision and the reasons for dissatisfaction. Within 30 working days of the receipt of the letter requesting reconsideration, the director will review both the reconsideration request and evidence provided. The director shall issue a final decision in writing.

These rules are intended to implement Iowa Code sections 331.388 to 331.398.
[ARC 1173C, IAB 11/13/13, effective 1/1/14]

441—25.22 to 25.40 Reserved.

DIVISION III MINIMUM DATA SET

441—25.41(331) Minimum data set. Each county shall maintain data on all clients served through the MH/DD services fund.

25.41(1) Submission of data. Each county shall submit to DHS a copy of the data regarding each individual that the county serves through the central point of coordination process.

a. DHS state payment program, state supplementary assistance program, mental health institutes, state resource centers, Medicaid program, and Medicaid managed care contractors shall provide the equivalent data in a compatible format on the same schedule as the required submission from the counties.

b. DHS shall maintain the data in the data analysis unit for research and analysis purposes only. Only summary data shall be reported to policymakers or the public.

25.41(2) Data required. The data to be submitted are as follows:

a. Basic client information including a unique identifier, name, address, county of residence and county of legal settlement.

b. The state I.D. number for state payment cases.

c. Demographic information including date of birth, sex, ethnicity, marital status, education, residential living arrangement, current employment status, monthly income, income sources, type of insurance, insurance carrier, veterans' status, guardianship status, legal status in the system, source of referral, diagnosis in the current version of the DSM, diagnosis in the current version of the ICD, disability group (i.e., intellectual disability, developmental disability, chronic mental illness, mental illness), central point of coordination (county number preceded by A 1), and central point of coordination (CPC) name.

d. Service information including the decision on services, date of decision, date client terminated from CPC services and reason for termination, residence, approved service, service beginning dates, service ending dates, reason for terminating each service, approved units of services, unit rate for service, expenditure data, and provider data.

e. Counties shall not be penalized in any fashion for failing to collect data elements in situations of crisis or in outreach efforts to identify or engage people in needed mental health services. For the purposes of this rule:

(1) Situations of crisis include but are not limited to voluntary and involuntary hospitalizations, legal and transportation services associated with involuntary hospitalizations, emergency outpatient services, mobile crisis team services, jail diversion services, mental health services provided in a county jail, and other services for which the county is required to pay but does not have access to the client to collect the required information.

(2) Outreach efforts to identify or engage people in needed mental health services include but are not limited to mental health advocate services; services for homeless persons, refugees, or other legal immigrants; services for state cases who do not have documentation with them and are unable to help the county locate appropriate records; consultation; education to raise public awareness; 12-step or other support groups for persons with dual disorders; and drop-in centers.

f. Although all of the data in the minimum data set are important to provide support for program analysis, a county shall be penalized for noncompliance with this rule if the county does not provide 100 percent reporting of the data elements listed in this paragraph. Beginning with the data reported for state fiscal year 2008, less than 100 percent reporting for the following items shall be viewed as noncompliance unless the data are exempted by paragraph "e":

(1) Client identifiers:

1. Lname3 (the first three letters of the client's last name).
2. Last4SSN (the last four digits of the client's social security number).
3. SEX (the client's sex).
4. BDATE (the client's birth date).

(2) CPC (central point of coordination).

(3) Payment information:

1. PYMTDATE (CoMIS payment date).
2. FUND CODE (CoMIS fund code).
3. DG (CoMIS diagnosis).
4. COACODE (CoMIS chart of accounts code).
5. BEGDATE (CoMIS service beginning date).
6. ENDDATE (CoMIS service ending date).
7. UNITS (CoMIS units of service).
8. COPD (CoMIS county paid).

(4) ValidSSN (valid social security number indicator).

(5) IsPerson (IsPerson indicator).

g. Although all of the data in the minimum data set are important to provide support for program analysis, a county shall be penalized for noncompliance with this rule if the county does not provide 90 percent reporting of the data elements listed in this paragraph beginning with the data reported for fiscal year 2008. Less than 90 percent reporting for the following items shall be viewed as noncompliance unless the data are exempted by paragraph "e":

(1) Application Date (application date).

- (2) RESCO (residence county).
 - (3) LEGCO (legal county).
 - (4) Provider ID (vendor number).
- h. The department shall analyze the data received on or before December 1 each year by December 15 or by the next business day if December 15 falls on a weekend or holiday.
- (1) When a county's data submission does not meet the specifications in paragraph "f" or "g," the department will notify the county by E-mail.
 - (2) The county shall have 30 days from the date of the E-mail notice to submit the missing data or to provide an explanation of why the data cannot be reported.
 - (3) If the county does not report the data or provide an adequate explanation within 30 days, the department shall find the county in noncompliance.
- i. The department shall post the aggregate reports received by December 1 on the department's Web site within 90 days.
- 25.41(3) Method of data collection.** A county may choose to collect this information using the county management information system (CoMIS) that was designed by the department or may collect the information through some other means. If a county chooses to use another system, the county must be capable of supplying the information in the same format as CoMIS.
- a. Except as provided in subparagraph (3), each county shall submit the following files in Microsoft Excel format (version 97 to 2000) or comma-delimited text file (CSV) format using data from the associated CoMIS table or from the county's chosen management information system:

Files to submit	Associated CoMIS Table
WarehouseClient.xls or WarehouseClient.csv	Client Data
WarehouseIncome.xls or WarehouseIncome.csv	Income Review
WarehousePayment.xls or WarehousePayment.csv	Payment
WarehouseProvider.xls or WarehouseProvider.csv	Provider
WarehouseProviderServices.xls or WarehouseProviderServices.csv	tblProviderServices
WarehouseService.xls or WarehouseService.csv	Service Authorizations

- (1) Paragraphs "b" through "g" list the data required in each file and specify the structure or description for each data item to be reported.
- (2) The field names used in the report files must be exactly the same as indicated in the corresponding paragraph, including spaces, and must be entered in the first row for each sheet.
- (3) The file labeled WarehouseService.xls or WarehouseService.csv or service authorization (described in paragraph "g" of this subrule) shall be removed from this requirement on June 30, 2011, if data from this file have not been used by that date.

b. File name: WarehouseClient.xls or WarehouseClient.csv.

Sheet name: Warehouse_Client_Transfer_Query.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESKO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute

Field Name	Data Type	Field Size	Format	Description
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, then use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth
SEX	Text	1		Sex of client: M = Male F = Female
Last Update	Date	10	mm/dd/yyyy	Date of last update to client record
SID	Text	8	9999999a	State identification number of client, if applicable (format of a valid number is 7 digits plus 1 alphabetical character).
ADD1	Text	50		First address line
ADD2	Text	50		Second address line (if applicable)
CITY	Text	50		City address line
STATE	Text	2		State code
ZIP	Number	5	0 decimal places	5-digit ZIP code
ETHN	Number	1	0 decimal places	Ethnicity of client: 0 = Unknown 1 = White, not Hispanic 2 = African-American, not Hispanic 3 = American Indian or Alaskan native 4 = Asian or Pacific Islander 5 = Hispanic 6 = Other (biracial; Sudanese; etc.)
MARITAL	Number	1	0 decimal places	Marital status of client: 1 = Single, never married 2 = Married (includes common-law marriage) 3 = Divorced 4 = Separated 5 = Widowed
EDUC	Number	2	0 decimal places	Education level of the client
RARG	Number	2	0 decimal places	Residential arrangement of client: 1 = Private residence/household 2 = State MHI 3 = State resource center 4 = Community supervised living 5 = Foster care or family life home 6 = Residential care facility 7 = RCF/MR 8 = RCF/PMI 9 = Intermediate care facility 10 = ICF/MR 11 = ICF/PMI 12 = Correctional facility 13 = Homeless shelter or street 14 = Other
LARG	Number	1	0 decimal places	Living arrangement of client: 1 = Lives alone 2 = Lives with relatives 3 = Lives with persons unrelated to client
INS	Number	1	0 decimal places	Health insurance owned by client: 1 = Client pays 3 = Medicaid 4 = Medicare 5 = Private third party 6 = Not insured 7 = Medically Needy

Field Name	Data Type	Field Size	Format	Description
INSCAR	Text	50		First insurance company name, if applicable
INSCAR1	Text	50		Second insurance company name, if applicable
INSCAR2	Text	50		Third insurance company name, if applicable
VET	Text	1		Veteran status of client: Y = Yes N = No
CONSERVATOR	Number	1	0 decimal places	Conservator status of client: 1 = Self 2 = Other
GUARDIAN	Number	1	0 decimal places	Guardian status of client: 1 = Self 2 = Other
LEGSTAT	Number	1	0 decimal places	Legal status of client: 1 = Voluntary 2 = Involuntary, civil commitment 3 = Involuntary, criminal commitment
REFSO	Number	1	0 decimal places	Referral source of client: 1 = Self 2 = Family or friend 3 = Targeted case management 4 = Other case management 5 = Community corrections 6 = Social service agency other than case management 7 = Other
DSM (current version)	Text	50		DSM (current version) diagnosis code of client
ICD (current version)	Text	50		ICD (current version) diagnosis code (optional for county use; not tied to CoMIS entry)
DG	Number	2	0 decimal places	Disability group of client: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other categories
Application Date	Date	10	mm/dd/yyyy	Date of client's initial application
Outcome decision	Number	1	0 decimal places	Decision on client's application: 1 = Application accepted 2 = Application denied 3 = Decision pending
Decision date	Date	10	mm/dd/yyyy	Date decision was made on client's application
Denial reason	Text	2		Denial reason code: 00 = Not applicable 01 = Over income guidelines 1A = Over resource guidelines 02 = Does not meet county plan criteria 2A = Legal settlement in another county 2B = State case 3A = Brain injury 3B = Alzheimer's 3C = Substance abuse 3D = Other 04 = Does not meet service plan criteria 05 = Client desires to discontinue process 5A = Client fails to return requested information

Field Name	Data Type	Field Size	Format	Description
Client exit date from CPC	Date	10	mm/dd/yyyy	Date client was terminated from CPC services
Exit reason	Number	1	0 decimal places	Reason client left the CPC system: 0 = Unknown 1 = Client voluntarily withdrew 2 = Client deceased 3 = Unable to locate consumer 4 = Ineligible due to reasons other than income 5 = Ineligible, over income guidelines 6 = Client moved out of state 7 = Client no longer needs service 8 = Client has legal settlement in another county
Review Date	Date	10	mm/dd/yyyy	Date of last application review
PhoneNumber	Text	50		Phone number of client
ValidSSN	Text	3	Generated for ComIS users in the data extract only	Populate this field with YES if the client has a valid social security number. If the client does not have a valid social security number, populate this field with NO.
IsPerson	Text	3	Generated for ComIS users in the data extract only	Populate this field with YES if the client is a person. If the client entry represents a nonperson such as administrative costs, populate this field with NO.

c. File name: WarehouseIncome.xls or WarehouseIncome.csv.

Sheet name: Warehouse_Income_Transfer_Query.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESCO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, then use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth
SEX	Text	1		Sex of client: M = Male F = Female

Field Name	Data Type	Field Size	Format	Description
EMPL	Number	2	0 decimal places	Employment situation of client: 1 = Unemployed, available for work 2 = Unemployed, unavailable for work 3 = Employed full-time 4 = Employed part-time 5 = Retired 6 = Student 7 = Work activity employment 8 = Sheltered work employment 9 = Supported employment 10 = Vocational rehabilitation 11 = Seasonally employed 12 = In the armed forces 13 = Homemaker 14 = Other or not applicable 15 = Volunteer
House Hold Size	Number	2	0 decimal places	Number of people in client's household
INCSOUR	Number	2	0 decimal places	Primary income source of client: 1 = Family and friends 2 = Private relief agency 3 = Social security disability benefits 4 = Supplemental Security Income 5 = Social security benefits 6 = Pension 7 = Food assistance 8 = Veterans benefits 9 = Workers compensation 10 = General assistance 11 = Family investment program (FIP) 12 = Wages
Public Assistance Payments	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Social Security	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Social Security Disability	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
SSI	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
VA Benefits	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
R/R Pension	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Child Support	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Employment Wages	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Dividend Interest	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Other Income	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Description 1	Text	50		Description of "Other Income"
Cash on hand	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Checking	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Savings	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Stocks/Bonds	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Time Certificates	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)

Field Name	Data Type	Field Size	Format	Description
Trust Funds	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Other Resources	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Description 2	Text	50		Description of "Other Resources" (where applicable)
Other Resources 2	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Description 3	Text	50		Description of "Other Resources 2"
Date reviewed	Date	10	mm/dd/yyyy	Date income was last reviewed (where applicable)

d. File name: WarehousePayment.xls or WarehousePayment.csv. Sheet name: Warehouse_Payment_Transfer_Quer.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESCO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth
SEX	Text	1		Sex of client: M = Male F = Female
PYMTDATE	Date	10	mm/dd/yyyy	Date county approves or makes payment
VENNAME	Text	50		Vendor or provider paid
COCODE	Number	3	0 decimal places	County where service was provided
FUND CODE	Text	10		Fund code for payment
DG	Number	2	0 decimal places	Disability group code for payment: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other categories
COACODE	Number	5	0 decimal places	Chart of accounts code for payment
BEGDATE	Date	10	mm/dd/yyyy	Beginning date of payment period
ENDDATE	Date	10	mm/dd/yyyy	Ending date of payment period
UNITS	Number	4	0 decimal places	Number of service units for payment
COPD	Currency	14	2 decimal places	Amount paid by the county
RECEIVED	Currency	14	2 decimal places	Amount received for reimbursement (if applicable)

e. File name: WarehouseProvider.xls or WarehouseProvider.csv. Sheet name: Warehouse_Provider_Transfer_Que. (If the provider has more than one office location, enter information for the headquarters office.)

Field Name	Data Type	Field Size	Format	Description
Provider ID	Text	50		Provider identifier (tax ID code)
Provider Name	Text	50		Provider name
Provider Address1	Text	50		Provider address line 1
Provider Address2	Text	50		Provider address line 2 (if applicable)
City	Text	50		Provider city
State	Text	2		Provider state code
Zip	Text	10		Provider ZIP code
COCODE	Number	3	0 decimal places	Provider county code
PhoneNumber	Text	50		Provider phone number
Date of Last Update	Date	10	mm/dd/yyyy	Provider last updated date

f. File name: WarehouseProviderServices.xls or WarehouseProviderServices.csv. Sheet name: Warehouse_Provider_Services_Tra.

Field Name	Data Type	Field Size	Format	Description
Provider ID	Text	50		Provider identifier (tax ID code)
Provider Name	Text	50		Provider name
FUND CODE	Text	10		Fund code for payment
DG	Number	2	0 decimal places	Disability group code for payment: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other categories
COACODE	Number	5	0 decimal places	Chart of accounts code for service
RATE	Currency	14	2 decimal places	Payment rate

g. File name: WarehouseService.xls or WarehouseService.csv. Sheet name: Warehouse_Service_Transfer_Quer.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESCO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa 200 = Iowa nonresident 900 = Undetermined or in dispute
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, then use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth
SEX	Text	1		Sex of client: M = Male F = Female

Field Name	Data Type	Field Size	Format	Description
FUND CODE	Text	10		Fund code for service
DG	Number	2	0 decimal places	Disability group code for payment: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other category
COACODE	Number	5	0 decimal places	Chart of accounts code for service
Begin Date	Date	10	mm/dd/yyyy	Beginning date of service period
End Date	Date	10	mm/dd/yyyy	Ending date of service period
Ending Reason	Number	1	0 decimal places	Reason for terminating approval of service: 0 = NA 1 = Voluntary withdrawal 2 = Client no longer needs service 3 = Ineligible, over income guidelines 4 = Ineligible due to other than income 5 = Client moved out of state 6 = Client deceased 7 = Reauthorization
Units	Number	4	0 decimal places	Average number of service units approved monthly
Rate	Currency	14	2 decimal places	Dollar amount per service unit
Review Date	Date	10	mm/dd/yyyy	Date for next service review

This rule is intended to implement Iowa Code sections 331.438 and 331.439.
 [ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—25.42 to 25.50 Reserved.

DIVISION IV INCENTIVE AND EFFICIENCY POOL FUNDING

PREAMBLE

These rules establish requirements for counties to receive funding from the incentive and efficiency pool. To be eligible for these funds, a county must select five performance indicators, submit a proposal, collect data, report data, and show improvement over time on the selected performance indicators.

441—25.51(77GA,HF2545) Desired results areas. In order to receive funds from the incentive and efficiency pool established in 1998 Iowa Acts, House File 2545, section 8, subsection 2, each county shall collect and report performance measure data in the following areas:

25.51(1) Equity of access. Each county shall measure the extent to which services are available and used. Each county shall:

- a. Report annually the total number of consumers served, as well as an unduplicated total of the number of consumers served by disability category.
- b. Calculate and report annually the percentage of service provision by dividing the number of consumers served in a year by the county's population as defined in 1998 Iowa Acts, House File 2545, section 7.
- c. Calculate and report annually the percentage of denial of access by dividing the number of new, completed applications denied by the total number of new applications for service that year. A new, completed application shall be defined as an initial application of a consumer or any former consumer who is reapplying for service eligibility after more than 30 days of not being enrolled in the system, for which the consumer has supplied the information required on the application form.
- d. Report annually the county's eligibility guidelines, which may include, but are not limited to, the income level below which an individual or family must be in order to be eligible for county-funded

services, the maximum amount of resources which an individual or family may have in order to be eligible for county-funded services, covered populations, and service access criteria.

25.51(2) *Community-based supports.* Each county shall measure the extent to which community-based supports are available and used. Each county shall calculate and report annually:

a. The service setting percentage by dividing the unduplicated number of persons served in each of the following service settings in a fiscal year by the total unduplicated number of consumers served, both in total and by population group: mental health institutes, state hospital schools, intermediate care facilities for the mentally retarded, other living arrangements over five beds as captured by the county chart of accounts, and employment settings which include sheltered workshops, enclaves and supported employment.

b. The home-based percentage by subtracting the number of consumers currently being served in residential placements from the total unduplicated number of consumers served, and dividing the difference by the total number of consumers served. The calculation shall be made both in total and by population group.

c. The inpatient spending percentage by dividing the amount the county spent for inpatient services by the amount the county spent for outpatient services. Each county shall also divide the unduplicated number of consumers who received inpatient services during the fiscal year by the total unduplicated number of consumers who received services during that same fiscal year. Inpatient services shall be defined as any acute care for which the county is wholly or partially financially responsible.

25.51(3) *Consumer participation.* Each county shall measure the extent to which consumers participate in all aspects of the service system.

a. Each county shall report annually on the number of opportunities during the year for consumers to participate in planning activities, which may include, but are not limited to, open forums, focus groups, consumer advisory committee meetings, and planning council meetings by calculating the total number of consumers participating in these activities and dividing by the unduplicated number of consumers served and also by the total population of the county. In addition, the county shall report duplicated and unduplicated total attendance at all of these meetings. These calculations shall be made for consumers and family members separately.

b. Each county which has a planning group shall calculate and report annually the planning group percentage by dividing the number of consumers who actively serve on the planning group by the total number of people on the planning group. This calculation shall be made for consumers and family members separately. For the purposes of this subrule, a planning group is any group of individuals designated by the board of supervisors, or if no designation has been made, any group acknowledged by the central point of coordination administrator as assisting in the development of the county management plan.

c. Each county shall conduct a consumer satisfaction survey following adoption of more detailed rules for the survey.

25.51(4) *Administration.* Each county shall measure the extent to which the county services system is administered efficiently and effectively. Each county shall:

a. Calculate and report annually the administrative cost percentage by dividing the amount spent administering the county services system by the total amount spent from the services fund for the fiscal year.

b. Calculate and report annually the service responsiveness average by measuring the number of days between the date a new, completed application was submitted and the date a notice of decision of eligibility was sent to the consumer, adding all of these numbers of days, and dividing by the total number of new, completed applications for the fiscal year. A new, completed application shall be defined as an initial application of a consumer or an application of any former consumer who is reapplying for service eligibility after more than 30 days of not being enrolled in the system, for which the consumer has supplied the information required on the application form.

c. Report annually the number of appeals filed as a percent of the unduplicated total number of consumers served per year.

441—25.52(77GA,HF2545) Methodology for applying for incentive funding. Beginning with the county management plan for the fiscal year which begins July 1, 1999, each county applying for funding under 1998 Iowa Acts, House File 2545, section 8, subsection 2, shall include with its county management plan a performance improvement proposal for improving the county's performance on at least five performance measures. Three of the measures must be selected from at least two of the desired results areas stated in rule 441—25.51(77GA,HF2545). For the remaining two measures, the county either may propose measures not identified in these rules or may use measures described in these rules. A performance improvement proposal is not a mandatory element of a county management plan.

25.52(1) Performance improvement proposal. Each county shall identify the performance measures which the county has targeted for improvement and shall propose a percentage change for each indicator. The proposal shall include the county's rationale for selecting the indicators and may include any supporting information the county deems necessary. The proposal shall describe the process the county will use to involve consumers in the evaluation.

25.52(2) Committee responsibility. The state county management committee shall review all county proposals, and may either accept the proposal, request modifications, or reject the proposal. In order to interpret and provide context for each county's performance improvement proposal, the state county management committee shall, by January 1, 1999, establish the background data to be collected and aggregated for all counties.

25.52(3) County ineligibility. A county which does not have an accepted proposal prior to July 1 will be ineligible to receive incentive funds for that fiscal year. A county may apply for an extension by petitioning the state county management committee prior to July 1. The petition shall describe the circumstances which will cause the proposal to be delayed and identify the date by which the proposal will be submitted. In addition, the state county management committee may grant an extension for the purposes of negotiation.

441—25.53(77GA,HF2545) Methodology for awarding incentive funding. Each county shall report on all performance measures listed in this division, plus any additional performance measures the county has selected, by December 1 of each year.

25.53(1) Reporting. Each county shall report performance measure information on forms, or by electronic means, developed for the purpose by the department in consultation with the state county management committee.

25.53(2) Scoring. The department shall analyze each county's report to determine the extent to which the county achieved the levels contained in the proposal accepted by the state county management committee. Prior to distribution of incentive funding to counties, results of the analysis shall be shared with the state county management committee.

25.53(3) County ineligibility. A county which does not report performance measure data by December 1 will be ineligible to receive incentive funds for that fiscal year. A county may apply for an extension by petitioning the state county management committee prior to December 1. The petition shall describe the circumstances which will cause the report to be delayed and identify the date by which the report will be submitted.

441—25.54(77GA,HF2545) Subsequent year performance factors. For any fiscal year which begins after July 1, 1999, the state county management committee shall not apply any additional performance measures until the county management information system (CoMIS) developed and maintained by the division of mental health and developmental disabilities has been modified, if necessary, to collect and calculate required data elements and performance measures and each county has been given the opportunity to establish baseline measures for those measures.

441—25.55(77GA,HF2545) Phase-in provisions.

25.55(1) State fiscal year 1999. For the fiscal year which begins July 1, 1998, each county shall collect data as required above in order to establish a baseline level on all performance measures. A county

which collects and reports all required data by December 1, 1999, shall be deemed to have received a 100 percent score on the county's performance indicators.

25.55(2) State fiscal year 2000. A county which submits a proposal with its management plan for the fiscal year which begins July 1, 1999, and reports the levels achieved on the selected performance measures by December 1, 2000, shall be deemed to have received a 100 percent score on the county's performance indicators, regardless of the actual levels achieved.

These rules are intended to implement 1998 Iowa Acts, House File 2545, section 8, subsection 2.

441—25.56 to 25.60 Reserved.

DIVISION V
RISK POOL FUNDING

PREAMBLE

These rules establish a risk pool board to administer the risk pool fund established by the legislature and set forth the requirements for counties for receiving and repaying funding from the fund.

441—25.61(426B) Definitions.

“*Available pool*” means those funds remaining in the risk pool less any actuarial and other direct administrative costs.

“*Central point of coordination (CPC)*” means the administrative entity designated by a county board of supervisors, or the boards of a consortium of counties, to act as the single entry point to the service system as required in Iowa Code section 331.440.

“*Commission*” means the mental health, mental retardation, developmental disabilities, and brain injury commission.

“*Division*” means the mental health and disability services division of the department of human services.

“*Mandated services*” means those services for which a county is required to pay. Mandated services include, but may not be limited to, the following:

1. The costs for commitments for persons with mental illness, chronic mental illness, mental retardation, or developmental disabilities.

2. Inpatient services at the state mental health institutes for persons with mental illness or chronic mental illness.

3. Inpatient services at the state resource centers for persons with mental retardation or developmental disabilities.

4. Medicaid-funded care in an intermediate care facility for persons with mental retardation.

5. Medicaid-funded partial hospitalization and day treatment services for persons with chronic mental illness.

6. Medicaid-funded case management services for persons with mental retardation or developmental disabilities and for anyone not covered under the Iowa Plan.

7. Services provided under the Medicaid home- and community-based services mental retardation waiver.

8. Services provided under the Medicaid home- and community-based services brain injury waiver for which the county is responsible according to rule 441—83.90(249A).

9. Medicaid habilitation services for persons with chronic mental illness.

“*Services fund*” means a county's mental health, mental retardation, and developmental disabilities services fund created in Iowa Code section 331.424A.

441—25.62(426B) Risk pool board. This ten-member board consists of two county supervisors, two county auditors, a member of the commission who is not a member of a county board of supervisors, a member of the county finance committee created in Iowa Code chapter 333A who is not an elected official, a representative of a provider of mental health or developmental disabilities services selected

from nominees submitted by the Iowa Association of Community Providers, and two central point of coordination administrators, all appointed by the governor, subject to confirmation by two-thirds of the members of the senate, and one member appointed by the director of the department of human services.

25.62(1) Organization.

a. The members of the board shall annually elect from the board's voting membership a chairperson and vice-chairperson of the board.

b. Members appointed by the governor shall serve three-year terms.

25.62(2) Duties and powers of the board. The board's powers and duties are to make policy and to provide direction for the administration of the risk pool established by Iowa Code section 426B.5, subsection 2. In carrying out these duties, the board shall do all of the following:

a. Recommend to the commission for adoption rules governing the risk pool fund.

b. Determine application requirements to ensure prudent use of risk pool assistance.

c. Accept or reject applications for assistance in whole or in part.

d. Review the fiscal year-end financial records for all counties that are granted risk pool assistance and determine if repayment is required.

e. Approve actuarial and other direct administrative costs to be paid from the pool.

f. Compile a list of requests for risk pool assistance that are beyond the amount available in the risk pool fund for a fiscal year and the supporting information for those requests and submit the list and supporting information to the commission, the department of human services, and the general assembly.

g. Perform any other duties as mandated by law.

25.62(3) Board action.

a. A quorum shall consist of two-thirds of the membership appointed and qualified to vote.

b. When a quorum is present, an action is carried by a majority of the qualified members of the board.

25.62(4) Board minutes.

a. Copies of administrative rules and other materials considered are made part of the minutes by reference.

b. Copies of the minutes are kept on file in the office of the administrator of the division.

25.62(5) Board meetings.

a. The board shall meet in August of each year and may hold special meetings at the call of the chairperson or at the request of a majority of the voting members.

b. Any county making application for risk pool funds must be represented at the board meeting for awarding funds when that request is considered.

(1) The division shall notify the county of the date, time and location of the meeting.

(2) Any other persons with questions about the date, time or location of the meeting may contact the Administrator, Division of Mental Health and Disability Services, Department of Human Services, Hoover State Office Building, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, telephone (515)281-7277.

c. The board shall comply with applicable provisions of Iowa's open meetings law, Iowa Code chapter 21.

25.62(6) Records. Any records maintained by the board or on behalf of the board shall be made available to the public for examination in compliance with Iowa's open records law, Iowa Code chapter 22. To the extent possible, before submitting applications, records and documents, applicants shall delete any confidential information. These records shall be maintained in the office of the division.

25.62(7) Conflict of interest. A board member cannot be a part of any presentation to the board of that board member's county's application for risk pool funds nor can the board member be a part of any action pertaining to that application.

25.62(8) Robert's Rules of Order. In cases not covered by these rules, Robert's Rules of Order shall govern.

25.62(9) Report. On or before March 1 and September 1 of each fiscal year, the department of human services shall provide the risk pool board with a report of the financial condition of each funding source administered by the board. The report shall include, but is not limited to, an itemization of the

funding source's balances, types and amount of revenues credited and payees and payment amounts for the expenditures made from the funding source during the reporting period.

[ARC 7879B, IAB 6/17/09, effective 6/1/09]

441—25.63(426B) Application process.

25.63(1) Applicants. A county may be eligible for risk pool assistance when the county demonstrates that it meets the conditions in this subrule.

a. Basic eligibility.

- (1) The county complies with the requirements of Iowa Code section 331.439.
- (2) The county levied the maximum amount allowed for the county's services fund under Iowa Code section 331.424A for the fiscal year of application.
- (3) In the fiscal year that commenced two years before the fiscal year of distribution, the county's services fund ending balance under generally accepted accounting principles was equal to or less than 20 percent of the county's actual gross expenditures for that fiscal year.

b. Circumstances indicating need for assistance. Risk pool assistance is needed for one or more of the following purposes:

- (1) To continue support for mandated services.
- (2) To avoid the need for reduction or elimination of:
 1. Critical services, creating risk to a consumer's health or safety;
 2. Critical emergency or mobile crisis services, creating risk to the public's health or safety;
 3. Services or other support provided to an entire disability category; or
 4. Services or other support provided to maintain consumers in a community setting, creating risk of placement in a more restrictive, higher-cost setting.

25.63(2) Application procedures.

a. Format for submission. The county shall submit the application package electronically or send an original plus 15 copies to the division. Facsimiles are not acceptable.

b. Deadline. The division must receive the application no later than 4:30 p.m. on July 1 of each year; or, if July 1 is a holiday, Saturday or Sunday, the division must receive the application no later than 4:30 p.m. on the first working day thereafter.

c. Signature. The application shall be signed and dated by both the chairperson of the county board of supervisors and the central point of coordination administrator.

d. Notice of receipt. Staff of the division shall notify each county of receipt of the county's application.

e. Content. In addition to Form 470-3723, Risk Pool Application, the application package shall include the following forms for the fiscal year that commenced two years before the fiscal year of distribution:

- (1) Form 634C, Service Area 4 Supporting Detail (pages 1 to 8).
- (2) Form 638R, Statement of Revenues, Expenditures, and Changes in Fund Balance—Actual and Budget (pages 1 and 2).
- (3) If the budget has been amended, Form 653A-R, Record of Hearing and Determination on the Amendment to County Budget (sheet 2), as last amended.

25.63(3) Request for additional information. Staff shall review all applications for completeness. If an application is not complete, staff of the division shall contact the county within four working days after July 1 to request the information needed to complete the application. If July 1 is a holiday, Saturday or Sunday, the division shall make this contact within five working days after July 1. The county shall submit the required information within five working days from the date of the division's request for the additional information.

[ARC 7879B, IAB 6/17/09, effective 6/1/09]

441—25.64(426B) Methodology for awarding risk pool funding. The risk pool board shall make an eligibility decision on each application within 45 days after receiving the application and shall make a funding decision no later than August 15.

25.64(1) Notice of decision. The risk pool board shall send a notice of decision of the board's action to the chairperson of the applying county's board of supervisors. Copies of the notice of decision shall be sent to the county auditor and the central point of coordination administrator.

25.64(2) Distribution of funds. The total amount of the risk pool shall be limited to the available pool for a fiscal year.

a. If the total dollar amount of the approved applications exceeds the available pool, the board shall prorate the amount paid for an approved application. The funds will be prorated to each county based upon the proportion of each approved county's request to the total amount of all approved requests.

b. The division shall authorize the issuance of warrants payable to the county treasurers for the amounts due. The warrants shall be issued on or before September 15.

[ARC 7879B, IAB 6/17/09, effective 6/1/09]

441—25.65(426B) Repayment provisions.

25.65(1) Required repayment. Counties shall be required to repay risk pool funds if the county's actual need for risk pool assistance was less than the amount of risk pool assistance granted to the county. The county shall refund the lesser of:

- a. The amount of assistance awarded; or
- b. An amount such that the fund balance after refund will not exceed 5 percent of the expenditures for the year as determined on a modified accrual basis.

25.65(2) Year-end report. Each county granted risk pool funds shall complete a year-end financial report as required by Iowa Code section 225C.6A(2)(c)(3). The division shall review the accrual information and notify the mental health risk pool board if any county that was granted assistance in the prior year received more than the county's actual need based on the submitted financial report.

25.65(3) Notification to county. The chairperson of the mental health risk pool board shall notify each county by January 1 of each fiscal year of the amount to be reimbursed. The county shall reimburse the risk pool within 30 days of receipt of notification by the chairperson of the mental health risk pool board. If a county fails to reimburse the mental health risk pool, the board may request a revenue offset through the department of revenue. Copies of the overpayment and request for reimbursement shall be sent to the county auditor and the central point of coordination administrator of the county.

[ARC 7879B, IAB 6/17/09, effective 6/1/09]

441—25.66(426B) Appeals. The risk pool board may accept or reject an application for assistance from the risk pool fund in whole or in part. The decision of the board is final and is not appealable.

These rules are intended to implement Iowa Code section 426B.5, subsection 2.

441—25.67 to 25.70 Reserved.

DIVISION VI TOBACCO SETTLEMENT FUND RISK POOL FUNDING

PREAMBLE

These rules provide for use of an appropriation from the tobacco settlement fund to establish a risk pool fund which may be used by counties with limited county mental health, mental retardation and developmental disabilities services funds to pay for increased compensation of the service staff of eligible purchase of service (POS) providers and establish the requirements for counties for receiving and repaying the funding. Implementation of the rate increases contemplated by the tobacco settlement fund in a timely manner will require cooperation among all eligible counties and providers.

441—25.71(78GA,ch1221) Definitions.

“*Adjusted actual cost*” means a POS provider's cost as computed using the financial and statistical report for the provider's fiscal year which ended during the state fiscal year beginning July 1, 1998 (state fiscal year 1999), as adjusted by multiplying those actual costs by 103.4 percent or the percentage

adopted by the risk pool board in accordance with 2000 Iowa Acts, chapter 1221, section 3, subsection 3, paragraph "c."

"*Department*" means the Iowa department of human services.

"*Division*" means the mental health and developmental disabilities division of the department of human services.

"*Financial and statistical report*" means a report prepared by a provider and submitted to host counties that is prepared in accordance with department rules for cost determination set forth in 441—Chapter 150.

"*Host county*" means the county in which the primary offices of a POS provider are located. However, if a POS provider operates separate programs in more than one county, "*host county*" means each county in which a separate program is operated.

"*Purchase of service provider*" or "*POS provider*" means a provider of sheltered work, work activity, supported employment, job placement, enclave services, adult day care, transportation, supported community living services, or adult residential services paid by a county from the county's services fund created in Iowa Code section 331.424A under a state purchase of service or county contract.

"*Risk pool board*" means that board established by Iowa Code section 426B.5, subsection 3.

"*Separate program*" means a POS service operated in a county other than the county in which the provider's home office is located and for which the provider allocates costs separately from similar programs located in the county where the provider's home office is located.

"*Services fund*" means the fund defined in Iowa Code section 331.424A.

"*Tobacco settlement fund loan*" or "*TSF loan*" means the tobacco settlement fund risk pool funds a county received in a fiscal year in which the county did not levy the maximum amount allowed for the county's mental health, mental retardation, and developmental disabilities services fund under Iowa Code section 331.424A. The repayment amount shall be limited to the amount by which the actual amount levied was less than the maximum amount allowed.

441—25.72(78GA,ch1221) Risk pool board. The risk pool board is organized and shall take action and keep minutes and records as set out in rule 441—25.62(426B).

A risk pool board member cannot be a part of any presentation to the board of that board member's county's application for tobacco settlement fund risk pool funds nor can the board member be a part of any action pertaining to that application. If a risk pool board member is employed by or is a board member of a POS provider whose increases in compensation caused the host county to apply to the fund, the board member cannot be a part of any presentation to the board nor can the board member be a part of any action pertaining to that application.

441—25.73(78GA,ch1221) Rate-setting process. For services provided on or after July 1, 2000, each county shall increase its reimbursement rates for each program to the lesser of the adjusted actual cost or 105 percent of the rate paid for services provided on June 30, 2000.

25.73(1) Financial and statistical report. Each provider of POS services shall submit a financial and statistical report to each host county for each program that the provider operates within that county. These reports shall include actual costs for each separate program for the provider's fiscal year that ended during state fiscal year 1999 and state fiscal year 2000. These reports shall be submitted to the central point of coordination (CPC) administrator of the host county or counties no later than August 15, 2000.

25.73(2) Rate determination. The CPC administrator in each host county shall receive and review provider financial and statistical reports for each separate program for which that county is the host county. If the host county determines that all or part of the provider's increase in costs is attributable to increases in service staff compensation and that the adjusted actual cost is more than the rate paid by the county on June 30, 2000, the CPC administrator shall notify the provider in writing of the new rate for each program no later than September 1, 2000.

If a rate paid for services provided on June 30, 2000, exceeds the adjusted actual cost, the county shall not be required to adjust the rate for services provided on or after July 1, 2000.

The provider shall, no later than September 11, 2000, send to the CPC administrator of any other counties with consumers in those programs a copy of the rate determination signed by the CPC administrator of the host county. A county may delay payment of the reimbursement rate established pursuant to this subrule until the risk pool board has completed action as to adopting or not adopting a different percentage for the definition of adjusted actual cost, provided however that any increased rates required by 2000 Iowa Acts, chapter 1221, section 3, subsection 2, paragraph "c," shall be paid retroactively for all services provided on or after July 1, 2000.

25.73(3) Exemptions.

a. A POS provider that has negotiated a reimbursement rate increase with a host county as of July 1, 2000, has the option of exemption from the provisions of these rules. However, a county shall not be eligible to receive tobacco settlement funds for any rates established outside of the process established in these rules.

b. Nothing in these rules precludes a county from increasing reimbursement rates of POS providers by an amount that is greater than that specified in these rules. However, a county shall not be eligible for tobacco settlement funds for the amount of any rate increase in excess of the amount established pursuant to these rules.

441—25.74(78GA,ch1221) Application process.

25.74(1) Who may apply. If a county determines that payment of POS provider rates in accordance with these rules will cause the county to expend more funds in FY2001 than budgeted for POS services, the county may apply for assistance from the tobacco settlement fund. However, any fiscal year 2000 projected accrual basis fund balances in excess of 25 percent of fiscal year 2000 services fund gross expenditures will reduce the amount for which a county is eligible. In considering the cost of implementing these provisions, a county shall not include the cost of rate increases granted to any providers who fail to complete financial and statistical reports as provided in these rules.

25.74(2) How to apply. The county shall send the original and 15 copies of Form 470-3768, Tobacco Settlement Fund Risk Pool Application, to the division. The division must receive the application no later than 4:30 p.m. on September 25, 2000. Facsimiles and electronic mail are not acceptable. The application shall be signed and dated by the chairperson of the county board of supervisors, the county auditor, and the CPC administrator. Staff of the division shall notify each county of receipt of the county's application.

25.74(3) Request for additional information. Staff shall review all applications for completeness. If an application is not complete, staff of the division shall contact the county by October 5, 2000, and request the information needed to complete the application. The county shall submit the required information by October 16, 2000.

441—25.75(78GA,ch1221) Methodology for awarding tobacco settlement fund risk pool funding.

25.75(1) Review of applications. The risk pool board shall review all of the applications from counties for assistance from the tobacco settlement fund. If the total amount requested from the tobacco settlement fund does not exceed \$2 million, eligible counties shall be awarded funding pursuant to this division. The risk pool board shall determine for each county whether any or all of the assistance granted to that county is a TSF loan.

25.75(2) Notice of decision. The risk pool board shall notify the chair of the applying county's board of supervisors of the board's action no later than November 3, 2000. Copies shall be sent to the county auditor and the CPC administrator.

25.75(3) Distribution of funds. The total amount of the risk pool shall be limited to \$2 million. If the total dollar amount of the eligible applications exceeds the available pool, the risk pool board shall revise the percentage adjustment to actual cost to arrive at adjusted actual cost as defined in this division and prorate funding to the eligible counties. If it becomes necessary to revise the percentage adjustment used to determine adjusted actual cost, the risk pool board shall determine if applicant counties remain eligible under this program.

25.75(4) Notification of adjustment. If the risk pool board rolls back the percentage adjustment used to determine adjusted actual cost, the risk pool board shall notify the chair of the board of supervisors of all counties, and copies shall be sent to the county auditor and the CPC administrator of each county. Each host county shall recalculate the reimbursement rate under this division using the revised adjusted actual cost percentage and notify each provider in writing of the revised rate within 30 days of receiving notice of the percentage adjustment. The provider shall, within 30 days of receipt of notice, send to the CPC administrator of any other counties with consumers in those programs a copy of the revised rate determination signed by the CPC administrator of the host county.

441—25.76(78GA,ch1221) Repayment provisions.

25.76(1) Required repayment. Counties shall be required to repay TSF loans by January 1, 2002. Repayments shall be credited to the tobacco settlement fund.

25.76(2) Notification to county. In the notice of decision provided pursuant to these rules, the chairperson of the risk pool board shall notify each county of the portion, if any, of the assistance that is considered a TSF loan. If a county fails to reimburse the tobacco settlement fund by January 1, 2002, the board may request a revenue offset through the department of revenue. Copies of the overpayment and request for reimbursement shall be sent to the county auditor and the CPC administrator of the county.

441—25.77(78GA,ch1221) Appeals. The risk pool board may accept or reject an application for assistance from the tobacco settlement fund risk pool fund in whole or in part. The decision of the board is final and is not appealable.

These rules are intended to implement 2000 Iowa Acts, chapter 1221, section 3, as amended by chapter 1232, section 4.

441—25.78 to 25.80 Reserved.

DIVISION VII
COMMUNITY MENTAL HEALTH CENTER WAIVER REQUEST

PREAMBLE

This division establishes a process for the mental health and developmental disabilities commission to grant a waiver to any county not affiliated with a community mental health center.

441—25.81(225C) Waiver request. Counties that have not established or that are not affiliated with a community mental health center under Iowa Code chapter 230A are required to expend a portion of the money received from the MI/MR/DD/BI community services fund to contract with a community mental health center for services. When a county determines that a contractual arrangement is undesirable or unworkable, it may request a waiver from this requirement for a fiscal year. The waiver request and justification may be submitted to the mental health and developmental disabilities commission with the application for MI/MR/DD/BI community services funds on Form 470-0887, Waiver Request, or it may be submitted separately. The commission may grant a waiver if the request successfully demonstrates that all of the following conditions are met:

25.81(1) Accreditation of provider. The provider or network of providers that the county has contracted with to deliver the identified mental health services is accredited as another mental health provider pursuant to 441—Chapter 24.

25.81(2) Contracted services. The county has contracted to provide services that are equal to or greater than the smallest set of services provided by an accredited community mental health center in the department's service area for that county.

25.81(3) Eligible populations. The county contract includes the following eligible populations:

- a. Children.
- b. Adults.
- c. Elderly.
- d. Chronically mentally ill.

e. Mentally ill.

This rule is intended to implement Iowa Code section 225C.7.

441—25.82 to 25.90 Reserved

DIVISION VIII
CRITERIA FOR EXEMPTING COUNTIES FROM JOINING INTO REGIONS TO ADMINISTER
MENTAL HEALTH AND DISABILITY SERVICES

441—25.91(331) Exemption from joining into mental health and disability services region.

25.91(1) Definitions.

“*Applicant*” means a single county or two counties that submit an application for an exemption from the requirement to join a region of three or more contiguous counties.

“*Clear lines of accountability*” means the governing board’s organizational structure makes it evident that the ultimate responsibility for the administration of non-Medicaid-funded mental health and disability services lies with the governing board and that the governing board directly and solely supervises the organization’s chief executive officer.

“*Coordinator of disability services*” means a person who meets the qualifications of a coordinator of disability services as defined in Iowa Code section 331.390(3) “*b*” and is responsible for ensuring that individuals receive effective service coordination consistent with the county’s or counties’ management plan.

“*Core services*” means core services mandated to be provided by the regional service system as defined in Iowa Code section 331.397.

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

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

“*Evidence-based practice*” means interventions that have been rigorously tested, have yielded consistent, replicable results, and have proven safe, beneficial, and effective.

“*Penetration rate*,” for the purposes of this rule, means the per capita number of adults in the adult population of a county who are receiving mental health and disability services.

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

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

25.91(2) Application for exemption from the requirement to form a region of three or more contiguous counties. The following requirements apply to an application for exemption from the requirement to form a region of three or more contiguous counties:

a. The applicant shall submit a written statement that the applicant intends to apply for an exemption from the requirement to form a region of three or more contiguous counties. The statement must be signed by the chairperson of the county board of supervisors of the applicant’s county. The signed written statement of intent must be received by the department on or before May 1, 2013, at 4:30 p.m.

b. The applicant shall submit a written application on forms specified by the department with required supporting documentation. The department shall only accept applications that are complete, signed by the applicant’s chairperson of the county board of supervisors, dated, and received by the department on or before June 30, 2013, at 4:30 p.m.

c. The director of the department shall issue a decision on the application within 45 days of receiving the application. The director shall deny an application if the application does not meet the criteria described in Iowa Code or rule.

25.91(3) Applicant criteria. The application shall include written documentation and evidence that the applicant has:

a. The capacity to provide required core services and perform required functions described in Iowa Code section 331.397.

b. A contract with a community mental health center or a federally qualified health center that provides psychiatric and outpatient mental health services in the applicant's county or counties or written intent from the community mental health center or federally qualified health center to enter into such a contract.

c. A contract with a hospital with an inpatient psychiatric unit or a state mental health institute located in or within reasonably close proximity that has the capacity to provide inpatient services to the applicant or written intent from the state mental health institute or inpatient psychiatric unit to enter into such a contract.

d. An administrative structure with clear lines of accountability. A description of the applicant's administrative functions shall be included with the application.

e. Taken steps to determine and demonstrate that forming a region of three or more contiguous counties is not workable.

25.91(4) Core services and required functions standards. The department shall review the application to determine if the applicant has provided written documentation and evidence for the availability of:

a. A 24-hour, 7-day-a-week, 365-days-per-year telephone response system for mental health and disability-related emergencies in the applicant's county or counties.

b. Service providers in the applicant's county or counties that demonstrate the capability of providing evidence-based practices that the applicant has independently verified meet established fidelity to evidence-based service models including, but not limited to:

- (1) Assertive community treatment or strengths-based case management.
- (2) Integrated treatment of co-occurring substance abuse and mental health disorders.
- (3) Supported employment.
- (4) Family psychoeducation.
- (5) Illness management and recovery.
- (6) Permanent supportive housing.

c. Service providers in the applicant's county or counties that are trained to provide effective services to persons with two or more of the following co-occurring conditions: mental illness, intellectual disability, developmental disability, brain injury, or substance use disorder. Training for serving persons with co-occurring conditions shall be training identified by the Substance Abuse and Mental Health Services Administration, the Dartmouth Psychiatric Research Center or other generally recognized professional organization specified in the application.

d. Service providers in the applicant's county or counties that are trained to provide effective trauma-informed care. Trauma-informed care training shall be training identified by the National Center for Trauma-Informed Care or other generally recognized professional organization specified in the application.

25.91(5) Service capacity. The department shall review the material provided in the application and by the applicant and other counties in their required county reports to determine if the applicant demonstrates that it has:

a. Sufficient financial resources to fund required core services.

b. A penetration rate that is at least equal to or exceeds the statewide per capita average for individuals with a mental illness or individuals with an intellectual disability.

c. A per capita use of inpatient psychiatric hospital services that is less than or equal to the statewide per capita average.

d. A per capita use of intermediate care facilities for individuals with intellectual disabilities that is less than or equal to the statewide per capita average.

e. A per capita use of outpatient mental health services that is greater than or equal to the statewide per capita average.

f. A per capita use of supported community living services that is greater than or equal to the statewide per capita average.

g. An average cost of service per individual served that is equal to or less than the statewide average.

h. Administrative costs, as a percentage of non-Medicaid service expenditures, that are less than or equal to the statewide average.

25.91(6) Provider network sufficiency. The department shall review the application to determine if the applicant provided written documentation and evidence of:

a. A contract with a community mental health center that provides services in the applicant's county or counties or a federally qualified health center that provides psychiatric and outpatient mental health services in the applicant's county or counties or written intent by a community mental health center or federally qualified health center to enter into such a contract.

b. Contracts with licensed and accredited providers to provide each service in the required core service domains or written intent by providers to enter into such contracts.

c. Adequate numbers of licensed and accredited providers to ensure availability of core services so that there is no waiting list for services due to lack of available providers.

d. A contract with an inpatient psychiatric hospital unit or state mental health institute within reasonably close proximity or written intent by an inpatient psychiatric hospital unit or state mental health institute to enter into such a contract.

25.91(7) to 25.91(9) Reserved.

25.91(10) Staffing. The department shall review the application to determine if the applicant provided written documentation and evidence of:

a. Clear lines of accountability.

b. The inclusion of one or more coordinators of disability services on the county administrator staff.

25.91(11) Reserved.

25.91(12) Determination that formation of a region is unworkable. The department shall review the application to determine if the applicant has provided documentation and convincing evidence that the applicant has evaluated the feasibility of forming into a region of three or more contiguous counties and that forming into such a region is unworkable.

25.91(13) Compliance with requirements of a mental health and disability services region. The applicant shall continuously fulfill all of the requirements of a region under Iowa Code chapters 331 and 225C for a regional service system, regional service system management plan, regional governing board, and regional administrator and any other requirements applicable to a region of counties providing local mental health and disability services. If the applicant does not fulfill these requirements, the department may address the deficiencies in the following order:

a. Require compliance with a corrective action plan that may include, but is not limited to, participation in technical assistance provided or arranged by the department, revision of the regional management plan, or other corrective actions required by the department.

b. Reduce the amount of the annual state funding provided through the mental health and disabilities regional services fund for the regional service system, not to exceed 15 percent of the amount of the annual state funding.

c. Withdraw approval for the county exemption.

This rule is intended to implement Iowa Code section 331.389.

[ARC 0576C, IAB 2/6/13, effective 1/8/13; ARC 0735C, IAB 5/15/13, effective 8/1/13]

441—25.92 to 25.94 Reserved.

DIVISION IX
DATA SUBMISSION TO DETERMINE MEDICAID OFFSET FOR COUNTIES

PREAMBLE

These rules define the department's standards for the submission of county mental health and disability services expenditure data so that the department can calculate the Medicaid offset for each county consistent with 2014 Iowa Acts, House File 2473, section 82.

[ARC 1671C, IAB 10/15/14, effective 9/25/14]

441—25.95(426B) Definitions.

“Department” means the Iowa department of human services.

“Medicaid offset amount” means the amount resulting from the calculations described in Iowa Code section 426B.3 as amended by 2014 Iowa Acts, House File 2463, section 82(5) “d.”

“Uniform chart of accounts for Iowa county governments” means the set of codes used by counties to organize and delineate revenues and expenditures. The codes related to mental health and disability services expenditures identify diagnosis and types of services.

[ARC 1671C, IAB 10/15/14, effective 9/25/14]

441—25.96(426B) Data to determine Medicaid offset. Each county must submit to the department a report that provides the county mental health and disability services data needed to calculate the Medicaid offset for the county.

25.96(1) Data required. Each county is required to submit expenditure data as specified by the department based on the agreement by the department and representatives of the mental health and disability services regions consistent with the requirements of Iowa Code section 426B.3 as amended by 2014 Iowa Acts, House File 2463, section 82(5) “b.”

25.96(2) Submission of mental health and disability services data.

a. Counties must submit the required data to the department by 4:30 p.m. on September 19, 2014, consistent with data submissions as required in subrule 25.41(3).

b. If a county fails to submit data within the required time frame or a county submits data that is demonstrably inaccurate, the department will use a pro-rata methodology to determine the county’s Medicaid offset using data submitted by other counties.

[ARC 1671C, IAB 10/15/14, effective 9/25/14]

These rules are intended to implement Iowa Code section 225C.6 and 2014 Iowa Acts, House File 2463, section 82.

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[Filed Emergency After Notice ARC 2164C (Notice ARC 2062C, IAB 7/22/15), IAB 9/30/15,
effective 10/1/15]

- ◊ Two or more ARCs

CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS
OF MEDICAL AND REMEDIAL CARE
[Prior to 7/1/83, Social Services[770] Ch 77]
[Prior to 2/11/87, Human Services[498]]

441—77.1(249A) Physicians. All physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa are eligible to participate in the program. Physicians in other states are also eligible if duly licensed to practice in that state.

441—77.2(249A) Retail pharmacies. Retail pharmacies are eligible to participate if they meet the requirements of this rule.

77.2(1) Licensure. Participating retail pharmacies must be licensed in the state of Iowa or duly licensed in another state. Out-of-state retail pharmacies delivering, dispensing, or distributing drugs by any method to an ultimate user physically located in Iowa must be duly licensed by Iowa as a nonresident pharmacy for that purpose.

77.2(2) Survey participation. As a condition of participation, retail pharmacies are required to make available drug acquisition cost invoice information, product availability information if known, dispensing cost information, and any other information deemed necessary by the department to assist in monitoring and revising reimbursement rates pursuant to 441—subrule 79.1(8) or for the efficient operation of the pharmacy benefit.

a. A pharmacy shall produce and submit all requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

b. A pharmacy shall submit information to the department or its designee within the time frame indicated following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy.

c. Any dispensing or acquisition cost information submitted to the department that specifically identifies a pharmacy's individual costs shall be held confidential.

[ARC 0485C, IAB 12/12/12, effective 2/1/13]

441—77.3(249A) Hospitals.

77.3(1) Qualifications. All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.

77.3(2) Referral to health home services provider. As a condition of participation in the medical assistance program, hospitals must establish procedures for referring to health home services providers any members who seek or need treatment in the hospital emergency department and who are eligible for health home services pursuant to 441—subrule 78.53(2).

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0198C, IAB 7/11/12, effective 7/1/12]

441—77.4(249A) Dentists. All dentists licensed to practice in the state of Iowa are eligible to participate in the program. Dentists in other states are also eligible if duly licensed to practice in that state.

NOTE: DENTAL LABORATORIES—Payment will not be made to a dental laboratory.

441—77.5(249A) Podiatrists. All podiatrists licensed to practice in the state of Iowa are eligible to participate in the program. Podiatrists in other states are also eligible if duly licensed to practice in that state.

441—77.6(249A) Optometrists. All optometrists licensed to practice in the state of Iowa are eligible to participate in the program. Optometrists in other states are also eligible if duly licensed to practice in that state.

441—77.7(249A) Opticians. All opticians in the state of Iowa are eligible to participate in the program. Opticians in other states are also eligible to participate.

NOTE: Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

441—77.8(249A) Chiropractors. All chiropractors licensed to practice in the state of Iowa are eligible to participate providing they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) by the Social Security Administration. Chiropractors in other states are also eligible if duly licensed to practice in that state and determined eligible to participate in Title XVIII of the Social Security Act.

441—77.9(249A) Home health agencies. Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6).

77.9(1) Definitions.

“*Assets*” includes any listing that identifies Medicaid members to whom home health services were furnished by a participating or formerly participating home health agency.

“*Rider*” means a notice issued by a surety that a change in the bond has occurred or will occur.

“*Uncollected overpayment*” means a Medicaid overpayment, including accrued interest, for which the home health agency is responsible that has not been recouped by the department within 60 days from the date of notification that an overpayment has been identified.

77.9(2) Parties to surety bonds. The surety bond shall name the home health agency as the principal, the Iowa department of human services as the obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety. The bond shall be issued by a company holding a current Certificate of Authority issued by the U.S. Department of the Treasury in accordance with 31 U.S.C. Sections 9304 to 9308 and 31 CFR Part 223 as amended to November 30, 1984, Part 224 as amended to May 29, 1996, and Part 225 as amended to September 12, 1974. The bond shall list the surety’s name, street address or post office box number, city, state and ZIP code. The company shall not have been determined by the department to be unauthorized in Iowa due to:

a. Failure to furnish timely confirmation of the issuance of and the validity and accuracy of information appearing on a surety bond that a home health agency presents to the department that shows the surety company as surety on the bond.

b. Failure to timely pay the department in full the amount requested, up to the face amount of the bond, upon presentation by the department to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company’s liability on the bond.

c. Other good cause.

The department shall give public notice of a determination that a surety company is unauthorized in Iowa and the effective date of the determination by publication of a notice in the newspaper of widest circulation in each city in Iowa with a population of 50,000 or more. A list of surety companies determined by the department to be unauthorized in Iowa shall be maintained and shall be available for public inspection by contacting the division of medical services of the department. The determination that a surety company is unauthorized in Iowa has effect only in Iowa and is not a debarment, suspension, or exclusion for the purposes of Federal Executive Order No. 12549.

77.9(3) Surety company obligations. The bond shall guarantee payment to the department, up to the face amount of the bond, of the full amount of any uncollected overpayment, including accrued interest, based on payments made to the home health agency during the term of the bond. The bond shall provide that payment may be demanded from the surety after available administrative collection methods for collecting from the home health agency have been exhausted.

77.9(4) Surety bond requirements. Surety bonds secured by home health agencies participating in Medicaid shall comply with the following requirements:

a. Effective dates and submission dates.

(1) Home health agencies participating in the program on June 10, 1998, shall secure either an initial surety bond for the period January 1, 1998, through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(2) Home health agencies seeking to participate in Medicaid and Medicare for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(3) Medicare-certified home health agencies seeking to participate in Medicaid for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(4) Home health agencies seeking to participate in Medicaid after purchasing the assets of or an ownership interest in a participating or formerly participating agency shall secure an initial surety bond effective as of the date of purchase of the assets or the transfer of the ownership interest for the balance of the current fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

(5) Home health agencies which continue to participate in Medicaid after the period covered by an initial surety bond shall secure a surety bond for each subsequent fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

b. *Amount of bond.* Bonds for any period shall be in the amount of \$50,000 or 15 percent of the home health agency's annual Medicaid payments during the most recently completed state fiscal year, whichever is greater. After June 1, 2005, all bonds shall be in the amount of \$50,000. At least 90 days before the start of each home health agency's fiscal year, the department shall provide notice of the amount of the surety bond to be purchased and submitted to the Iowa Medicaid enterprise provider services unit.

c. *Other requirements.* Surety bonds shall meet the following additional requirements. The bond shall:

(1) Guarantee that upon written demand by the department to the surety for payment under the bond and the department's furnishing to the surety sufficient evidence to establish the surety's liability under the bond, the surety shall within 60 days pay the department the amount so demanded, up to the stated amount of the bond.

(2) Provide that the surety's liability for uncollected overpayments is based on overpayments determined during the term of the bond.

(3) Provide that the surety's liability to the department is not extinguished by any of the following:

1. Any action by the home health agency or the surety to terminate or limit the scope or term of the bond unless the surety furnishes the department with notice of the action not later than 10 days after the date of notice of the action by the home health agency to the surety and not later than 60 days before the effective date of the action by the surety.

2. The surety's failure to continue to meet the requirements in subrule 77.9(2) or the department's determination that the surety company is an unauthorized surety under subrule 77.9(2).

3. Termination of the home health agency's provider agreement.

4. Any action by the department to suspend, offset, or otherwise recover payments to the home health agency.

5. Any action by the home health agency to cease operations, sell or transfer any assets or ownership interest, file for bankruptcy, or fail to pay the surety.

6. Any fraud, misrepresentation, or negligence by the home health agency in obtaining the surety bond or by the surety (or the surety's agent, if any) in issuing the surety bond; except that any fraud, misrepresentation, or negligence by the home health agency in identifying to the surety (or the surety's agent) the amount of Medicaid payments upon which the amount of the surety bond is determined shall not cause the surety's liability to the department to exceed the amount of the bond.

7. The home health agency's failure to exercise available appeal rights under Medicaid or assign appeal rights to the surety.

(4) Provide that if a home health agency fails to furnish a bond following the expiration date of an annual bond or if a home health agency fails to furnish a rider for a year in which a rider is required or if the home health agency's provider agreement with the department is terminated, the surety shall remain liable under the most recent annual bond or rider to a continuous bond for two years from the date the home health agency was required to submit the annual bond or rider to a continuous bond or for two years from the termination date of the provider agreement.

(5) Provide that actions under the bond may be brought by the department or by an agent designated by the department.

(6) Provide that the surety may appeal department decisions.

77.9(5) Exemption from surety bond requirements for government-operated home health agencies. A home health agency operated by a federal, state, local, or tribal government agency is exempt from the bonding requirements of this rule if, during the preceding five years, the home health agency has not had any uncollected overpayments. Government-operated home health agencies having uncollected overpayments during the preceding five years shall not be exempted from the bonding requirements of this rule.

77.9(6) Government-operated home health agency that loses its exemption. A government-operated home health agency which has met the criteria for an exemption under subrule 77.9(6) but is later determined by the department not to meet the criteria shall submit a surety bond within 60 days of the date of the department's written notification to the home health agency that it no longer meets the criteria for an exemption, for the period and in the amount required in the notice from the department.

441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

441—77.11(249A) Ambulance service. Providers of ambulance service are eligible to participate providing they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act).

441—77.12(249A) Behavioral health intervention. A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is enrolled in the Iowa Plan for Behavioral Health pursuant to 441—Chapter 88, Division IV. Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 135C.33(5)“a”(1) before employment of a staff member who will provide direct care.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9487B, IAB 5/4/11, effective 7/1/11]

441—77.13(249A) Hearing aid dispensers. Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

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

441—77.14(249A) Audiologists. Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

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

441—77.15(249A) Community mental health centers. Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority.

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

441—77.16(249A) Screening centers. Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in 441—78.18(249A) and meet the department of public health's standards for a child health screening center. The staff members must be employed by or under contract with the screening center. Screening centers shall direct applications to participate to the Iowa Medicaid enterprise provider services unit.

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

441—77.17(249A) Physical therapists. Physical therapists are eligible to participate when they are licensed, in independent practice; and are eligible to participate in the Medicare program.

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

441—77.18(249A) Orthopedic shoe dealers and repair shops. Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

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

441—77.19(249A) Rehabilitation agencies. Rehabilitation agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

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

441—77.20(249A) Independent laboratories. Independent laboratories are eligible to participate providing they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.

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

441—77.21(249A) Rural health clinics. Rural health clinics are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

441—77.22(249A) Psychologists. All psychologists licensed to practice in the state of Iowa and meeting the current credentialing requirements of the National Register of Health Service Psychologists are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the current credentialing requirements of the National Register of Health Service Psychologists.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.
[ARC 2165C, IAB 9/30/15, effective 12/1/15]

441—77.23(249A) Maternal health centers. A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A)). The prenatal and postpartum care shall be in accordance with the latest edition of the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services. The team must have at least a physician, a registered nurse, a licensed dietitian and a person with at least a bachelor's degree in social work, counseling, sociology or psychology. Team members must be employed by or under contract with the center.

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

441—77.24(249A) Ambulatory surgical centers. Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program

if the board of dental examiners has issued a current permit pursuant to 650—Chapter 29 for any dentist to administer deep sedation or general anesthesia at the facility.

441—77.25(249A) Home- and community-based habilitation services. To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall be an enrolled provider of habilitation with the Iowa Plan for Behavioral Health and meet the general requirements in subrules 77.25(2), 77.25(3), and 77.25(4) and shall meet the requirements in the subrules applicable to the individual services being provided.

77.25(1) Definitions.

“*Guardian*” means a guardian appointed in probate or juvenile court.

“*Major incident*” means an occurrence involving a member during service provision that:

1. Results in a physical injury to or by the member that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a member’s location being unknown by provider staff who are assigned protective oversight.

“*Member*” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“*Minor incident*” means an occurrence involving a member during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

77.25(2) Organization and staff.

a. The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

b. The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

c. A person providing direct care shall be at least 16 years of age.

d. A person providing direct care shall not be an immediate family member of the member.

77.25(3) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS habilitation service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

a. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the member’s file.

b. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

- (1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the member involved.
2. The date and time the incident occurred.
3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the member's file.

c. *Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of members served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.25(4) Restraint, restriction, and behavioral intervention. The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.

c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

e. Corporal punishment and verbal or physical abuse are prohibited.

77.25(5) Case management. The department of human services, a county or consortium of counties, or a provider under subcontract to the department or to a county or consortium of counties is eligible to participate in the home- and community-based habilitation services program as a provider of case management services provided that the agency meets the standards in 441—Chapter 24.

77.25(6) Day habilitation. The following providers may provide day habilitation:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.27(8).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services and began providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency's last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph "a," "d," "g," or "h."

c. An agency that is not accredited by the Commission on Accreditation of Rehabilitation Facilities but has applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

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

e. An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

f. An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

g. An agency that is certified by the department to provide day habilitation services under the home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A).

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

i. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

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

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

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

77.25(7) Home-based habilitation. The following agencies may provide home-based habilitation services:

a. An agency that is certified by the department to provide supported community living services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited under 441—Chapter 24 to provide supported community living services.

c. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.

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

e. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

f. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

g. A residential care facility of 16 or fewer beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic

mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

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

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

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

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

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

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

d. An agency that is certified by the department to provide prevocational services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

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

a. An agency that is certified by the department to provide supported employment services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

c. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

d. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

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

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

77.25(10) *Provider enrollment.* A prospective provider that meets the criteria in this rule and the provider criteria of the Iowa Plan for Behavioral Health contractor must be enrolled through the Iowa Plan for Behavioral Health contractor as an approved provider of a specific component of home- and community-based habilitation services. Enrollment carries no assurance that the approved provider will receive funding. The Iowa Medicaid enterprise will enroll providers with Medicaid only when the provider is enrolled in the Iowa Plan for Behavioral Health. Payment for services will be made to a provider only when the provider is enrolled in the Iowa Plan for Behavioral Health and the provider is authorized to provide the services. This includes payments made by the Iowa Medicaid enterprise for services provided to members who are not eligible to enroll in the Iowa Plan for Behavioral Health.

a. The Iowa Plan for Behavioral Health contractor shall review compliance with standards for initial enrollment. Review of a provider may occur at any time.

b. The department or the Iowa Plan for Behavioral Health contractor may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This information may include:

(1) Current accreditations.

(2) Evaluations.

(3) Inspection reports.

(4) Reviews by regulatory and licensing agencies and associations.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13]

441—77.26(249A) Behavioral health services. The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

77.26(1) Licensed marital and family therapists (LMFT). Any person licensed by the board of behavioral science as a marital and family therapist pursuant to 645—Chapter 31 is eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

77.26(2) Licensed independent social workers (LISW). Any person licensed by the board of social work as an independent social worker pursuant to 645—Chapter 280 is eligible to participate. An independent social worker in another state is eligible to participate when duly licensed to practice in that state.

77.26(3) Licensed master social workers (LMSW).

a. A person licensed by the board of social work as a master social worker pursuant to 645—Chapter 280 is eligible to participate when the person:

(1) Holds a master's or doctoral degree as approved by the board of social work; and

(2) Provides treatment under the supervision of an independent social worker licensed pursuant to 645—Chapter 280.

b. A master social worker in another state is eligible to participate when the person:

(1) Is duly licensed to practice in that state; and

(2) Provides treatment under the supervision of an independent social worker duly licensed in that state.

77.26(4) Licensed mental health counselors (LMC). Any person licensed by the board of behavioral science as a mental health counselor pursuant to Iowa Code chapter 154D and 645—Chapter 31 is eligible to participate. A mental health counselor in another state is eligible to participate when duly licensed to practice in that state.

77.26(5) Certified alcohol and drug counselors. Any person certified by the nongovernmental Iowa board of substance abuse certification as an alcohol and drug counselor is eligible to participate.

This rule is intended to implement Iowa Code chapter 249A as amended by 2011 Iowa Acts, Senate File 233.

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

441—77.27(249A) Birth centers. Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

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

441—77.28(249A) Area education agencies. An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

77.28(1) Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

77.28(2) Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

77.28(3) Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

77.28(4) Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

- a. Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(3);
 - b. Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;
 - c. Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;
 - d. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
 - e. Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

77.28(5) Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

77.28(6) Personnel providing vision services shall be:

- a. Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;
- b. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
- c. Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

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

[ARC 1807C, IAB 1/7/15, effective 3/1/15]

441—77.29(249A) Case management provider organizations. Case management provider organizations are eligible to participate in the Medicaid program provided that they meet the standards for the populations being served. Providers shall meet the following standards:

77.29(1) Standards in 441—Chapter 24. Providers shall meet the standards in 441—Chapter 24 when they are the department of human services, a county or consortium of counties, or an agency or provider under subcontract to the department or a county or consortium of counties providing case management services to persons with mental retardation, developmental disabilities or chronic mental illness.

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

441—77.30(249A) HCBS health and disability waiver service providers. HCBS health and disability waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the member served or the parent or stepparent of a member aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A provider hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS health and disability waiver program if they meet the standards in subrule 77.30(18) and also meet the standards set forth below for the service to be provided:

77.30(1) Homemaker providers. Homemaker providers shall be agencies that are:

- a. Certified as a home health agency under Medicare, or
- b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.30(2) Home health aide providers. Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.30(3) Adult day care providers. Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.30(4) Nursing care providers. Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.30(5) Respite care providers.

a. The following agencies may provide respite services:

- (1) Home health agencies that are certified to participate in the Medicare program.
- (2) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.

(3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).

(8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(9) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

- c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

- d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver

and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.30(6) Counseling providers. Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.30(7) Consumer-directed attendant care providers. The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.30(8) Interim medical monitoring and treatment providers.

a. The following providers may provide interim medical monitoring and treatment services:

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

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.30(9) Home and vehicle modification providers. The following providers may provide home and vehicle modification:

- a. Area agencies on aging as designated in 17—4.4(231).
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
- d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.30(10) Personal emergency response system providers. Personal emergency response system providers shall be agencies that meet the conditions of participation set forth in subrule 77.33(2).

77.30(11) Home-delivered meals. The following providers may provide home-delivered meals:

- a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- d. Restaurants licensed and inspected under Iowa Code chapter 137F.
- e. Hospitals enrolled as Medicaid providers.
- f. Home health aide providers meeting the standards set forth in subrule 77.33(3).
- g. Medical equipment and supply dealers certified to participate in the Medicaid program.
- h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.30(12) Nutritional counseling. The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

- a. Hospitals enrolled as Medicaid providers.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- d. Home health agencies certified by Medicare.
- e. Independent licensed dietitians approved by an area agency on aging.

77.30(13) Financial management service. Members who elect the consumer choices option shall work with a financial institution that meets the following qualifications.

- a. The financial institution shall either:
 - (1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or
 - (2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).
- b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.
- c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.
- d. The financial institution shall enroll as a Medicaid provider.

77.30(14) Independent support brokerage. Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications.

- a. The broker must be at least 18 years of age.
- b. The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.
- c. The broker shall not provide any other paid service to the member.
- d. The broker shall not work for an individual or entity that is providing services to the member.
- e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.

f. The broker must complete independent support brokerage training approved by the department.

77.30(15) *Self-directed personal care.* Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the following requirements.

a. A business providing self-directed personal care services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing self-directed personal care services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing self-directed personal care services shall:

(1) Be at least 16 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of self-directed personal care services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(16) *Individual-directed goods and services.* Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.

a. A business providing individual-directed goods and services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing individual-directed goods and services shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of individual-directed goods and services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(17) *Self-directed community supports and employment.* Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements.

a. A business providing community supports and employment shall:

- (1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
 - (2) Have current liability and workers' compensation coverage.
 - b. An individual providing self-directed community supports and employment shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.
 - c. All personnel providing self-directed community supports and employment shall:
 - (1) Be at least 18 years of age.
 - (2) Be able to communicate successfully with the member.
 - (3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
 - (4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
 - (5) Not be the parent or stepparent of a minor child member or the spouse of a member.
 - d. The provider of self-directed community supports and employment shall:
 - (1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
 - (2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(18) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS health and disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, home-delivered meals, or personal emergency response.

a. *Definitions.*

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. *Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14]

441—77.31(249A) Occupational therapists. Occupational therapists are eligible to participate if they are licensed and in private practice independent of the administrative and professional control of an employer such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll.

77.31(1) Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.31(2) Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

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

441—77.32(249A) Hospice providers. Hospice providers are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program.

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

441—77.33(249A) HCBS elderly waiver service providers. HCBS elderly waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.33(22) and also meet the standards set forth below for the service to be provided:

77.33(1) Adult day care providers. Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.33(2) Emergency response system providers. Emergency response system providers must meet the following standards:

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

77.33(3) Home health aide providers. Home health aide providers shall be agencies certified to participate in the Medicare program as home health agencies.

77.33(4) Homemaker providers. Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.33(5) Nursing care. Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.33(6) Respite care providers.

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Camps certified by the American Camping Association.

(4) Respite providers certified under the home- and community-based services intellectual disability waiver.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.33(4).

(6) Adult day care providers that meet the conditions set forth in subrule 77.33(1).

(7) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
2. An emergency medical care release.
3. Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.
4. The consumer's medical issues, including allergies.
5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.33(7) *Chore providers.* The following providers may provide chore services:

a. Home health agencies certified under Medicare.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.

f. Community businesses that are engaged in the provision of chore services and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.33(8) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

- d. Restaurants licensed and inspected under Iowa Code chapter 137F.
- e. Hospitals enrolled as Medicaid providers.
- f. Home health aide providers meeting the standards set forth in subrule 77.33(3).
- g. Medical equipment and supply dealers certified to participate in the Medicaid program.
- h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.33(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

- a. Area agencies on aging as designated in 17—4.4(231).
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Providers eligible to participate as home and vehicle modification providers under the health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
- d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.33(10) *Mental health outreach providers.* Community mental health centers or other mental health providers accredited by the mental health and developmental disabilities commission pursuant to 441—Chapter 24 may provide mental health outreach services.

77.33(11) *Transportation providers.* The following providers may provide transportation:

- a. Area agencies on aging as designated in 17—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Regional transit agencies as recognized by the Iowa department of transportation.
- d. Rescinded IAB 3/10/99, effective 5/1/99.
- e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- f. Transportation providers contracting with the nonemergency medical transportation contractor.

77.33(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

- a. Hospitals enrolled as Medicaid providers.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- d. Home health agencies certified by Medicare.
- e. Independent licensed dietitians.

77.33(13) *Assistive device providers.* The following providers may provide assistive devices:

- a. Medicaid-enrolled medical equipment and supply dealers.
- b. Area agencies on aging as designated according to department on aging rules 17—4.4(231) and 17—4.9(231).
- c. Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.

d. Community businesses that are engaged in the provision of assistive devices and that:

- (1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and
- (2) Submit verification of current liability and workers' compensation coverage.

77.33(14) *Senior companions.* Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.

77.33(15) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

- a. An individual who contracts with the member to provide attendant care service and who is:
- (1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.33(16) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.33(17) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.33(18) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.33(19) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.33(20) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

77.33(21) *Case management providers.* A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the following standards:

a. The case management provider shall be an agency or individual that:

(1) Is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission as meeting the standards for case management services in 441—Chapter 24; or

(2) Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or

(3) Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or

(4) Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (CQL) to provide case management; or

(5) Is approved by the department on aging as meeting the standards for case management services in 17—Chapter 21; or

(6) Is authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services and that:

1. Meets the qualifications for case managers in 641—subrule 80.6(1); and

2. Provides a current IDPH local public health services contract number.

b. A case management provider shall not provide direct services to the consumer. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest. A person cannot be the first-line supervisor of both

case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:

- (1) Specific procedures to identify conflicts of interest.
- (2) Procedures to eliminate any conflict of interest that is identified.
- (3) Procedures for handling complaints of conflict of interest, including written documentation.
- c. If the case management provider organization subcontracts case management services to another entity:
 - (1) That entity must also meet the provider qualifications in this subrule; and
 - (2) The contractor is responsible for verification of compliance.

77.33(22) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS elderly waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of assistive devices, chore service, goods and services purchased under the consumer choices option, home and vehicle modification, home-delivered meals, personal emergency response, or transportation.

a. *Definitions.*

“*Major incident*” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

- (1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
 1. The staff member’s supervisor.
 2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
 3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. *Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.33(23) Assisted living on-call service. Assisted living on-call service providers shall be assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13]

441—77.34(249A) HCBS AIDS/HIV waiver service providers. HCBS AIDS/HIV waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program if they meet the standards in subrule 77.34(14) and also meet the standards set forth below for the service to be provided:

77.34(1) Counseling providers. Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.34(2) Home health aide providers. Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.34(3) Homemaker providers. Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.34(4) Nursing care providers. Nursing care providers shall be agencies which are certified to meet the standards under the Medicare program for home health agencies.

77.34(5) Respite care providers.

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals enrolled as providers in the Iowa Medicaid program.

(3) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.34(3).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.34(7).

(8) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.34(6) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Home health aide providers meeting the standards set forth in subrule 77.34(2).

b. Home care providers meeting the standards set forth in subrule 77.34(3).

c. Hospitals enrolled as Medicaid providers.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Restaurants licensed and inspected under Iowa Code chapter 137F.

f. Community action agencies as designated in Iowa Code section 216A.93. Home-delivered meals providers subcontracting with community action agencies or with letters of approval from the community action agencies stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

g. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

h. Medical equipment and supply dealers certified to participate in the Medicaid program.

77.34(7) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.34(8) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.34(9) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.34(10) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.34(11) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.34(12) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.34(13) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

77.34(14) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or to home-delivered meals.

a. *Definitions.*

“*Major incident*” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
 2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.
 - (3) The following information shall be reported:
 1. The name of the consumer involved.
 2. The date and time the incident occurred.
 3. A description of the incident.
 4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
 5. The action that the provider staff took to manage the incident.
 6. The resolution of or follow-up to the incident.
 7. The date the report is made and the handwritten or electronic signature of the person making the report.
 - (4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.
- d. *Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 1149C, IAB 10/30/13, effective 1/1/14]

441—77.35(249A) Federally qualified health centers. Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of their eligibility as allowed by Section 6404(b) of Public Law 101-239.

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

441—77.36(249A) Advanced registered nurse practitioners. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to board of nursing rules 655—Chapter 7.

77.36(1) Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with board of nursing rules 655—Chapter 7.

77.36(2) Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

77.36(3) Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

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

441—77.37(249A) Home- and community-based services intellectual disability waiver service providers. Providers shall be eligible to participate in the Medicaid HCBS intellectual disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service.

The standards in subrule 77.37(1) apply only to providers of supported employment, respite providers certified according to subparagraph 77.37(15) "a"(8), and providers of supported community living services that are not residential-based. The standards and certification processes in subrules

77.37(2) through 77.37(7) and 77.37(9) through 77.37(12) apply only to supported employment providers and non-residential-based supported community living providers.

The requirements in subrule 77.37(13) apply to all providers. EXCEPTION: A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the review requirements in subrule 77.37(13). Also, services must be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

77.37(1) Organizational standards (Outcome 1). Organizational outcome-based standards for home- and community-based services intellectual disability providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumer's needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve.

These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.37(2) Rights and dignity. Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

- b. (Outcome 3) Consumers live in positive environments.
- c. (Outcome 4) Consumers work in positive environments.
- d. (Outcome 5) Consumers exercise their rights and responsibilities.
- e. (Outcome 6) Consumers have privacy.
- f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.
- g. (Outcome 8) Consumers decide which personal information is shared and with whom.
- h. (Outcome 9) Consumers make informed choices about where they work.
- i. (Outcome 10) Consumers make informed choices on how they spend their free time.
- j. (Outcome 11) Consumers make informed choices about where and with whom they live.
- k. (Outcome 12) Consumers choose their daily routine.
- l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
- m. (Outcome 14) Consumers have a social network and varied relationships.
- n. (Outcome 15) Consumers develop and accomplish personal goals.
- o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.
- p. (Outcome 17) Consumers maintain good health.
- q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.
- r. (Outcome 19) The consumer's desire for intimacy is respected and supported.
- s. (Outcome 20) Consumers have an impact on the services they receive.

77.37(3) Contracts with consumers. The provider shall have written procedures which provide for the establishment of an agreement between the consumer and the provider.

a. The agreement shall define the responsibilities of the provider and the consumer, the rights of the consumer, the services to be provided to the consumer by the provider, all room and board and copay fees to be charged to the consumer and the sources of payment.

b. Contracts shall be reviewed at least annually.

77.37(4) The right to appeal. Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.37(5) Storage and provision of medication. If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

If the provider has a physician on staff or under contract, the physician shall review and document the provider's prescribed medication regime at least annually in accordance with current medical practice.

77.37(6) Research. If the provider conducts research involving human subjects, the provider shall have written policies and procedures for research which ensure the rights of consumers and staff.

77.37(7) Abuse reporting requirements. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

77.37(8) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS intellectual disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. *Definitions.*

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"*Minor incident*" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff consumer's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until

the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. *Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.37(9) Intake, admission, service coordination, discharge, and referral.

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral. Service coordination means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

b. The provider shall ensure the rights of persons applying for services.

77.37(10) Certification process. Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.37(11) Initial certification. The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable region and other interested parties.

(4) The prospective provider's written agreement to work cooperatively with the state, counties and regions to be served by the provider.

c. Providers applying for initial certification shall be offered technical assistance.

77.37(12) Period of certification. Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and

significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.37(1) and 77.37(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) Three-year certification with excellence. An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) Three-year certification with follow-up monitoring. An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together are 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) One-year certification. An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) Probational certification. A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended, and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the

notification shall not be certified. The department shall be notified immediately to discontinue funding for that provider's service. If a member is in immediate jeopardy, the case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)"e."

(2) The provider has failed to provide information requested pursuant to paragraph 77.37(13)"f."

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)"h."

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from a home- and community-based services intellectual disability waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.37(13) Review of providers. Reviews of compliance with standards as indicated in this chapter shall be conducted by designated members of the HCBS staff.

a. This review may include on-site case record audits; review of administrative procedures, clinical practices, personnel records, performance improvement systems and documentation; and interviews with staff, consumers, the board of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

b. A review visit shall be scheduled with the provider with additional reviews conducted at the discretion of the department.

c. The on-site review team will consist of designated members of the HCBS staff.

d. Following a certification review, the certification review team leader shall submit a copy of the department's written report of findings to the provider within 30 working days after completion of the certification review.

e. The provider shall develop a plan of corrective action, if applicable, identifying completion time frames for each review recommendation.

f. Providers required to make corrective actions and improvements shall submit the corrective action and improvement plan to the Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 30 working days after the receipt of a report issued as a result of the review team's visit. The corrective actions may include: specific problem areas cited, corrective actions to be

implemented by the provider, dates by which each corrective measure will be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

g. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to 77.37(13) "e" and 77.37(13) "f."

h. The department may conduct a site visit to verify all or part of the information submitted.

77.37(14) Supported community living providers.

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

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. All supported community living providers shall meet the following requirements:

(1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification. These timelines shall include:

1. Implementation of necessary staff training and consumer input.

2. Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.

(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.

e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.37(15) Respite care providers.

a. The following agencies may provide respite services:

(1) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

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

(5) Camps certified by the American Camping Association.

(6) Adult day care providers that meet the conditions of participation set forth in subrule 77.37(25).

(7) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(8) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of 77.37(1) and 77.37(3) through 77.37(9).

- (9) Assisted living programs certified by the department of inspections and appeals.
- b. Respite providers shall meet the following conditions:
- (1) Providers shall maintain the following information that shall be updated at least annually:
1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
 2. An emergency medical care release.
 3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
 4. The consumer's medical issues, including allergies.
 5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

- c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

- d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.37(16) Supported employment providers.

a. The following agencies may provide supported employment services:

- (1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service.

- (2) An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

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

- (4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

- (5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Member vacation, sick leave and holiday compensation.

- (2) Procedures for payment schedules and pay scale.

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

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

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

77.37(17) Home and vehicle modification providers. The following providers may provide home and vehicle modification:

a. Providers certified to participate as supported community living service providers under the home- and community-based services intellectual disability or brain injury waiver.

b. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

c. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.37(18) Personal emergency response system providers. Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2) to maintain certification.

77.37(19) Nursing providers. Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.37(20) Home health aide providers. Home health aide providers shall be agencies which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

77.37(21) Consumer-directed attendant care providers. The following providers may provide consumer-directed attendant care service:

- a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.37(22) Interim medical monitoring and treatment providers.

- a. The following providers may provide interim medical monitoring and treatment services:

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

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.37(23) Residential-based supported community living service providers.

a. The department shall contract only with public or private agencies to provide residential-based supported community living services.

b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:

(1) Agencies licensed as group living foster care facilities under 441—Chapter 114.

(2) Agencies licensed as residential facilities for mentally retarded children under 441—Chapter 116.

(3) Other agencies providing residential-based supported community living services that meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's mental retardation and developmental disabilities services and children's mental health issues. Identification and reporting of child abuse shall be covered in training at least every five years, in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

• Children, their families, and their legal representatives decide what personal information is shared and with whom.

- Children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.
- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.
- Current functioning is evaluated.
- Plans are made for the future based on the review and evaluation.

4. The agency must have a governing body that receives and uses input from a wide range of local community interests and consumer representatives and provides oversight that ensures the provision of high-quality supports and services to children.

5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the consumer. The service provider shall distribute the policies for consumer appeals and procedures to children, their parents, and their legal representatives.

c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:

- (1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.
 - (2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.
 - (3) The provider's written agreement to work cooperatively with the department.
 - d. As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child, as follows:
 - (1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.
 - (2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.
 - (3) The service plan shall identify the following:
 1. Strengths and needs of the child.
 2. Goals to be achieved to meet the needs of the child.
 3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.
 4. Specific service activities to be provided to achieve the objectives.
 5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.
 6. Date of service initiation and date of individual service plan development.
 7. Service goals describing how the child will be reunited with the child's family and community.
 - (4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.
 - (5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.
- At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.
- (6) The individual service plan shall be revised when any of the following occur:
 1. Service goals or objectives have been achieved.
 2. Progress toward goals and objectives is not being made.
 3. Changes have occurred in the identified service needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.
 4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.
 - (7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.
 - (8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.
 - e. The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

- (1) Rescinded IAB 8/7/02, effective 10/1/02.
- (2) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.
- (3) The provider supplies the bureau of long-term care with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:
 1. How the transition will occur.
 2. What physical change will need to take place in the living units.
 3. How children and their families will be involved in the transitioning process.
 4. How this transition will affect children's social and educational environment.
 - f. Certification process and review of service providers.
- (1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.37(10).
- (2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.37(11).
- (3) Period and conditions of certification.
 1. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.
 2. Recertification. After the initial certification, recertification shall be based on an on-site review and shall be contingent upon demonstration of compliance with certification requirements.
An exit conference shall be held with the provider to share preliminary findings of the recertification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.
Recertification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate one year from the month of issuance.
Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.
3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification review to give the provider time to establish and implement corrective actions and improvement activities.
During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.
Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.
4. Immediate jeopardy. If, during the course of any review, a review team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.
The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider shall not be certified. The department shall immediately discontinue funding for that provider's service. If this action is appealed and the member or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk. The case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.
5. Abuse reporting. As a mandatory reporter, each review team member shall follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department shall establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department's approval decision exists which is beyond the control of the provider or department.
- A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

- The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13) "e" and numbered paragraph 77.37(23) "f"(3)"4."
- The provider has failed to provide information requested pursuant to paragraph 77.37(13) "f" and numbered paragraph 77.37(23) "f"(3)"4."
- The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13) "h" and subparagraph 77.37(23) "f"(3).
- There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

(4) Providers of residential-based supported community living services shall be subject to reviews of compliance with program requirements pursuant to subrule 77.37(13).

77.37(24) *Transportation service providers.* The following providers may provide transportation:

- a. Accredited providers of home- and community-based services.
- b. Regional transit agencies as recognized by the Iowa department of transportation.
- c. Transportation providers that contract with county governments.
- d. Community action agencies as designated in Iowa Code section 216A.93.
- e. Nursing facilities licensed under Iowa Code chapter 135C.
- f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.

g. Transportation providers contracting with the nonemergency medical transportation contractor.

77.37(25) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.37(26) *Prevocational services providers.* Providers of prevocational services must be accredited by one of the following:

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

77.37(27) *Day habilitation providers.* Day habilitation services may be provided by:

- a. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.41(14).
- b. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services that began providing services that qualify as day habilitation under 441—subrule 78.41(14) since their last accreditation survey. The agency may provide day habilitation services until the current

accreditation expires. When the current accreditation expires, the agency must qualify under paragraph "a" or "d."

c. Agencies not accredited by the Commission on Accreditation of Rehabilitation Facilities that have applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.41(14). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. Agencies accredited by the Council on Quality and Leadership.

e. Agencies that have applied to the Council on Quality and Leadership for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

77.37(28) Financial management service. Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.37(29) Independent support brokerage. Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.37(30) Self-directed personal care. Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.37(31) Individual-directed goods and services. Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.37(32) Self-directed community supports and employment. Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14]

441—77.38(249A) Assertive community treatment. Services in the assertive community treatment (ACT) program shall be rendered by a multidisciplinary team composed of practitioners from the disciplines described in this rule. The team shall be under the clinical supervision of a psychiatrist. The program shall designate an individual team member who shall be responsible for administration of the program, including authority to sign documents and receive payment on behalf of the program.

77.38(1) Minimum composition. At a minimum, the team shall consist of a nurse, a mental health service provider, and a substance abuse treatment professional.

77.38(2) Psychiatrists. A psychiatrist on the team shall be a physician (MD or DO) who:

- a. Is licensed under 653—Chapter 9,
- b. Is certified as a psychiatrist by the American Board of Medical Specialties' Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry, and
- c. Has experience treating serious and persistent mental illness.

77.38(3) Registered nurses. A nurse on the team shall:

- a. Be licensed as a registered nurse under 655—Chapter 3, and
- b. Have experience treating persons with serious and persistent mental illness.

77.38(4) Mental health service providers. A mental health service provider on the team shall be:

- a. A mental health counselor or marital and family therapist who:
 - (1) Is licensed under 645—Chapter 31, and
 - (2) Has experience treating persons with serious and persistent mental illness; or
- b. A social worker who:
 - (1) Is licensed as a master or independent social worker under 645—Chapter 280, and
 - (2) Has experience treating persons with serious and persistent mental illness.

77.38(5) Psychologists. A psychologist on the team shall:

- a. Be licensed under 645—Chapter 240, and
- b. Have experience treating persons with serious and persistent mental illness.

77.38(6) Substance abuse treatment professionals. A substance abuse treatment professional on the team shall:

- a. Be an appropriately credentialed counselor pursuant to 641—paragraph 155.21(8) “i,” and
- b. Have at least three years of experience treating substance abuse.

77.38(7) Peer specialists. A peer specialist on the team shall be a person with serious and persistent mental illness who has met all requirements of a nationally standardized peer support training program, including at least 30 hours of training and satisfactory completion of an examination.

77.38(8) Community support specialists. A community support specialist on the team shall be a person who:

- a. Has a bachelor’s degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services), and
- b. Has experience supporting persons with serious and persistent mental illness.

77.38(9) Case managers. A case manager on the team shall be a person who:

- a. Has a bachelor’s degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services),
- b. Has experience managing care for persons with serious and persistent mental illness, and
- c. Meets the qualifications of “qualified case managers and supervisors” in rule 441—24.1(225C).

77.38(10) Advanced registered nurse practitioners. An advanced registered nurse practitioner on the team shall:

- a. Be licensed under 655—Chapter 7,
- b. Have a mental health certification, and
- c. Have experience treating serious and persistent mental illness.

77.38(11) Physician assistants. A physician assistant on the team shall:

- a. Be licensed under 645—Chapter 326,
- b. Have experience treating persons with serious and persistent mental illness, and
- c. Practice under the supervision of a psychiatrist.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—77.39(249A) HCBS brain injury waiver service providers. Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department’s brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

77.39(1) Organizational standards (Outcome 1). Organizational outcome-based standards for HCBS BI providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.39(2) Rights and dignity. Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.

h. (Outcome 9) Consumers make informed choices about where they work.

i. (Outcome 10) Consumers make informed choices on how they spend their free time.

- j. (Outcome 11) Consumers make informed choices about where and with whom they live.
- k. (Outcome 12) Consumers choose their daily routine.
- l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
- m. (Outcome 14) Consumers have a social network and varied relationships.
- n. (Outcome 15) Consumers develop and accomplish personal goals.
- o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.
- p. (Outcome 17) Consumers maintain good health.
- q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.
- r. (Outcome 19) The consumer's desire for intimacy is respected and supported.
- s. (Outcome 20) Consumers have an impact on the services they receive.

77.39(3) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.39(4) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

77.39(5) *Research.* If the provider conducts research involving consumers, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that consumers' rights are protected.

77.39(6) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS brain injury waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. *Definitions.*

"*Major incident*" means an occurrence involving a consumer during service provision that:

- 1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
- 2. Results in the death of any person;
- 3. Requires emergency mental health treatment for the consumer;
- 4. Requires the intervention of law enforcement;
- 5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
- 6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
- 7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"*Minor incident*" means an occurrence involving a consumer during service provision that is not a major incident and that:

- 1. Results in the application of basic first aid;
- 2. Results in bruising;
- 3. Results in seizure activity;
- 4. Results in injury to self, to others, or to property; or
- 5. Constitutes a prescription medication error.

b. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's

supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. *Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.39(7) Intake, admission, service coordination, discharge, and referral.

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

b. The provider shall ensure the rights of persons applying for services.

77.39(8) Certification process. Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

- (2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.39(9) Initial certification. The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

c. Providers applying for initial certification shall be offered technical assistance.

77.39(10) Period of certification. Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.39(1) and 77.39(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department shall immediately discontinue funding for that provider's service.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.39(11) "d."

(2) The provider has failed to provide information requested pursuant to paragraph 77.39(11) "e."

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.39(11) "f."

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.39(11) Departmental reviews. Reviews of compliance with standards as indicated in this chapter shall be conducted by the division of mental health and developmental disabilities quality assurance review staff. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, consumers, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews shall be conducted annually with additional reviews conducted at the discretion of the department.

b. Following a departmental review, the department shall submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

c. The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

d. The corrective action plan shall be submitted to the Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114, and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

e. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.39(11) "c" and "d."

f. The department may conduct a site visit to verify all or part of the information submitted.

77.39(12) Case management service providers. Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

77.39(13) Supported community living providers.

a. The department shall certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.

d. The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.

(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.

e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.39(14) Respite service providers. Respite providers are eligible to be providers of respite service in the HCBS brain injury waiver if they have documented training or experience with persons with a brain injury.

a. The following agencies may provide respite services:

- (1) Respite providers certified under the HCBS intellectual disability waiver.
- (2) Adult day care providers that meet the conditions of participation set forth in subrule 77.39(20).
- (3) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
- (4) Camps certified by the American Camping Association.
- (5) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
- (6) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(7) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(8) Home health agencies that are certified to participate in the Medicare program.

(9) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).

(10) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually:
 1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
 2. An emergency medical care release.
 3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
 4. The consumer's medical issues, including allergies.
 5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.
- (2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.39(15) Supported employment providers.

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

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

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Member vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

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

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

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

77.39(16) Home and vehicle modification providers. The following providers may provide home and vehicle modification:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.39(17) Personal emergency response system providers. Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

a. Providers shall be certified annually.

b. The service provider shall submit documentation to the department supporting continued compliance with the requirements set forth in subrule 77.33(2) 90 days before the expiration of the current certification.

77.39(18) Transportation service providers. This service is not to be provided at the same time as supported community service, which includes transportation. The following providers may provide transportation:

a. Area agencies on aging as designated in rule 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Providers with purchase of service contracts to provide transportation pursuant to 441—Chapter 150.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation contractor.

77.39(19) Specialized medical equipment providers. The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.43(8).

77.39(20) Adult day care providers. Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.39(21) Family counseling and training providers. Family counseling and training providers shall be one of the following:

a. Providers certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

b. Providers licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

c. Providers accredited under the mental health service provider standards established by the mental health and developmental and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

d. Individuals who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

e. Agencies certified as brain injury waiver providers pursuant to rule 441—77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441—83.81(249A).

77.39(22) Prevocational services providers. Providers of prevocational services must meet the Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers.

77.39(23) Behavioral programming providers. Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements.

a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441—83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of one of the following:

(1) Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

(2) Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

(3) Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

(4) Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) Brain injury waiver providers certified pursuant to rule 441—77.39(249A).

77.39(24) Consumer-directed attendant care providers. The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

- (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
 - (3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
 - (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
 - b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.
 - c. Home health agencies which are certified to participate in the Medicare program.
 - d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
 - e. Community action agencies as designated in Iowa Code section 216A.93.
 - f. Providers certified under an HCBS waiver for supported community living.
 - g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.
 - h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.39(25) *Interim medical monitoring and treatment providers.*

- a. The following providers may provide interim medical monitoring and treatment services:
 - (1) Home health agencies certified to participate in the Medicare program.
 - (2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).
- b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:
 - (1) Be at least 18 years of age.
 - (2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.
 - (3) Not be a usual caregiver of the member.
 - (4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.
- c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.39(26) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.39(27) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.39(28) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.39(29) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.39(30) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 1638C, IAB 10/1/14, effective 11/5/14]

441—77.40(249A) Lead inspection agencies. The Iowa department of public health and agencies certified by the Iowa department of public health pursuant to 641—subrule 70.5(5) are eligible to participate in the Medicaid program as providers of lead inspection services.

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

441—77.41(249A) HCBS physical disability waiver service providers. Providers shall be eligible to participate in the Medicaid physical disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the requirements of subrule 77.41(1).

77.41(1) Enrollment process. Reviews of compliance with standards for initial enrollment shall be conducted by the department's quality assurance staff. Enrollment carries no assurance that the approved provider will receive funding.

Review of a provider may occur at any time.

The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include, but is not limited to:

- a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.
- b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.41(2) Consumer-directed attendant care providers. The following providers may provide consumer-directed attendant care service:

- a. An individual who contracts with the member to provide consumer-directed attendant care and who is:
 - (1) At least 18 years of age.
 - (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
 - (3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
 - (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.
- c. Home health agencies that are certified to participate in the Medicare program.
- d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
- e. Community action agencies as designated in Iowa Code section 216A.103.
- f. Providers certified under an HCBS waiver for supported community living.
- g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.
- h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.41(3) Home and vehicle modification providers. The following providers may provide home and vehicle modifications:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.41(4) Personal emergency response system providers. Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

77.41(5) Specialized medical equipment providers. The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.46(4).

77.41(6) Transportation service providers. The following providers may provide transportation:

a. Area agencies on aging as designated in 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Transportation providers contracting with the nonemergency medical transportation contractor.

77.41(7) Financial management service. Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.41(8) Independent support brokerage. Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.41(9) Self-directed personal care. Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.41(10) Individual-directed goods and services. Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.41(11) Self-directed community supports and employment. Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the subrule requirements in 77.30(17).

77.41(12) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, specialized medical equipment, personal emergency response, and transportation.

a. *Definitions.*

“Major incident” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or

7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.

2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.

3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

- (3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13]

441—77.42(249A) Public health agencies. Public health agencies are eligible to participate in the medical assistance program when they serve as a public health entity within the local board of health jurisdiction pursuant to 641—subrule 77.3(3).

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0358C, IAB 10/3/12, effective 11/7/12]

441—77.43(249A) Infant and toddler program providers. An agency is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the agency:

1. Is in good standing under the infants and toddlers with disabilities program administered by the department of education, the department of public health, the department of human services, and the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA); and

2. Meets the following additional requirements.

77.43(1) Licensure. Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

- h. Medical transportation shall be provided by licensed drivers.
- i. Other services shall be provided by staff who are:
 - (1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);
 - (2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
 - (3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);
 - (4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);
 - (5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);
 - (6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);
 - (7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);
 - (8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);
 - (9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or
 - (10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.43(2) Documentation requirements. As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

- a. Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.
- b. An assessment and response to interventions and services.
- c. An individual family service plan (IFSP) including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.5(256B,34CFR300).
- d. Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the individual family service plan (IFSP).

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

441—77.44(249A) Local education agency services providers. School districts accredited by the department of education pursuant to 281—Chapter 12, the Iowa Braille and Sight Saving School governed by the state board of regents pursuant to Iowa Code section 262.7(4), and the State School for the Deaf governed by the state board of regents pursuant to Iowa Code section 262.7(5) are eligible to participate in the medical assistance program as providers of local education agency (LEA) services under rule 441—78.50(249A) if the following conditions are met.

77.44(1) Licensure. Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

- a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.
- b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.
- c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.
- d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

- (1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
 - (2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;
 - (3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;
 - (4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
 - (5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.
 - e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.
 - f. Personnel providing vision services shall be:
 - (1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;
 - (2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
 - (3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.
 - g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).
 - h. Medical transportation shall be provided by licensed drivers.
 - i. Other services shall be provided by staff who are:
 - (1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);
 - (2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
 - (3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);
 - (4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);
 - (5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);
 - (6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);
 - (7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);
 - (8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);
 - (9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or
 - (10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.44(2) Documentation requirements. As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

- a. Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.
- b. An assessment and response to interventions and services.
- c. Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

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

441—77.45(249A) Indian health service 638 facilities. A health care facility owned and operated by American Indian or Alaskan native tribes or tribal organizations with funding authorized by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638) is eligible to participate in the medical assistance program if the following conditions are met:

77.45(1) Licensure. Services must be rendered by practitioners who meet applicable professional licensure requirements.

77.45(2) Documentation. Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

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

441—77.46(249A) HCBS children's mental health waiver service providers. HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.46(1) and also meet the standards in subrules 77.46(2) to 77.46(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

77.46(1) General provider standards. All providers of HCBS children's mental health waiver services shall meet the following standards:

a. *Fiscal capacity.* Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

b. *Direct care staff.*

(1) Direct care staff must be at least 18 years of age.

(2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the consumer or the parent or stepparent of the consumer.

c. *Outcome-based standards and quality assurance.*

(1) Providers shall implement the following outcome-based standards for the rights and dignity of children with serious emotional disturbance:

1. Consumers are valued.
2. Consumers are a part of community life.
3. Consumers develop meaningful goals.
4. Consumers maintain physical and mental health.
5. Consumers are safe.
6. Consumers and their families have an impact on the services received.

(2) The department's quality assurance staff shall conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review shall include interviews with the consumer and the consumer's parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.

(5) Corrective action shall be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action shall be available from the department's quality assurance staff.

d. *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS children's mental health waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and must comply with the following incident management and reporting requirements. EXCEPTION:

The conditions in this paragraph do not apply to providers of environmental modifications and adaptive devices.

(1) Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

(2) Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(3) Notification procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident, the staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(4) Reporting procedure for major incidents. By the end of the next calendar day after a major incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(5) Information to be reported. The following information shall be reported about a major incident:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(6) Response to report. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about a major incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(7) Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.46(2) Environmental modifications, adaptive devices, and therapeutic resources providers. The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children's mental health waiver:

a. A community business that:

(1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and

(2) Submits verification of current liability and workers' compensation insurance.

b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.

c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.

d. A provider enrolled under the HCBS home- and community-based services intellectual disability or brain injury waiver as a supported community living provider.

e. A provider enrolled under the HCBS children's mental health waiver as a family and community support services provider.

77.46(3) Family and community support services providers.

a. *Qualified providers.* The following agencies may provide family and community support services under the children's mental health waiver:

(1) Behavioral health intervention providers qualified under 441—77.12(249A).

(2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. *Staff training.* The agency shall meet the following training requirements as a condition of providing family and community support services under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.36(1)"c" for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. *Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

d. *Intake, admission, and discharge.* As a condition of providing services under the children's mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

77.46(4) In-home family therapy providers.

a. *Qualified providers.* The following agencies may provide in-home family therapy under the children's mental health waiver:

(1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

(2) Mental health professionals licensed pursuant to 645—Chapter 31, 240, or 280 or possessing an equivalent license in another state.

b. *Staff training.* The agency shall meet the following training requirements as a condition of providing in-home family therapy under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.46(1)"c" for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and service provision to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. *Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in

441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

d. *Intake, admission, and discharge.* As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

77.46(5) Respite care providers.

a. *Qualified providers.* The following agencies may provide respite services under the children's mental health waiver:

(1) Providers certified or enrolled as respite providers under another Medicaid HCBS waiver.

(2) Group living foster care facilities for children licensed in good standing by the department according to 441—Chapters 112 and 114 to 116.

(3) Camps certified in good standing by the American Camping Association.

(4) Home health agencies that are certified in good standing to participate in the Medicare program.

(5) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(6) Adult day care providers that are certified in good standing by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

(7) Assisted living programs certified in good standing by the department of inspections and appeals.

(8) Residential care facilities for persons with mental retardation licensed in good standing by the department of inspections and appeals.

(9) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

b. *Staff training.* The agency shall meet the following training requirements as a condition of providing respite care under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1) "c."

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. *Consumer-specific information.* The following information must be written, current, and accessible to the respite provider during service provision:

(1) The consumer's legal and preferred name, birth date, and age, and the address and telephone number of the consumer's usual residence.

(2) The consumer's typical schedule.

(3) The consumer's preferences in activities and foods or any other special concerns.

(4) The consumer's crisis intervention plan.

d. *Written notification of injury.* The respite provider shall inform the parent, guardian or usual caregiver that written notification must be given to the respite provider of any recent injuries or illnesses that have occurred before respite provision.

e. *Medication dispensing.* Respite providers shall develop policies and procedures for the dispensing, storage, and recording of all prescription and nonprescription medications administered during respite provision. Home health agencies must follow Medicare regulations regarding medication dispensing.

f. *Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, a respite provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

g. *Service documentation.* Documentation of respite care shall be made available to the consumer, parents, guardian, or usual caregiver upon request.

h. *Capacity.* A facility providing respite care under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in a location and for a duration consistent with the facility's licensure.

i. *Service provided outside home or facility.* For respite care to be provided in a location other than the consumer's home or the provider's facility:

(1) The care must be approved by the parent, guardian or usual caregiver;

(2) The care must be approved by the interdisciplinary team in the consumer's service plan;

(3) The care must be consistent with the way the location is used by the general public; and

(4) Respite care in these locations shall not exceed 72 continuous hours.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 1149C, IAB 10/30/13, effective 1/1/14]

441—77.47(249A) Health home services providers. Subject to the requirements of this rule, a designated provider may participate in the medical assistance program as a provider of health home services.

77.47(1) Qualifications. A designated provider of health home services must be a Medicaid-enrolled entity or provider that is determined through the provider enrollment process to have the systems and infrastructure in place to provide health home services.

a. *Staffing.* At a minimum, a qualifying provider must fill the following roles:

- (1) Designated practitioner.
- (2) Dedicated care coordinator.
- (3) Health coach.
- (4) Clinic support staff.

b. *Data management.* A qualifying provider shall ensure that all clinical data related to the member are maintained with the member's medical records through the use of health information technology.

c. *Collaboration with case managers.* Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2) "a"(1) or (2) must collaborate, at least quarterly, with targeted case managers, other case managers, or DHS service workers for each member receiving case management services. Strategies to prevent duplication of coordination efforts by the health home and case managers or service workers must be developed by the health home and documented upon request. Documentation may include but is not limited to records of joint staffing meetings where a member's medical needs, current activities, and waiver services needs are reviewed and appropriately updated.

d. *Provision of integrated health home services.* Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2) "a"(3) or (4) must be integrated health homes that:

- (1) Consist of a team of health care professionals trained in providing health home services to members with a serious mental illness (SMI) and to members with a serious emotional disturbance (SED);
- (2) Have a direct agreement with the Iowa Medicaid managed behavioral health organization to provide health home services for members with SMI or SED;
- (3) Coordinate all community and social support services needs for members enrolled in the health home; and
- (4) Follow a system of care model in providing health home services to members with SED, including collaboration with the child welfare, public health, juvenile justice, and education systems.

77.47(2) Report on quality measures. As a condition of participation in the medical assistance program as a provider of health home services and of receiving payment for health home services provided, a designated provider must report to the Iowa Medicaid enterprise on measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the Iowa Medicaid enterprise with such information.

77.47(3) Selection. As a condition of payment for health home services provided to a Medicaid member eligible to receive such services pursuant to 441—subrule 78.53(2), a designated provider must be selected by the member as the member's health home, as reported by provider attestation.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

441—77.48(249A) Speech-language pathologists. Speech-language pathologists who are enrolled in the Medicare program are eligible to participate in Medicaid. Speech-language pathologists who are not enrolled in the Medicare program are eligible to participate in Medicaid if they are licensed and in independent practice, as an individual or as a group.

77.48(1) Speech-language pathologists in another state are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.48(2) Speech-language pathologists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158.
[ARC 0360C, IAB 10/3/12, effective 12/1/12]

441—77.49(249A) Physician assistants. All physician assistants licensed to practice in the state of Iowa are eligible for participation in the program. Physician assistants duly licensed to practice in other states are also eligible for participation. Enrollment is for the purpose of providing professional services for Medicaid members including orders and referrals, as required under Public Law 111-148, Section 6401, otherwise known as the Patient Protection and Affordable Care Act (PPACA). Enrollment will not affect the provider's payment arrangements with facilities or supervising providers.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0580C, IAB 2/6/13, effective 4/1/13]

441—77.50(249A) Ordering and referring providers. A provider who provides services, including orders and referrals, to a Medicaid member shall be enrolled as a Medicaid provider as a condition of payment eligibility for services rendered to that Medicaid member. A provider who does not individually bill for services rendered due to, for example, payment arrangements with a facility or supervising provider, shall also be required to enroll. Enrollment will be for the purpose of ordering or referring items and providing professional services to Medicaid members and will not affect the provider's payment arrangements with such facilities or supervising providers.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0580C, IAB 2/6/13, effective 4/1/13]

441—77.51(249A) Accountable care organizations. Subject to the requirements of this rule, a designated provider may participate in the medical assistance program as an accountable care organization (ACO).

77.51(1) ACO qualifications. ACO entities must meet the following requirements for participation as an ACO:

a. An ACO must be a Medicaid-enrolled provider. An ACO must complete enrollment in accordance with rule 441—79.14(249A).

b. The ACO shall execute a provider participation agreement in accordance with rule 441—79.6(249A).

c. An ACO must complete Form 470-5264, Iowa Wellness Plan ACO Readiness Application. The department reserves the right to approve the application.

d. The department and ACO shall enter into an agreement on Form 470-5218, Iowa Medicaid Accountable Care Organization (ACO) Agreement. The ACO shall comply with all requirements as identified in Form 470-5218.

e. The department reserves the right to restrict ACO enrollment so that the mixture of enrolled ACOs best matches the needs of the Medicaid member population.

77.51(2) Member selection. Medicaid members eligible for services from providers attributed to an ACO shall be required to choose their providers in accordance with 441—subrules 88.3(2) and 88.3(7).

This rule is intended to implement Iowa Code section 249A.4.
[ARC 1698C, IAB 10/29/14, effective 1/1/15]

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¹ December 15, 2002, effective date of 77.37(14) "e"(2) and 77.39(13) "e" delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.

CHAPTER 78
AMOUNT, DURATION AND SCOPE OF
MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]
[Prior to 2/11/87, Human Services[498]]

441—78.1(249A) Physicians' services. Payment will be approved for all medically necessary services and supplies provided by the physician including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment shall be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health.

- b. Routine physical examinations. Rescinded IAB 8/1/07, effective 8/1/07.
- c. Treatment of certain foot conditions as specified in 78.5(2) "a," "b," and "c."
- d. Acupuncture treatments.
- e. Rescinded 9/6/78.

f. Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program shall be utilized in determining when a given procedure is unproven or experimental in nature.

g. Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by the 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."

- h. Elective, non-medically necessary cesarean section (C-section) deliveries.

78.1(2) Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

a. Drugs are covered as provided by rule 441—78.2(249A).
b. Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

- (1) Colostomy and ileostomy appliances.
- (2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.
- (3) Disposable irrigation trays or sets.
- (4) Disposable catheterization trays or sets.
- (5) Indwelling Foley catheter.
- (6) Disposable saline enemas.
- (7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. Rescinded IAB 1/30/08, effective 4/1/08.

e. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a physician must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

f. Nonprescription drugs. Rescinded IAB 1/30/08, effective 4/1/08.

78.1(3) Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug is not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury. When injecting an amphetamine or legend vitamin, prior approval must be obtained as specified in 78.1(2) "a"(3).

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment for vaccines available through the Vaccines for Children (VFC) Program will be approved only if the VFC program stock has been depleted.

g. Payment will not be approved for injections of "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

78.1(4) For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

- (1) Correction of a congenital anomaly; or
- (2) Restoration of body form following an accidental injury; or
- (3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

- (1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program. This list is for example purposes only and is not considered all inclusive.

(1) Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

78.1(5) The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 78.10(249A).

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 441—78.15(249A).

78.1(7) No payment shall be made for the services of a private duty nurse.

78.1(8) Payment for mileage shall be the same as that in effect in part B of Medicare.

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

b. When only one patient is seen in a single visit the allowance shall be based on a follow-up home visit. When more than one patient is seen in a single visit, payment shall be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

c. Payment will be approved for mileage in connection with nursing home visits when:

- (1) It is necessary for the physician to travel outside the home community, and
- (2) There are not physicians in the community in which the nursing home is located.

d. Payment will be approved for tasks related to a resident receiving nursing facility care which are performed by a physician's employee who is a nurse practitioner, clinical nurse specialist, or physician assistant as specified in 441—paragraph 81.13(13)“e.” On-site supervision of the physician is not required for these services.

78.1(10) Payment will be approved in independent laboratory when it has been certified as eligible to participate in Medicare.

78.1(11) Rescinded, effective 8/1/87.

78.1(12) Payment will be made on the same basis as in Medicare for services associated with treatment of chronic renal disease including physician's services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis. Payment will be made for deductibles and coinsurance for those persons eligible for Medicare.

78.1(13) Payment will be made to the physician for services rendered by auxiliary personnel employed by the physician and working under the direct personal supervision of the physician, when such services are performed incident to the physician's professional service.

a. Auxiliary personnel are nurses, physician's assistants, psychologists, social workers, audiologists, occupational therapists and physical therapists.

b. An auxiliary person is considered to be an employee of the physician if the physician:

- (1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.
- (2) Sets work standards.
- (3) Establishes job description.
- (4) Withholds taxes from the wages of the auxiliary personnel.

c. Direct personal supervision in the office setting means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

Direct personal supervision outside the office setting, such as the member's home, hospital, emergency room, or nursing facility, means the physician must be present in the same room as the auxiliary person.

Advanced registered nurse practitioners certified under board of nursing rules 655—Chapter 7 performing services within their scope of practice are exempt from the direct personal supervision requirement for the purpose of reimbursement to the employing physicians. In these exempted circumstances, the employing physicians must still provide general supervision and be available to provide immediate needed assistance by telephone. Advanced registered nurse practitioners who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

A physician assistant licensed under board of physician assistants' professional licensure rules in 645—Chapter 325 is exempt from the direct personal supervision requirement but the physician must still provide general supervision and be available to provide immediate needed assistance by telephone. Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician

has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

78.1(14) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a physician for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.1(15) The certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification.

78.1(16) No payment will be made for sterilization of an individual under the age of 21 or who is mentally incompetent or institutionalized. Payment will be made for sterilization performed on an individual who is aged 21 or older at the time the informed consent is obtained and who is mentally competent and not institutionalized when all the conditions in this subrule are met.

a. The following definitions are pertinent to this subrule:

(1) Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing and which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment of an operation on the genital urinary tract. Mental illness or retardation is not considered an illness or injury.

(2) Hysterectomy means a medical procedure or operation to remove the uterus.

(3) Mentally incompetent individual means a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(4) Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

b. The sterilization shall be performed as the result of a voluntary request for the services made by the person on whom the sterilization is performed. The person's consent for sterilization shall be documented on:

(1) Form 470-0835 or 470-0835(S), Consent Form, or

(2) An official sterilization consent form from another state's Medicaid program that contains all information found on the Iowa form and complies with all applicable federal regulations.

c. The person shall be advised prior to the receipt of consent that no benefits provided under the medical assistance program or other programs administered by the department may be withdrawn or withheld by reason of a decision not to be sterilized.

d. The person shall be informed that the consent can be withheld or withdrawn any time prior to the sterilization without prejudicing future care and without loss of other project or program benefits.

e. The person shall be given a complete explanation of the sterilization. The explanation shall include:

(1) A description of available alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.

(2) A thorough description of the specific sterilization procedure to be performed and benefits expected.

(3) A description of the attendant discomforts and risks including the type and possible effects of any anesthetic to be used.

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs

not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

g. The information in paragraphs "b" through "f" shall be effectively presented to a blind, deaf, or otherwise handicapped individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual's choice present when consent is obtained.

h. The consent form described in paragraph 78.1(16) "b" shall be attached to the claim for payment and shall be signed by:

- (1) The person to be sterilized,
- (2) The interpreter, when one was necessary,
- (3) The physician, and
- (4) The person who provided the required information.

i. Informed consent shall not be obtained while the individual to be sterilized is:

- (1) In labor or childbirth, or
- (2) Seeking to obtain or obtaining an abortion, or
- (3) Under the influence of alcohol or other substance that affects the individual's state of awareness.

j. Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization and only when one or more of the following conditions is met:

(1) The individual or representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing, or

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy and has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

78.1(17) Abortions. Payment for an abortion or related service is made when Form 470-0836 is completed for the applicable circumstances and is attached to each claim for services. Payment for an abortion is made under one of the following circumstances:

a. The physician certifies that the pregnant woman's life would be endangered if the fetus were carried to term.

b. The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition.

c. The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of the rape.

d. The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of incest.

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross-reference 78.28(3))

78.1(19) Preprocedure review by the 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 stem cell transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome, follicular lymphoma, Fanconi anemia, paroxysmal nocturnal hemoglobinuria, pure red cell aplasia, amegakaryocytosis/congenital thrombocytopenia, beta thalassemia major, sickle cell disease, Hurler's syndrome (mucopolysaccharidosis type 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

(3) Autologous stem cell transplants for treatment of the following conditions: acute leukemia; chronic lymphocytic leukemia; plasma cell leukemia; non-Hodgkin's lymphomas; Hodgkin's lymphoma; relapsed Hodgkin's lymphoma; lymphomas presenting poor prognostic features; follicular lymphoma; neuroblastoma; medulloblastoma; advanced Hodgkin's disease; primitive neuroendocrine tumor (PNET); atypical/rhabdoid tumor (ATRT); Wilms' tumor; Ewing's sarcoma; metastatic germ cell tumor; or multiple myeloma.

(4) Liver transplants for persons with extrahepatic biliary arteria 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 for persons with inoperable congenital heart defects, heart failure, or related conditions. Artificial hearts and ventricular assist devices as a temporary life-support system until a human heart becomes available for transplants are covered. Artificial hearts and ventricular assist devices as a permanent replacement for a human heart are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by the Iowa Medicaid enterprise medical services prior authorization unit. (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 version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians or other appropriately licensed practitioners under the supervision of or in collaboration with a physician and who are acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

a. Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

b. Separate payment shall be available only for application of topical fluoride varnish, which shall be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening shall not be available, as this service is already part of and paid under the EPSDT screening examination.

c. Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician's supervision that this application is not a substitute for comprehensive dental care.

d. Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

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

[ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0846C, IAB 7/24/13, effective 7/1/13; ARC 1052C, IAB 10/2/13, effective 11/6/13; ARC 1297C, IAB 2/5/14, effective 4/1/14; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.2(249A) Prescribed outpatient drugs. Payment will be made for “covered outpatient drugs” as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) subject to the conditions and limitations specified in this rule.

78.2(1) Qualified prescriber. All drugs are covered only if prescribed by a legally qualified practitioner (physician, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner). Pursuant to Public Law 111-148, Section 6401, any practitioner prescribing drugs must be enrolled with the Iowa Medicaid enterprise in order for such prescribed drugs to be eligible for payment.

78.2(2) Prescription required. As a condition of payment for all drugs, including “nonprescription” or “over-the-counter” drugs that may otherwise be dispensed without a prescription, a prescription shall be transmitted as specified in Iowa Code sections 124.308 and 155A.27, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions shall be available for audit by the department.

78.2(3) Qualified source. All drugs are covered only if marketed by manufacturers that have signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990).

78.2(4) Prescription drugs. Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A as amended by 2010 Iowa Acts, Senate File 2088, section 347.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required. However, prior authorization shall not be required for such a drug for a member whose regimen on the drug was established before January 1, 2011, as verified by documented pharmacy claims.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed Form 470-4914, Fax Confidentiality Certificate, and

2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

b. Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act.

(2) Drugs used for anorexia, weight gain, or weight loss.

(3) Drugs used for cosmetic purposes or hair growth.

(4) Rescinded IAB 2/8/12, effective 3/14/12.

(5) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer’s designee.

(6) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (drugs identified through the Drug Efficacy Study Implementation (DESI) review)).

(7) “Covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including a member who is not enrolled in a Medicare Part D plan.

(8) Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility, as defined in subparagraph (1).

(9) Drugs used for the treatment of sexual or erectile dysfunction, except when used to treat a condition other than sexual or erectile dysfunction for which the drug has been approved by the U.S. Food and Drug Administration.

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

78.2(5) Nonprescription drugs. The following drugs that may otherwise be dispensed without a prescription are covered subject to the prior authorization requirements stated below and as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

Acetaminophen tablets 325 mg, 500 mg
Acetaminophen elixir 160 mg/5 ml
Acetaminophen solution 100 mg/ml
Acetaminophen suppositories 120 mg
Artificial tears ophthalmic solution
Artificial tears ophthalmic ointment
Aspirin tablets 325 mg, 650 mg, 81 mg (chewable)
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
Aspirin tablets, buffered 325 mg
Bacitracin ointment 500 units/gm
Benzoyl peroxide 5%, gel, lotion
Benzoyl peroxide 10%, gel, lotion
Calcium carbonate chewable tablets 500 mg, 750 mg, 1000 mg, 1250 mg
Calcium carbonate suspension 1250 mg/5 ml
Calcium carbonate tablets 600 mg
Calcium carbonate-vitamin D tablets 500 mg-200 units
Calcium carbonate-vitamin D tablets 600 mg-200 units
Calcium citrate tablets 950 mg (200 mg elemental calcium)
Calcium gluconate tablets 650 mg
Calcium lactate tablets 650 mg
Cetirizine hydrochloride liquid 1 mg/ml
Cetirizine hydrochloride tablets 5 mg
Cetirizine hydrochloride tablets 10 mg
Chlorpheniramine maleate tablets 4 mg
Clotrimazole vaginal cream 1%
Diphenhydramine hydrochloride capsules 25 mg
Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
Epinephrine racemic solution 2.25%
Ferrous sulfate tablets 325 mg
Ferrous sulfate elixir 220 mg/5 ml
Ferrous sulfate drops 75 mg/0.6 ml
Ferrous gluconate tablets 325 mg
Ferrous fumarate tablets 325 mg
Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
Ibuprofen suspension 100 mg/5 ml
Ibuprofen tablets 200 mg
Insulin
Lactic acid (ammonium lactate) lotion 12%
Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine syrup 5 mg/5 ml

Loratadine tablets 10 mg
Magnesium hydroxide suspension 400 mg/5 ml
Magnesium oxide capsule 140 mg (85 mg elemental magnesium)
Magnesium oxide tablets 400 mg
Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
Miconazole nitrate cream 2% topical and vaginal
Miconazole nitrate vaginal suppositories, 100 mg
Multiple vitamin and mineral products with prior authorization
Neomycin-bacitracin-polymyxin ointment
Niacin (nicotinic acid) tablets 50 mg, 100 mg, 250 mg, 500 mg
Nicotine gum 2 mg, 4 mg
Nicotine lozenge 2 mg, 4 mg
Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
Pediatric oral electrolyte solutions
Permethrin lotion 1%
Polyethylene glycol 3350 powder
Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
Pseudoephedrine hydrochloride liquid 30 mg/5 ml
Pyrethrins-piperonyl butoxide liquid 0.33-4%
Pyrethrins-piperonyl butoxide shampoo 0.3-3%
Pyrethrins-piperonyl butoxide shampoo 0.33-4%
Salicylic acid liquid 17%
Senna tablets 187 mg
Sennosides-docusate sodium tablets 8.6 mg-50 mg
Sennosides syrup 8.8 mg/5 ml
Sennosides tablets 8.6 mg
Sodium bicarbonate tablets 325 mg
Sodium bicarbonate tablets 650 mg
Sodium chloride hypertonic ophthalmic ointment 5%
Sodium chloride hypertonic ophthalmic solution 5%
Tolnaftate 1% cream, solution, powder
Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

78.2(6) Quantity prescribed and dispensed.

a. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe a quantity of prescription medication sufficient for up to a 31-day supply. Oral contraceptives may be prescribed in 90-day quantities.

b. Oral solid forms of covered nonprescription items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription or the currently available consumer package size except when dispensed via a unit-dose system.

78.2(7) Lowest cost item. The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

78.2(8) Consultation. In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990), a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation shall be found in rules of the Iowa board of pharmacy.

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

[ARC 8097B, IAB 9/9/09, effective 11/1/09; ARC 9175B, IAB 11/3/10, effective 1/1/11; ARC 9699B, IAB 9/7/11, effective 9/1/11; ARC 9834B, IAB 11/2/11, effective 11/1/11; ARC 9882B, IAB 11/30/11, effective 1/4/12; ARC 9981B, IAB 2/8/12, effective 3/14/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13]

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Medicaid enterprise. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross-reference 78.28(5)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

78.3(1) Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

78.3(2) No payment will be approved for private duty nursing.

78.3(3) Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

78.3(4) Services provided for intestinal or gastric bypass surgery for treatment of obesity requires prior approval, which must be obtained by the attending physician before surgery is performed.

78.3(5) Payment will be approved for drugs provided inpatients subject to the same provisions specified in 78.2(1) and 78.2(4) "b"(1) to (10) except for 78.2(4) "b"(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

a. Payment will be approved for drugs and supplies provided outpatients subject to the same provisions specified in 78.2(1) through 78.2(4) except for 78.2(4) "b"(7). The basis of payment for drugs provided outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

b. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.3(6) Payment for nursing care provided by a hospital shall be made to those hospitals which have been certified by the department of inspections and appeals as meeting the standards for a nursing facility.

78.3(7) Payment for inpatient hospital tests for purposes of diagnosis and treatment shall be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient's condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient's diagnosis or treatment.

78.3(8) Rescinded IAB 2/6/91, effective 4/1/91.

78.3(9) Payment will be made for sterilizations in accordance with 78.1(16).

78.3(10) Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

a. *Recipient selection and education.*

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

- Intake.
- Preparation and waiting period.
- Preadmission.
- Hospitalization.
- Discharge planning.
- Follow-up.

b. Staffing and resource commitment.

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified.

The team should consist of:

A surgeon director.

A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

- Anesthesiology.
- Cardiology.
- Dialysis.
- Gastroenterology.
- Hepatology.
- Immunology.
- Infectious diseases.
- Nephrology.
- Neurology.
- Pathology.
- Pediatrics.
- Psychiatry.
- Pulmonary medicine.
- Radiology.
- Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include the following:

Persons with expertise in the following areas available at the transplant center:

Anesthesiology.

Blood bank services.

Cardiology.

Cardiovascular surgery.

Dialysis.

Dietary services.

Gastroenterology.

Infection control.

Laboratory services (pathology, microbiology, immunology, tissue typing, and monitoring of immunosuppressive drugs).

Legal counsel familiar with transplantation laws and regulations.

Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.

Respiratory therapy.

Pharmaceutical services.

Physical therapy.

Psychiatry.

Psycho-social.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI). As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. *Experience and survival rates.*

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year.

For approval of an extrarenal organ transplant program it is highly desirable that the institution: 1. has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or 2. has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level.

To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

d. Organ procurement. The transplant center will participate in a nationwide organ procurement and typing network.

Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria.

The transplant center must be a member of the National Organ Procurement and Transplant Network.

e. Maintenance of data, research, review and evaluation.

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

These data should be maintained in the computer at the transplant center monthly.

The transplant center will submit the above data to the United Network of Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research.

Ongoing research regarding the transplanted organs is required.

The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program.

The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient.

The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program.

The transplant center will provide information to members of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process.

The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

f. Application procedure. A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to the Iowa Medicaid enterprise provider services unit. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to the Iowa Medicaid enterprise provider services unit.

g. Review and approval of facilities. An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes which would affect its approved status. Specifically, a facility must report any significant decrease in its experience level or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

78.3(11) Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

78.3(12) Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16) “*a*” and “*r*” to determine if a medical emergency exists.

Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual’s health unless immediate medical treatment is given.

The determination of whether a medical emergency exists will be based on the patient’s medical condition including presenting symptoms and medical history prior to treatment or evaluation.

78.3(13) Payment for patients in acute hospital beds who are determined by IFMC to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “*f*”(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “*f*”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by IFMC that the lower level of care is required or (b) for the days IFMC determines in an outlier review that the lower level of care was required.

78.3(14) Payment for patients in acute hospital beds who are determined by IFMC to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “*f*”(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “*f*”(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by IFMC that the lower level of care is required or (b) for the days IFMC determines in an outlier review that the lower level of care was required.

78.3(15) Payment for inpatient hospital charges associated with surgical procedures on the “Outpatient/Same Day Surgery List” produced by the Iowa Foundation for Medical Care shall be made only when attending physician has secured approval from the hospital’s utilization review department prior to admittance to the hospital. Approval shall be granted when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The “Outpatient/Same Day Surgery List” shall be published by the department in the provider manuals for hospitals and physicians. The “Outpatient/Same Day Surgery List” shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor’s office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete or modify entries on the “Outpatient/Same Day Surgery List.”

78.3(16) Skilled nursing care in “swing beds.”

a. Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “*f*”(3) and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “*f*”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. Swing-bed placement is only intended to be short-term in nature.

b. Any payment for skilled nursing care provided in a hospital with a certified swing-bed program, for either initial admission or continued stay, will require prior authorization, subject to the following requirements:

- (1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.
- (2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16) "a."
- (3) The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).
- (4) As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:
 1. Complete a level of care (LOC) determination describing a member's LOC needs, using Form 470-5156, Swing Bed Certification.
 2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member's LOC needs.
 3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member's needs and that home-based care for the member is not available or appropriate.
- (5) Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an "appropriate" nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member's medical condition and corresponding LOC needs.
- (6) A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

Preadmission screening and resident review (PASRR) rules still apply for members being transferred to a nursing facility.

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

78.3(18) Preprocedure review by the IFMC is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 78.28(5))

78.3(19) Rescinded IAB 10/8/97, effective 12/1/97.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 0194C, IAB 7/11/12, effective 7/1/12; ARC 0354C, IAB 10/3/12, effective 12/1/12; ARC 0844C, IAB 7/24/13, effective 7/1/13; ARC 1054C, IAB 10/2/13, effective 11/6/13]

441—78.4(249A) Dentists. Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Services must be reasonable, necessary, and cost-effective for the prevention, diagnosis, and treatment of dental disease or injuries or for oral devices necessary for a medical condition. Payment will also be made for the following dental procedures:

78.4(1) Preventive services. Payment shall be made for the following preventive services:

- a. Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six-month period except for persons who, because of a physical or mental condition, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.
- b. Topical application of fluoride is payable once every 90 days. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants are payable for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

d. Space management services are payable in mixed dentition when premature loss of teeth would permit existing teeth to shift and cause a handicapping malocclusion or there is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if the condition is not corrected.

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

a. A comprehensive oral evaluation is payable once per member per dental practice in a three-year period when the member has not been seen by a dentist in the dental practice during the three-year period.

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

c. A full mouth radiograph survey, consisting of a minimum of 14 periapical films and bite-wing films, or a panoramic radiograph with bite-wings is a payable service once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six except when medically necessary. A panographic-type radiography with bite-wings is considered the same as a full mouth radiograph survey.

d. Supplemental bitewing films are payable only once in a 12-month period.

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.

i. Temporomandibular joint radiograph.

j. Cephalometric film.

k. Diagnostic casts are payable only for orthodontic cases or dental implants or when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

l. Cone beam images are payable when medically necessary for situations including, but not limited to, detection of tumors, positioning of severely impacted teeth, supernumerary teeth or dental implants.

78.4(3) Restorative services. Payment shall be made for the following restorative services:

a. Treatment of dental caries is payable in those areas which require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials are reimbursable only once for the same restoration in a two-year period.

c. Rescinded IAB 5/1/02, effective 7/1/02.

d. Crowns are payable when there is at least a fair prognosis for maintaining the tooth as determined by the Iowa Medicaid enterprise medical services unit and a more conservative procedure would not be serviceable.

(1) Stainless steel crowns are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. Placement on permanent posterior teeth is allowed only for members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown.

(2) Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.

(3) Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval shall be granted when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration or there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.

(4) Crowns with noble or high noble metals require prior authorization. Approval shall be granted for members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.

e. Cast post and core, post and composite or post and amalgam in addition to a crown are payable when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

f. Payment as indicated will be made for the following restoration procedures:

(1) Amalgam or acrylic buildups, including any pins, are considered a core buildup.

(2) One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid.

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Rescinded IAB 5/1/02, effective 7/1/02.

(5) Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, and local anesthesia are included in the restorative fee and may not be billed separately.

(7) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(8) More than four surfaces on an amalgam restoration will be reimbursed as a "four-surface" amalgam.

(9) An amalgam or composite restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

78.4(4) Periodontal services. Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is payable once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross-reference 78.28(2) "a"(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the member has demonstrated reasonable oral hygiene. Payment is also allowed for members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.

d. Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene. (Cross-reference 78.28(2) "a"(2))

e. Periodontal maintenance therapy requires prior authorization. Approval shall be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross-reference 78.28(2) "a"(3))

f. Tissue regeneration procedures require prior authorization. Approval shall be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.

g. Localized delivery of antimicrobial agents requires prior authorization. Approval shall be granted when at least one year has elapsed since periodontal scaling and root planing was completed,

the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

78.4(5) Endodontic services. Payment shall be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when there is presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a nonvital tooth.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment, including an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue is payable when nonsurgical treatment has been attempted and a reasonable time of approximately one year has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross-reference 78.28(2) "c")

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment shall be granted when the conventional treatment has been completed, a reasonable time has elapsed since the initial treatment, and failure has been demonstrated with a radiograph and narrative history. A reasonable period of time is approximately one year if the treating dentist is the same and may be less if the member must see a different dentist.

78.4(6) Oral surgery—medically necessary. Payment shall be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy, as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician's reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

a. Extractions, both surgical and nonsurgical.

b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.

c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.

d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.

e. Root recovery (surgical removal of residual root).

f. Oral antral fistula closure (or antral root recovery).

g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.

h. Surgical exposure of impacted or unerupted tooth to aid eruption.

i. Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

j. Payment may be made for postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

78.4(7) Prosthetic services. Payment may be made for the following prosthetic services:

a. An immediate denture or a first-time complete denture. Six months' postdelivery care is included in the reimbursement for the denture.

b. A removable partial denture replacing anterior teeth when prior approval has been received. Approval shall be granted when radiographs demonstrate adequate space for replacement of a missing anterior tooth. Six months' postdelivery care is included in the reimbursement for the denture.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture. (Cross-reference 78.28(2) "b"(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval shall be granted for members who:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay.

High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. (Cross-reference 78.28(2) "b"(2))

e. A fixed partial denture replacing posterior teeth when prior approval has been received. Approval shall be granted for members who meet the criteria for a removable partial denture and:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

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

g. Chairside relines and laboratory-processed relines are payable only once per prosthesis every 12 months, beginning 6 months after placement of the denture.

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

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

j. Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

k. Dental implants and related services when prior authorization has been received. Prior authorization shall be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

l. Replacement of complete or partial dentures in less than a five-year period requires prior authorization. Approval shall be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval shall also be granted for more than one denture replacement per arch within five years for members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.

m. A complete or partial denture rebase requires prior approval. Approval shall be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are in good condition.

n. An oral appliance for obstructive sleep apnea requires prior approval and must be custom-fabricated. Approval shall be granted in accordance with Medicare criteria.

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

a. Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross-reference 78.28(2) "c")

b. Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe

handicapping malocclusion with a score of 26 or above using the index from the "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J.A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

78.4(9) *Adjunctive general services.* Payment may be made for the following:

a. Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized member only when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.

b. Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

c. Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.

d. Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

e. Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist's office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for the writing of prescriptions.

f. Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.

g. Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval shall be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

78.4(10) *Orthodontic services to members 21 years of age or older.* Orthodontic procedures are not covered for members 21 years of age or older.

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

[ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0631C, IAB 3/6/13, effective 5/1/13]

441—78.5(249A) *Podiatrists.* Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

a. Durable plantar foot orthotic.

b. Plaster impressions for foot orthotic.

c. Molded digital orthotic.

d. Shoe padding when appliances are not practical.

e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.

f. Rams horn (hypertrophic) nails.

g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

a. Treatment of flatfoot. The term "flatfoot" is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated

foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2) "c." Payment shall be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist's office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

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

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) Payable professional services. Payable professional services are:

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation with a three-mirror lens.

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

(1) When spectacle lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.
2. Verification of lenses after fabrication.
3. Adjustment and alignment of completed lens order.

(2) New spectacle lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.
2. Up to four times per year for children one through three years of age.
3. Once every 12 months for children four through seven years of age.
4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Spectacle lenses made from polycarbonate or equivalent material are allowed for:

1. Children through seven years of age.
2. Members with vision in only one eye.
3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

- e. Rescinded IAB 4/3/02, effective 6/1/02.
- f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.
2. Sizing and measurements.
3. Fitting and adjustment.
4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.
2. One frame every 12 months is allowed for children four through seven years of age.
3. When there is a covered lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.
2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.

- g. Rescinded IAB 4/3/02, effective 6/1/02.

h. Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Contact lenses. Payment shall be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:

- (1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.
- (2) Up to 8 gas permeable contact lenses are allowed every 12 months for children one through three years of age.
- (3) Up to 6 gas permeable contact lenses are allowed every 12 months for children four through seven years of age.

(4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.

(5) Soft contact lenses and replacements are allowed when medically necessary.

78.6(2) Ophthalmic materials. Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

a. Corrected curve lenses, unless clinically contraindicated.

b. Standard plastic, plastic and metal combination, or metal frames.

c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

78.6(3) Reimbursement. The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice. Reimbursement for rose tint is included in the fee for the lenses.

a. Materials payable by fee schedule are:

(1) Spectacle lenses, single vision and multifocal.

(2) Frames.

(3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

(1) Contact lenses.

(2) Schroeder shield.

(3) Ptosis crutch.

(4) Safety frames.

(5) Subnormal visual aids.

(6) Photochromatic lenses.

78.6(4) Prior authorization. Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is at or better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

d. Approval for photochromatic tint shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Approval for press-on prisms shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

(Cross-reference 78.28(3))

78.6(5) Noncovered services. Noncovered services include, but are not limited to, the following services:

a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.

b. Glasses for occupational eye safety.

c. A second pair of glasses or spare glasses.

d. Cosmetic surgery and experimental medical and surgical procedures.

e. Sunglasses.

f. Progressive bifocal or trifocal lenses.

78.6(6) Therapeutically certified optometrists. Rescinded IAB 9/5/12, effective 11/1/12.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 0305C, IAB 9/5/12, effective 11/1/12]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross-reference 78.28(3))

78.7(1) to 78.7(3) Rescinded IAB 4/3/02, effective 6/1/02.

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

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) Covered services. Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) Indications and limitations of coverage.

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of “pain” is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient’s condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
G44.1	Vascular headache NEC*	G54.0-G54.4	Nerve root and plexus disorders, brachial plexus disorders, lumbosacral plexus disorders, cervical root disorders NEC, thoracic root disorders NEC, lumbosacral root disorders NEC	M48.30-M48.33	Traumatic spondylopathy, site unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region
G44.209	Tension headache, unspecified, not intractable	G54.8	Other nerve root and plexus disorders	M48.35-M48.38	Traumatic spondylopathy, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region
M47.21-M47.28	Other spondylosis with radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G54.9	Nerve root and plexus disorder, unspecified	M50.20-M50.23	Other cervical disc displacement
M47.811-M47.818	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G55	Nerve root and plexus compressions in diseases classified elsewhere	M50.30-M50.33	Other cervical disc degeneration

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
M47.891- M47.898	Other spondylosis, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	M43.00- M43.28	Spondylolysis; spondylolisthesis; fusion of spine	M51.24- M51.27	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
M54.2	Cervicalgia	M43.6	Torticollis	M51.34- M51.37	Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
M54.5	Low back pain	M46.00- M46.09	Spinal enthesopathy	M54.30- M54.32	Sciatica
M54.6	Pain in the thoracic spine	M46.41- M46.47	Discitis, unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region	M54.40- M54.42	Lumbago with sciatica
M54.81	Occipital neuralgia	M48.00- M48.08	Spinal stenosis	M96.1	Postlaminectomy syndrome, NEC
M54.89	Other dorsalgia	M48.34	Traumatic spondylopathy, thoracic region		
M54.9	Dorsalgia, unspecified	M50.10- M50.13	Cervical disc disorder with radiculopathy		
R51	Headache	M50.80- M50.83	Other cervical disc disorders		
		M50.90- M50.93	Cervical disc disorder, unspecified		
		M51.14- M51.17	Intervertebral disc disorders with radiculopathy, thoracic region, thoracolumbar region, lumbar region, lumbosacral region		
		M51.84- M51.87	Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders		
		M53.0	Cervicocranial syndrome		
		M53.1	Cervicobrachial syndrome		
		M53.2X1- M53.2X9	Spinal instabilities		
		M53.3	Sacrococcygeal disorders NEC		
		M53.80	Other specified dorsopathies, site unspecified		
		M53.84- M53.88	Other specified dorsopathies, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M53.9	Dorsopathy, unspecified		
		M54.10-M54.18	Radiculopathy		
		M60.80	Other myositis, unspecified site		
		M60.811, M60.812	Other myositis, shoulder, right, left		
		M60.819	Other myositis, unspecified shoulder		
		M60.821, M60.822	Other myositis, upper arm, right, left		
		M60.829	Other myositis, unspecified upper arm		
		M60.831, M60.832	Other myositis, forearm, right, left		
		M60.839	Other myositis, unspecified forearm		
		M60.841, M60.842	Other myositis, hand, right, left		
		M60.849	Other myositis, unspecified hand		
		M60.851, M60.852	Other myositis, thigh, right, left		
		M60.859	Other myositis, unspecified thigh		
		M60.861, M60.862	Other myositis, lower leg, right, left		
		M60.869	Other myositis, unspecified lower leg		
		M60.871, M60.872	Other myositis, ankle and foot, right, left		
		M60.879	Other myositis, unspecified ankle and foot		
		M60.88, M60.89	Other myositis, other site, multiple sites		
		M60.9	Myositis, unspecified		
		M62.830	Muscle spasm of back		
		M72.9	Fibroblastic disorder, unspecified		
		M79.1	Myalgia		
		M79.2	Neuralgia and neuritis, unspecified		
		M79.7	Fibromyalgia		
		M99.20-M99.23	Subluxation stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.30-M99.33	Osseous stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M99.40-M99.43	Connective tissue stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.50-M99.53	Intervertebral disc stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.60-M99.63	Osseous and subluxation stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		M99.70-M99.73	Connective tissue and disc stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		Q76.2	Congenital spondylolisthesis		
		S13.4XXA, S13.4XXD	Sprain of ligaments of cervical spine, initial encounter, subsequent encounter		
		S13.8XXA, S13.8XXD	Sprain of joints and ligaments of other parts of neck, initial encounter, subsequent encounter		
		S16.1XXA, S16.1XXD	Strain of muscle, fascia and tendon at neck level, initial encounter, subsequent encounter		
		S23.3XXA, S23.3XXD	Sprain of ligaments of thoracic spine, initial encounter, subsequent encounter		
		S23.8XXA, S23.8XXD	Sprain of other specified parts of thorax, initial encounter, subsequent encounter		
		S33.5XXA, S33.5XXD	Sprain of ligaments of lumbar spine, initial encounter, subsequent encounter		
		S33.6XXA, S33.6XXD	Sprain of sacroiliac joint, initial encounter, subsequent encounter		

* NEC means not elsewhere classified.

b. The neuromusculoskeletal conditions listed in the table in paragraph "a" generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity

of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

(1) The maximum therapeutic benefit has been achieved for a given condition.

(2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient's condition.

(3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) Documenting X-ray. An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph "c" of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient's name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient's clinical record.

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph "a" of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph "a" of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor's office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

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

[ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member's residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10) "a" may be provided in settings other than the member's residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member's community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, evidenced by the physician's signature and date on a plan of treatment.

78.9(1) Treatment plan. A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 62 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- a. Place of service.
- b. Type of service to be rendered and the treatment modalities being used.
- c. Frequency of the services.
- d. Assistance devices to be used.
- e. Date home health services were initiated.
- f. Progress of member in response to treatment.
- g. Medical supplies to be furnished.
- h. Member's medical condition as reflected by the following information, if applicable:
 - (1) Dates of prior hospitalization.
 - (2) Dates of prior surgery.
 - (3) Date last seen by a physician.
 - (4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 - (5) Prognosis.
 - (6) Functional limitations.
 - (7) Vital signs reading.
 - (8) Date of last episode of instability.
 - (9) Date of last episode of acute recurrence of illness or symptoms.
 - (10) Medications.
 - i. Discipline of the person providing the service.
 - j. Certification period (no more than 62 days).
 - k. Estimated date of discharge from the hospital or home health agency services, if applicable.
 - l. Physician's signature and date. The plan of care must be signed and dated by the physician before the claim for service is submitted for reimbursement.

78.9(2) Supervisory visits. Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) Skilled nursing services. Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received

the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician and included in the plan of care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) Physical therapy services. Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "b."

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) Occupational therapy services. Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "c."

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) Speech therapy services. Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "d."

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) Home health aide services. Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician and included in a plan of care shall be allowed as intermittent services. Increased services

provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) *Medical social services.*

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

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

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

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

- (1) The potential risk factors,
- (2) The medical factor or symptom which verifies the child is at risk,
- (3) The reason the member is unable to obtain care outside of the home,
- (4) The medically related task of the home health agency,
- (5) The member's diagnosis,
- (6) Specific services and goals, and
- (7) The medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.
- (4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.

- (5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.
- (6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.
- (7) Second pregnancy in 12 months.
- (8) Death of a close family member or significant other within the previous year.
- c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:
- (1) Aged 16 or under.
 - (2) First pregnancy for a woman aged 35 or over.
 - (3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.
 - (4) Preexisting mental or physical disabilities such as deaf, blind, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or mental retardation.
 - (5) Drug or alcohol abuse.
 - (6) Symptoms of postpartum psychosis.
 - (7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.
 - (8) Demonstrated disturbance in maternal and infant bonding.
 - (9) Discharge or release from hospital against medical advice before 36 hours postpartum.
 - (10) Insufficient antepartum care by history.
 - (11) Multiple births.
 - (12) Nonhospital delivery.
- d. The following list of potential high-risk factors may indicate a need for home health services to infants:
- (1) Birth weight of five pounds or under or over ten pounds.
 - (2) History of severe respiratory distress.
 - (3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.
 - (4) Disabling birth injuries.
 - (5) Extended hospitalization and separation from other family members.
 - (6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to mental retardation.
 - (7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.
 - (8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.
 - (9) Discharge or release against medical advice before 36 hours of age.
 - (10) Nutrition or feeding problems.
- e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:
- (1) Child or sibling victim of child abuse or neglect.
 - (2) Mental retardation or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.
 - (3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.
 - (4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.
 - (5) Malignancies such as leukemia or carcinoma.
 - (6) Severe injuries necessitating treatment or rehabilitation.
 - (7) Disruption in family or peer relationships.
 - (8) Suspected developmental delay.
 - (9) Nutritional deficiencies.

78.9(10) Private duty nursing or personal care services for persons aged 20 and under. Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.
5. Transportation services.
6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously

identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.28(9))

78.9(11) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 9315B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) General payment requirements. Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the member's name, diagnosis, prognosis, item(s) to be dispensed, quantity, and length of time the item is to be required and shall include the signature of the prescriber and the date of signature.

For items requiring prior authorization, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior authorization requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

- (1) Physical fitness equipment, e.g., an exercycle, weights.
- (2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.
- (3) Self-help devices, e.g., safety grab bars, raised toilet seats.
- (4) Training equipment, e.g., speech teaching machines, braille training texts.
- (5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.
- (6) Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator for which prior authorization has been granted. See 78.10(5) "k" for prior authorization requirements.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5) "n" for prior authorization requirements.

78.10(2) Durable medical equipment. DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. Durable medical equipment provided in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an intermediate care facility for persons with an intellectual disability when all of the following requirements and conditions have been met:

1. A Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile is completed by a physician, physician assistant, or advanced registered nurse practitioner and qualifies the member in accordance with Medicare criteria.

2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.

3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:

- The initial, periodic and ending reading on the time meter clock on each oxygen system, and
 - The dates of each initial, periodic and ending reading, and
 - Evidence of ongoing need for oxygen services.
4. The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.
5. Oxygen prescribed "PRN" or "as necessary" is not payable.
6. Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.

7. Payment is not allowed for oxygen services that are not documented according to the department of inspections and appeals requirements at 481—subrule 58.21(8).

(2) Speech generating devices for which prior authorization has been obtained. See 78.10(5)*"f"* for prior authorization requirements.

(3) Wheelchairs for members in an intermediate care facility for persons with an intellectual disability.

(4) Medicaid will provide separate payment for customized wheelchairs for members who are residents of nursing facilities, subject to the following:

1. The member's condition must necessitate regular use of a wheelchair on a long-term basis to enable independent mobility within the facility.

2. The member must require a wheelchair that is designed, assembled, modified, or constructed for the specific individual, in whole or in part, based on the individual's condition, measurements, and needs.

3. Prior authorization pursuant to rule 441—79.8(249A) is required.

b. The types of durable medical equipment covered through the Medicaid program include, but are not limited to:

Automated medication dispenser. See 78.10(5)*"d"* for prior authorization requirements.

Bathtub/shower chair, bench. See 78.10(5)*"g"* and *"j"* for prior authorization requirements.

Commode, shower commode chair. See 78.10(5)*"j"* for prior authorization requirements.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(5)*"a"* for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See 78.10(5)*"c"* for prior authorization requirements.

Insulin infusion pump. See 78.10(5)*"b"* and 78.10(5)*"e"* for prior authorization requirements.

Lymphedema pump.

Mobility device and accessories. See 78.10(5)*"i"* for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

Oxygen, subject to the limitations in 78.10(2)*"a"* and 78.10(2)*"c."*

Patient lift. See 78.10(5)*"h"* for prior authorization requirements.

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

Speech generating device. See 78.10(5)*"f"* for prior authorization requirements.

Traction equipment.

Ventilator.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, physician assistant, or advanced registered nurse practitioner shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, a Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile completed by a physician, physician assistant, or advanced registered nurse practitioner, shall qualify the member in accordance with Medicare criteria.

(2) If the member's condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician, physician assistant, or advanced registered nurse practitioner of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems shall be made only on a rental basis for the duration of use.

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

(6) Oxygen prescribed "PRN" or "as necessary" is not allowed.

78.10(3) Prosthetic devices. Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the member's condition may improve sometime in the future.

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

b. The types of prosthetic devices covered through the Medicaid program include, but are not limited to:

(1) Artificial eyes.

(2) Artificial limbs.

(3) Enteral delivery supplies and products. See 78.10(5) "l" for prior authorization requirements.

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

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

(6) Ostomy appliances.

(7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

(8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).

(9) Tracheotomy tubes.

(10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross-reference 78.28(4))

c. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and either:

(1) The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or

(2) The member is 36 weeks of age but younger than 108 weeks of age and there is documentation of either of the following conditions:

1. Cephalic index at least two standard deviations above the mean for the member's gender and age; or

2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) Medical supplies. Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active

pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member's caregiver for each refill.

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include, but are not limited to:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

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

Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5) "e" for prior authorization requirements.

Dialysis supplies.

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

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

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Incontinence products (for members three years of age and older).

Oral nutritional products. See 78.10(5) "m" for prior authorization requirements.

Ostomy appliances and supplies.

Respirator supplies.

Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

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

Ostomy appliances and supplies.

Shoes, diabetic.

78.10(5) Prior authorization requirements. Prior authorization pursuant to rule 441—79.8(249A) is required for the following medical equipment and supplies (Cross-reference 78.28(1)):

a. Enclosed beds. Payment for an enclosed bed shall be approved when prescribed for a member who meets all of the following conditions:

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

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

b. External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

c. Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a member with a diagnosis of a lung disorder if all of the following conditions are met:

- (1) Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease in lung function.
- (2) The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.
- (3) Treatment by flutter device failed or is contraindicated.
- (4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.
- (5) All other less costly alternatives have been tried.
 - d. Automated medication dispenser. Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:
 - (1) The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.
 - (2) The member is on two or more medications prescribed to be administered more than one time per day.
 - (3) The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.
 - (4) Less costly alternatives, such as medisets or telephone reminders, have failed.
 - e. Diabetic equipment and supplies. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior approval shall be granted when the member's medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.
 - f. Speech generating device. Payment shall be approved according to Medicare coverage criteria. Form 470-2145, Speech Generating Device System Selection, completed by a speech-language pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted with the request for prior authorization. In addition, documentation from a speech-language pathologist must include information on the member's educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. A minimum one-month trial period is required for all devices. The Iowa Medicaid enterprise consultant with expertise in speech-language pathology will evaluate each prior authorization request and make recommendations to the department.
 - g. Bathtub/shower chair, bench. Payment shall be approved for specialized bath equipment for members whose medical condition necessitates additional body support while bathing.
 - h. Patient lift, nonstandard. Payment shall be approved for a nonstandard lift, such as a portable, ceiling or electric lifter, when the member meets the Medicare criteria for a patient lift and a standard lifter (Hoyer type) will not work.
 - i. Power wheelchair attendant control. Payment shall be approved when the member has a power wheelchair and:
 - (1) Has a sip 'n puff attachment, or
 - (2) The medical documentation demonstrates the member's difficulty operating the wheelchair in tight space, or
 - (3) The medical documentation demonstrates the member becomes fatigued.
 - j. Shower commode chairs. Prior authorization shall be granted when documentation from a physician, physician assistant, advanced registered nurse practitioner, physical therapist or occupational therapist indicates that the member:
 - (1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and
 - (2) Needs upper body support while sitting, and
 - (3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.
 - k. Ventilator, secondary. Payment shall be approved according to the Medicare coverage criteria.

l. Enteral products and enteral delivery pumps and supplies. Payment shall be approved according to Medicare coverage criteria. EXCEPTION: The Medicare criteria for permanence is not required.

m. Oral nutritional products. Payment shall be approved when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for persons with an intellectual disability.

n. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved for bariatric equipment, pediatric equipment or other specialized medical equipment, supply, prosthetic or orthotic which:

(1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and

(2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider's cost to obtain the equipment or supply.

o. Customized wheelchairs for members who are residents of nursing facilities, subject to the requirements of 78.10(2) "a"(4).

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 8993B, IAB 8/11/10, effective 10/1/10; ARC 9256B, IAB 12/1/10, effective 1/1/11; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

a. The individual is admitted as a hospital inpatient or in an emergency situation.

b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

One patient - normal allowance

Two patients - 3/4 normal allowance per patient

Three patients - 2/3 normal allowance per patient

Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing

to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5) "j."

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

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

441—78.12(249A) Behavioral health intervention. Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a mental disorder, subject to the limitations in this rule.

78.12(1) Definitions.

"*Behavioral health intervention*" means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;
2. Improving a member's health and well-being related to the member's mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and
3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

"*Licensed practitioner of the healing arts*" or "*LPHA*," as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a physician assistant (PA), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who:

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

"*Mental disorder*" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding intellectual disabilities, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

78.12(2) Covered services.

a. *Service setting.*

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

b. *Crisis intervention.* Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

c. *Behavior intervention.* Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

d. *Family training.* Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and
2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.

e. *Skill training and development.* Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;
2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and
3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,
2. Conflict resolution skills,
3. Daily living skills,
4. Employment-related skills,
5. Interpersonal relationship skills,
6. Problem-solving skills, and

7. Social skills.

78.12(3) Excluded services.

a. Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, “habilitative services” means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

b. Respite, day care, education, and recreation services are not covered under behavioral health intervention.

78.12(4) Coverage requirements. Medicaid covers behavioral health intervention only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner’s scope of practice under state law has diagnosed the member with a psychological disorder.

b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member’s psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member’s need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,
2. Behavioral support in the community,
3. Specific skills impaired due to the member’s mental illness, and

4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

c. For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member’s current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

78.12(5) Approval of plan. The behavioral health intervention provider shall contact the Iowa Plan provider for authorization of the services.

a. *Initial plan.* The initial services implementation plan must meet all of the following criteria:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(6);

(2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;

(3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

(4) The provider meets the requirements of rule 441—77.12(249A); and

(5) The plan does not exceed six months’ duration.

b. *Subsequent plans.* The Iowa Plan contractor may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)“a” if the services are recommended by a licensed practitioner of the healing arts who has:

(1) Reexamined the member;

(2) Reviewed the original diagnosis and treatment plan; and

(3) Evaluated the member’s progress, including a formal assessment as required by 78.12(4)“c”(3).

78.12(6) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, “medically necessary” means that the service is:

- a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental disorder;
- b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;
- c. The least costly type of service that can reasonably meet the medical needs of the member; and
- d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:
 - (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
 - (2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[ARC 8504B, IAB 2/10/10, effective 3/22/10; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.13(249A) Nonemergency medical transportation. The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

78.13(1) Covered services. Nonemergency medical transportation services available are limited to:

- a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

- (1) Mileage reimbursement to the member, if the member is the driver.
- (2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.
- (3) Taxi service.
- (4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.
- (5) Wheelchair and stretcher vans.
- (6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

78.13(2) Exclusions. Nonemergency medical transportation is not available through the Iowa Medicaid program for:

- a. Transportation to obtain services not covered by Iowa Medicaid;
- b. Transportation to providers that are not enrolled in Iowa Medicaid;
- c. Transportation for members residing in nursing facilities or ICF>ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);
- d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;

e. Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;

f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

78.13(3) Conditions and limitations on covered services. Nonemergency medical transportation services are subject to the following limitations and conditions:

a. *Member request.* When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;
2. Unexpected preoperative appointments;
3. Hospital discharges;
4. Appointments for new medical conditions or tests; and
5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;
2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and
3. The other requirements of rule 441—78.13(249A) must be met.

b. *No free transportation alternatives available.* Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. *No member transportation alternatives available.* Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

- (1) Whether the member owns a vehicle;
- (2) Whether a member-owned vehicle is in working mechanical order and is licensed;
- (3) Whether the member has a valid driver's license and auto insurance;
- (4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and
- (5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. *Limitations on reimbursement for meals.* Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

- (1) The transportation being provided spans the entire meal period;
- (2) The one-way distance to or from the medical appointment is more than 50 miles;
- (3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and
- (4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

e. *Limitations on reimbursement for lodging expenses.* Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. *Closest medical provider.* Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

- (1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or
- (2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. *Member scheduling obligations.* Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. *Abusive behavior.* Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

i. *Member claim submission.* Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

78.13(4) Grievance procedure. The broker shall establish an internal grievance procedure for members and transportation providers.

- a. Members may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.”
- b. Transportation providers.

(1) Consent for state fair hearing.

1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.

2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.

3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

(2) For all transportation provider grievances not addressed by paragraph 78.13(4)"b," the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 1264C, IAB 1/8/14, effective 3/1/14; ARC 1976C, IAB 4/29/15, effective 7/1/15]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) Physician examination. The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

a. Has been advised that it may be in the member's best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) Audiological testings. A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) Hearing aid evaluation. A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) Hearing aid selection. A physician or audiologist may recommend a specific brand or model appropriate to the member's condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member's condition.

78.14(5) Travel. When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member's place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) Purchase of hearing aid. The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

a. A child needs the aid for speech development,

b. The aid is needed for educational or vocational purposes,

c. The aid is for a blind member,

d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or

e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) Payment for hearing aids.

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1) “a.”

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member’s hearing that would require a different hearing aid. (Cross-reference 78.28(4) “a”)

(2) Payment for a hearing aid costing more than \$650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross-reference 78.28(4) “b”):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 8008B, IAB 7/29/09, effective 8/1/09]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) Definitions.

“Custom-molded shoe” means a shoe that:

1. Has been constructed over a cast or model of the recipient’s foot;
2. Is made of leather or another suitable material of equal quality;
3. Has inserts that can be removed, altered, or replaced according to the recipient’s conditions and needs; and
4. Has some form of closure.

“Depth shoe” means a shoe that:

1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

“Insert” means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient’s foot or is made over a model of the foot.

78.15(2) Prescription. The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient’s diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) Diagnosis. The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

- (1) The reasons the recipient cannot be fitted with a depth shoe.
- (2) Pain.
- (3) Tissue breakdown or a high probability of tissue breakdown.
- (4) Any limitation on walking.

78.15(4) Frequency. Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

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

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1) "b" with the following exceptions:

- (1) Services by staff psychiatrists, or
- (2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or
- (3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1) "b"(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1) "b"(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6) "b."

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. *Program documentation.* Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

- (1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.
- (2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs "c" to "h" below.
- (3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.
- (4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.
- (5) Any accreditations or other types of approvals from national or state organizations.
- (6) The physical facility and any equipment to be utilized.
 - b. *Program standards.* Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:
 - (1) Staffing shall:
 1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.
 2. Reflect how program continuity will be provided.
 3. Reflect an interdisciplinary team of professionals and paraprofessionals.
 4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.
 5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.
 - (2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.
 - (3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.
 - (4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.
 - (5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. *Program services.* Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with

appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. *Admission criteria.* Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. *Individual treatment plan.* Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the "National Register of Health Service Providers in Psychology" or the "Iowa Register of Health Service Providers for Psychology." Approval will be evidenced by a signature of the physician or health service provider.

f. *Discharge criteria.* Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient's clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient's needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. *Coordination of services.* Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. *Stable milieu.* The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. *Chronic mental illness.* Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

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

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

- (1) Six screenings in the first year of life.
- (2) Four screenings between the ages of 1 and 2.
- (3) One screening a year at ages 3, 4, 5, and 6.
- (4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Rescinded IAB 12/3/08, effective 2/1/09.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.19(249A) Rehabilitation agencies.

78.19(1) *Coverage of services.*

a. *General provisions regarding coverage of services.*

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided to a member residing in a residential care facility are payable when the facility submits a signed statement that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability since these facilities are responsible for providing or paying for services required by members.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling

condition whose status is stable rather than posthospital. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1) "b"(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to

establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy

ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)
2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)
3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.
4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.
5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.
6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.
7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.
8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. *Occupational therapy services.*

- (1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of

public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b"(7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1) "b"(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b"(7), (8), and (16) apply to speech therapy. If the only goal

of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number "5" under 78.19(1) "b"(16) will not apply to trial therapy.

78.19(2) General guidelines for plans of treatment.

a. The minimum information to be included on medical information forms and treatment plans includes:

- (1) The patient's current medical condition and functional abilities, including any disabling condition.
- (2) The physician's signature and date (within the certification period).
- (3) Certification period.
- (4) Patient's progress in measurable statistics. (Refer to 78.19(1) "b"(16).)
- (5) The place services are rendered.
- (6) Dates of prior hospitalization (if applicable or known).
- (7) Dates of prior surgery (if applicable or known).
- (8) The date the patient was last seen by the physician (if available).
- (9) A diagnosis relevant to the medical necessity for treatment.
- (10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).
- (11) A brief summary of the initial evaluation or baseline.
- (12) The patient's prognosis.
- (13) The services to be rendered.
- (14) The frequency of the services and discipline of the person providing the service.
- (15) The anticipated duration of the services and the estimated date of discharge (if applicable).
- (16) Assistive devices to be used.
- (17) Functional limitations.
- (18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.
- (19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).

b. The information to be included when developing plans for teaching, training, and counseling include:

- (1) To whom the services were provided (patient, family member, etc.).
- (2) Prior teaching, training, or counseling provided.
- (3) The medical necessity of the rendered services.
- (4) The identification of specific services and goals.
- (5) The date of the start of the services.
- (6) The frequency of the services.
- (7) Progress in response to the services.
- (8) The estimated length of time the services are needed.

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

[ARC 0994C, IAB 9/4/13, effective 11/1/13]

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

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

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) Sterilization. Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

- a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or
- b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or
- c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.
- d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.
- e. Mileage at the same rate as in 78.1(8) when the following conditions are met:
 - (1) It is necessary for the psychologist to travel outside of the home community, and
 - (2) There is no qualified mental health professional more immediately available in the community, and
 - (3) The member has a medical condition which prohibits travel.
- f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.
- g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

- a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.
- b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.
- c. Psychological examinations employing unusual or experimental instrumentation.
- d. Individual and group psychotherapy without specification of condition, symptom, or complaint.
- e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

- a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.
- b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.25(1) Provider qualifications.

- a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.
- b. Rescinded IAB 12/3/08, effective 2/1/09.
- c. Education services and postpartum home visits shall be provided by a registered nurse.

- d. Nutrition services shall be provided by a licensed dietitian.
- e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) Services covered for all pregnant women. Services provided may include:

- a. Prenatal and postpartum medical care.
- b. Health education, which shall include:
 - (1) Importance of continued prenatal care.
 - (2) Normal changes of pregnancy including both maternal changes and fetal changes.
 - (3) Self-care during pregnancy.
 - (4) Comfort measures during pregnancy.
 - (5) Danger signs during pregnancy.
 - (6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.
 - (7) Preparation for baby including feeding, equipment, and clothing.
 - (8) Education on the use of over-the-counter drugs.
 - (9) Education about HIV protection.
- c. Home visit.
- d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).
- e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)“b.”

78.25(3) Enhanced services covered for women with high-risk pregnancies. Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

- a. Rescinded IAB 12/3/08, effective 2/1/09.
- b. Education, which shall include as appropriate education about the following:
 - (1) High-risk medical conditions.
 - (2) High-risk sexual behavior.
 - (3) Smoking cessation.
 - (4) Alcohol usage education.
 - (5) Drug usage education.
 - (6) Environmental and occupational hazards.
- c. Nutrition assessment and counseling, which shall include:
 - (1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
 - (2) Ongoing nutritional assessment.
 - (3) Development of an individualized nutritional care plan.
 - (4) Referral to food assistance programs if indicated.
 - (5) Nutritional intervention.
- d. Psychosocial assessment and counseling, which shall include:
 - (1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
 - (2) A profile of the client’s family composition, patterns of functioning and support systems.
 - (3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.
- e. A postpartum home visit within two weeks of the child’s discharge from the hospital, which shall include:

- (1) Assessment of mother's health status.
- (2) Physical and emotional changes postpartum.
- (3) Family planning.
- (4) Parenting skills.
- (5) Assessment of infant health.
- (6) Infant care.
- (7) Grief support for unhealthy outcome.
- (8) Parenting of a preterm infant.
- (9) Identification of and referral to community resources as needed.

78.25(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's Web site.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

- a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;
- b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and
- c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

- a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.
- b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.
- c. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239, or in local hospital utilization review offices. (Cross-reference 78.28(6))

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

[ARC 8205B, IAB 10/7/09, effective 11/11/09]

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Plan for Behavioral Health.

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.

“Care coordinator” means the professional who assists members in care coordination as described in paragraph 78.53(1) “b.”

“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.

“Integrated health home” means the provision of services to enrolled members as described in subrule 78.53(1).

“Interdisciplinary team” means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

“ISIS” means the department’s individualized services information system.

“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 or integrated health home care coordinator has completed an assessment of the member’s need for service, and, based on that assessment, the Iowa Medicaid enterprise medical services unit or the Iowa Plan for Behavioral Health contractor has determined that the member is in need of home- and community-based habilitation services. A member who is not eligible for integrated health home services shall receive Medicaid case management under 441—Chapter 90 as a home- and community-based habilitation service. The designated case manager or integrated health home care coordinator 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 or the Iowa Plan for Behavioral Health contractor has approved the member's plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated through ISIS or in a treatment plan that has been authorized by the Iowa Plan for Behavioral Health contractor shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member's needs.

(2) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

f. *Iowa Plan for Behavioral Health eligibility.* Members eligible to enroll in the Iowa Plan for Behavioral Health shall be eligible to receive home- and community-based habilitation services only through the Iowa Plan for Behavioral Health.

78.27(3) Application for services. The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the Iowa Plan for Behavioral Health contractor or by entering a program request for habilitation services in ISIS for members who are not eligible to enroll in the Iowa Plan for Behavioral Health for any reason. The department or the Iowa Plan for Behavioral Health contractor shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the comprehensive service plan or treatment 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 or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. *Development.* A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team for the member. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved.

(2) With the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise for members who are not eligible to enroll in the Iowa Plan for Behavioral Health, in the individualized services information system before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager, integrated health home care coordinator, or service worker within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise for members not eligible to enroll in the Iowa Plan for Behavioral Health, in the individualized services information system before the implementation of services. Services provided before the approval date are not payable.

b. *Service goals and activities.* The comprehensive service plan shall:

- (1) Identify observable or measurable individual goals.
- (2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;
2. The funding source for the service; and
3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;
2. The number of hours per day of on-site staff supervision needed by the member; and
3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. *Rights restrictions.* Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;
- (2) The need for the restriction; and
- (3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. *Emergency plan.* The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

(1) The member's interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

(2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

(3) Providers of applicable services shall provide for emergency backup staff.

e. *Plan approval.*

(1) A treatment plan that has been validated and authorized by the Iowa Plan for Behavioral Health contractor shall be considered approved.

(2) For members who are not Iowa Plan-eligible, services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2) "e."

78.27(5) Requirements for services. Home- and community-based habilitation services shall be provided in accordance with the following requirements:

- a. The services shall be based on the member's needs as identified in the member's comprehensive service plan.
- b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.
- c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.
- d. Service components that are the same or similar shall not be provided simultaneously.
- e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.
- f. Reimbursement is not available for room and board.
- g. Services shall be billed in whole units.
- h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) Case management. Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

- a. *Scope.* Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

- b. *Exclusions.*

- (1) Payment shall not be made for case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes.

- (2) Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) Home-based habilitation. "Home-based habilitation" means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. *Scope.* Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

- (1) Adaptive skill development;
- (2) Assistance with activities of daily living;
- (3) Community inclusion;
- (4) Transportation;
- (5) Adult educational supports;
- (6) Social and leisure skill development;
- (7) Personal care; and
- (8) Protective oversight and supervision.

b. *Exclusions.* Home-based habilitation payment shall not be made for the following:

- (1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.
- (2) Service activities associated with vocational services, day care, medical services, or case management.
- (3) Transportation to and from a day program.
- (4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or “bundled” service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) Day habilitation. “Day habilitation” means assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

a. *Scope.* Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member’s maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member’s:

- (1) Intellectual functioning;
- (2) Physical and emotional health and development;
- (3) Language and communication development;
- (4) Cognitive functioning;
- (5) Socialization and community integration;
- (6) Functional skill development;
- (7) Behavior management;
- (8) Responsibility and self-direction;
- (9) Daily living activities;
- (10) Self-advocacy skills; or
- (11) Mobility.

b. *Setting.* Day habilitation shall take place in a nonresidential setting separate from the member’s residence. Services shall not be provided in the member’s home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member’s home if the services are provided in an area apart from the member’s sleeping accommodations.

c. *Duration.* Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member’s comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

d. *Exclusions.* Day habilitation payment shall not be made for the following:

- (1) Vocational or prevocational services.
- (2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
- (3) Compensation to members for participating in day habilitation services.

78.27(9) Prevocational 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 rehabilitative 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 15 minutes. A maximum of 104 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 or the Iowa Plan for Behavioral Health contractor determines that:

- (1) The member is not eligible for or in need of home- and community-based habilitation services.
- (2) The service is not identified in the member's comprehensive service plan or treatment plan.
- (3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

- (5) Completion or receipt of required documents for the program has not occurred.

b. *Reduction.* A particular home- and community-based habilitation service may be reduced when the department or the Iowa Plan for Behavioral Health contractor 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 or the Iowa Plan for Behavioral Health contractor 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 or the Iowa Plan for Behavioral Health contractor 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.

(1) The Iowa Plan for Behavioral Health contractor shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7.

(2) The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

78.27(12) County reimbursement. Rescinded IAB 7/11/12, effective 7/1/12.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13]

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

78.28(1) Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization,

reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Automated medication dispenser. Payment shall be approved pursuant to the criteria at 78.10(5) "d."

c. Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5) "l."

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

e. Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5) "f."

f. Preprocedure review by the 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. Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5) "a."

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross-reference 78.10(2) "c")

i. Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5) "m."

j. Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5) "c."

k. Diabetic equipment and supplies. Payment will be approved pursuant to the criteria at 78.10(5) "e."

l. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5) "n."

m. Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5) "g."

n. Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5) "h."

o. Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5) "i."

p. Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5) "j."

q. Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.

r. Customized wheelchairs for members who are residents of nursing facilities, subject to the requirements of 78.10(2) "a"(4).

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

a. The following periodontal services:

(1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4) "b."

(2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4) "d."

(3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4) "e."

(4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4) "f."

(5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4) "g."

b. The following prosthetic services:

(1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) "b."

(2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) "d."

(3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) "c."

(4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) "e."

(5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7) "k."

(6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7) "l."

(7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7) "m."

(8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7) "n."

c. The following orthodontic services:

(1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8) "a."

(2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) "b."

(3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) "c."

d. The following restorative services:

(1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3) "d"(3).

(2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3) "d"(4).

e. Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5) "d."

f. Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9) "g."

78.28(3) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

d. Photochromatic tint. Approval shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Press-on prisms. Approval shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross-references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(4) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond

repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross-reference 78.14(7) "d"(1))

b. A hearing aid costing more than \$650. The department shall approve payment for either of the following purposes (Cross-reference 78.14(7) "d"(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(5) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross-reference 441—78.1(249A))

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

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

78.28(6) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

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

78.28(7) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(8) Rescinded IAB 1/3/96, effective 3/1/96.

78.28(9) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.9(10))

78.28(10) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross-reference 78.10(3) "b")

78.28(11) High-technology radiology procedures.

a. Except as provided in paragraph 78.28(11) "b," the following radiology procedures require prior approval:

- (1) Magnetic resonance imaging (MRIs);
- (2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;
- (3) Computed tomographic angiographs (CTAs);
- (4) Positron emission tomography (PETs); and
- (5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(11) "a," prior authorization is not required when any of the following applies:

(1) Radiology procedures are billed on a CMS 1500 claim for places of service "hospital inpatient" (POS 21) or "hospital emergency room" (POS 23), or on a UB04 claim with revenue code 45X;

- (2) The member has Medicare coverage;

(3) The member received notice of retroactive Medicaid eligibility after receiving a radiology procedure at a time prior to the member's receipt of such notice (see paragraph 78.28(11) "e"); or

(4) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted through the online system operated by the department's contractor for prior approval of high-technology radiology procedures.

e. Services are billed for members with retroactive eligibility.

(1) When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member's receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-0829, Request for Prior Authorization, before any claim for payment is submitted.

(2) Payment will be authorized only if the prior approval criteria were met and the service was provided to the member prior to the retroactive eligibility notification, as documented by the provider requesting retroactive authorization.

(3) Retroactive authorizations will not be granted when sought for reasons other than a member's retroactive Medicaid eligibility. Examples of such reasons include, but are not limited to, the following:

1. The provider was unaware of the high-technology radiology prior authorization requirement.
2. The provider was unaware that the member had current Medicaid eligibility or coverage.
3. The provider forgot to complete the required prior authorization process.

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

[ARC 754B, IAB 2/11/09, effective 4/1/09; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1696C, IAB 10/29/14, effective 1/1/15]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) Limitations.

- a. An assessment and a treatment plan are required.
- b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) Exclusions. Payment will not be approved for the following services:

- a. Services provided in a medical institution.
- b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.
- c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.
- d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) Payment.

- a. Payment shall be made only for time spent in face-to-face consultation with the member.
- b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

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

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

- a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.
- b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.31(249A) Hospital outpatient services.

78.31(1) Covered hospital outpatient services. Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs "g" to "m" are subject to a random sample retrospective review for medical necessity by the Iowa Foundation for Medical Care. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs "a" to "f" shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs "g" to "m" shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

- a. Emergency service.
- b. Outpatient surgery.
- c. Laboratory, X-ray and other diagnostic services.
- d. General or family medicine.
- e. Follow-up or after-care specialty clinics.
- f. Physical medicine and rehabilitation.
- g. Alcoholism and substance abuse.
- h. Eating disorders.
- i. Cardiac rehabilitation.

- j. Mental health.
- k. Pain management.
- l. Diabetic education.
- m. Pulmonary rehabilitation.
- n. Nutritional counseling for persons aged 20 and under.

78.31(2) Requirements for all outpatient services.

a. *Need for service.* It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. *Professional direction.* All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. *Goals and objectives.* The goals and objectives of the program must be clearly stated. Paragraphs "d" and "f" and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. *Treatment modalities used.* The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. *Criteria for selection and continuing treatment of patients.* The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. *Length of program.* There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. *Monitoring of services.* The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. *Vaccines.* In order to be paid for the outpatient administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.31(3) Application for certification. Hospital outpatient programs listed in subrule 78.31(1), paragraphs "g" to "m," must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff's relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) Requirements for specific types of service.

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

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

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

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

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

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association.

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

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

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

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

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

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

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

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

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

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

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

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

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

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

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

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

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

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

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

c. Cardiac rehabilitation.

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

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

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

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

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

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

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

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

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise

equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

- Referral form.
- Physician's orders.
- Laboratory reports.
- Electrocardiogram reports.
- History and physical examination.
- Angiogram report, if applicable.
- Operative report, if applicable.
- Preadmission interview.
- Exercise prescription.
- Rehabilitation plan, including participant's goals.
- Documentation for exercise sessions and progress notes.
- Nurse's progress reports.
- Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, disrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

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

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

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

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

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

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

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15]

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.

78.33(1) Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

a. Members who are 18 years of age or over and have a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

b. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

78.33(2) Notwithstanding subrule 78.33(1), payment shall not be made for targeted case management services for members who are enrolled in the Iowa Plan for Behavioral Health to receive habilitation pursuant to rule 441—78.27(249A) and are enrolled in an integrated health home as described in rule 441—78.53(249A). Members enrolled in the Iowa Plan for Behavioral Health for habilitation and an integrated health home shall receive care coordination in lieu of case management.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13]

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to members eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.34(1) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.34(2) Home health services. Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

a. Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

(8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.34(4) Nursing care services. Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.34(6) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7) "f" and the skilled activities listed in paragraph 78.34(7) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. *Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. *Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

- (8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. *Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.34(8) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.

- (19) New door opening.
 - (20) Pocket doors.
 - (21) Installation or relocation of controls, outlets, switches.
 - (22) Air conditioning and air filtering if medically necessary.
 - (23) Heightening of existing garage door opening to accommodate modified van.
 - (24) Bath chairs.
 - c. A unit of service is the completion of needed modifications or adaptations.
 - d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.
 - e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.
 - f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.
 - g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.
- (1) Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.
 - (2) The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.
 - h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.
- 78.34(10) Personal emergency response or portable locator system.**
- a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.
 - (1) The required components of the system are:
 1. An in-home medical communications transceiver.
 2. A remote, portable activator.
 3. A central monitoring station with backup systems staffed by trained attendants at all times.
 4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.
 - (2) The service shall be identified in the member's service plan.
 - (3) A unit of service is a one-time installation fee or one month of service.
 - (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.
 - b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.
 - (1) The required components of the portable locator system are:
 1. A portable communications transceiver or transmitter to be worn or carried by the member.
 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
 - (2) The service shall be identified in the member's service plan.
 - (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
 - (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.34(12) Nutritional counseling. Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.34(13) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13) "b"(3).

(6) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13) "b"(2) or the utilization adjustment factor in subparagraph 78.34(13) "b"(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the

case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. *Required service components.* To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. *Optional service components.* A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. *Development of the individual budget.* The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.
(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.

12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)"d." The savings plan shall meet the requirements in paragraph 78.34(13)"f."

f. *Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
 2. Be medically necessary, and
 3. Be approved by the member's case manager or service worker.
- (4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.
- (5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. *Budget authority.* The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.
(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member’s legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) “b” must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member’s legal representative provides services to the member as allowed by 441—paragraph 79.9(7) “b,” the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.
(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. *Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.
(2) The representative shall not be a current provider of service to the member.
(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.
(4) The representative shall not be paid for this service.

i. *Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. *Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee’s and member’s responsibilities.

k. *Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member’s representative:

- (1) Assist the member with developing the member’s initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.34(14) General service standards. All ill and handicapped waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.36(249A) Hospice services.

78.36(1) General characteristics. A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

- (1) Nursing care.
- (2) Medical social services.
- (3) Physician services.

(4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.

(5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.

(6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

(7) Homemaker and home health aide services.

(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.

(9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) Categories of care. Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) Residence in a nursing facility. For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) Approval for hospice benefits. Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. *Physician certification process.* The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. *Election procedures.* Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) *Election statement.* An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) *Change of designation.* An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) *Effective date.* An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) *Duration of election.* The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) *Revocation.* Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

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

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.37(1) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.37(2) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
- (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.37(5) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.37(7) Chore services. Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7) "a," as necessary to allow a member to remain in the member's own home safely and independently. A unit of service is 15 minutes.

a. Chore services are limited to the following services:

(1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;

(2) Minor repairs to walls, floors, stairs, railings and handles;

(3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;

(4) Lawn mowing and removal of snow and ice from sidewalks and driveways.

b. Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

78.37(8) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.37(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
 - (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
 - (3) Grab bars and handrails.
 - (4) Turnaround space adaptations.
 - (5) Ramps, lifts, and door, hall and window widening.
 - (6) Fire safety alarm equipment specific for disability.
 - (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
 - (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
 - (9) Keyless entry systems.
 - (10) Automatic opening device for home or vehicle door.
 - (11) Special door and window locks.
 - (12) Specialized doorknobs and handles.
 - (13) Plexiglas replacement for glass windows.
 - (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
 - (15) Motion detectors.
 - (16) Low-pile carpeting or slip-resistant flooring.
 - (17) Telecommunications device for the deaf.
 - (18) Exterior hard-surface pathways.
 - (19) New door opening.
 - (20) Pocket doors.
 - (21) Installation or relocation of controls, outlets, switches.
 - (22) Air conditioning and air filtering if medically necessary.
 - (23) Heightening of existing garage door opening to accommodate modified van.
 - (24) Bath chairs.
- c. A unit of service is the completion of needed modifications or adaptations.
- d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.
- e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.
- f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.
- g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.
- h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) Mental health outreach. Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.37(12) Nutritional counseling. Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) Assistive devices. Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) Senior companion. Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(15) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15) "f" and the skilled activities listed in paragraph 78.37(15) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. *Service documentation.* The consumer-directed attendant care individual and agency providers must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Assisted living facilities may choose to use Form 470-4389 or may devise another system that adheres to the requirements of rule 441—79.3(249A). Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

f. *Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. *Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

- (2) Intravenous therapy administered by a registered nurse.
 - (3) Parenteral injections required more than once a week.
 - (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
 - (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
 - (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
 - (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
 - (8) Colostomy care.
 - (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
 - (10) Postsurgical nursing care.
 - (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
 - (12) Preparing and monitoring response to therapeutic diets.
 - (13) Recording and reporting of changes in vital signs to the nurse or therapist.
- h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):
- (1) Any activity related to supervising a member. Only direct services are billable.
 - (2) Any activity that the member is able to perform.
 - (3) Costs of food.
 - (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
 - (5) Exercise that does not require skilled services.
 - (6) Parenting or child care for or on behalf of the member.
 - (7) Reminders and cueing.
 - (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
 - (9) Transportation costs.
 - (10) Wait times for any activity.

78.37(16) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.

2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.37(16) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.37(16) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.37(16) "b"(3).

(6) Anticipated costs for home and vehicle modification and assistive devices are not subject to the average cost in subparagraph 78.37(16) "b"(2) or the utilization adjustment factor in subparagraph 78.37(16) "b"(3). Anticipated costs for home and vehicle modification and assistive devices shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and assistive devices may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. *Required service components.* To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. *Optional service components.* A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.

2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
 3. Be accommodated within the member's budget without compromising the member's health and safety.
 4. Be provided to the member or directed exclusively toward the benefit of the member.
 5. Be the least costly to meet the member's needs.
 6. Not be available through another source.
- e. *Development of the individual budget.* The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:
- (1) The costs of the financial management service.
 - (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.
 - (3) The costs of any optional service component chosen by the member as described in paragraph 78.37(16) "d." Costs of the following items and services shall not be covered by the individual budget:
 1. Child care services.
 2. Clothing not related to an assessed medical need.
 3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
 4. Costs associated with shipping items to the member.
 5. Experimental and non-FDA-approved medications, therapies, or treatments.
 6. Goods or services covered by other Medicaid programs.
 7. Home furnishings.
 8. Home repairs or home maintenance.
 9. Homeopathic treatments.
 10. Insurance premiums or copayments.
 11. Items purchased on installment payments.
 12. Motorized vehicles.
 13. Nutritional supplements.
 14. Personal entertainment items.
 15. Repairs and maintenance of motor vehicles.
 16. Room and board, including rent or mortgage payments.
 17. School tuition.
 18. Service animals.
 19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
 20. Sheltered workshop services.
 21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
 22. Vacation expenses, other than the costs of approved services the member needs while on vacation.
 - (4) The costs of any approved home or vehicle modification or assistive device. When authorized, the budget may include an amount allocated for a home or vehicle modification or an assistive device. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or device.
 - (5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.37(16) "d." The savings plan shall meet the requirements in paragraph 78.37(16) "f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. *Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. *Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. *Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. *Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

78.37(17) Case management services. Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

- a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).
- b. Case management shall not include the provision of direct services by the case managers.
- c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

78.37(18) Assisted living on-call service. The assisted living on-call service provides staff on call 24 hours per day to meet a member's scheduled, unscheduled, and unpredictable needs in a manner that promotes maximum dignity and independence and provides safety and security. A unit of service is one day. To determine units of service provided, the provider will use census information based on member bed status each day.

78.37(19) General service standards. All elderly waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. Services must be billed in whole units.
- d. For all services with a 15-minute unit of service, the following rounding process will apply:

- (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
- (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
- (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
- (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member’s service plan.

78.38(1) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member’s family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member’s disability or terminal condition. Counseling services may be provided to the member’s caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member’s caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

- a. Observation and reporting of physical or emotional needs.
- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client’s health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.38(4) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by

the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.38(6) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.38(7) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.38(8) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8) "f" and the skilled activities listed in paragraph 78.38(8) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. *Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. *Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. *Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. *Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.38(9) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that

are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.38(9) "b "(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.38(9) "b "(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.38(9) "b "(3).

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.

2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
 3. Be accommodated within the member's budget without compromising the member's health and safety.
 4. Be provided to the member or directed exclusively toward the benefit of the member.
 5. Be the least costly to meet the member's needs.
 6. Not be available through another source.
- e. *Development of the individual budget.* The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:
- (1) The costs of the financial management service.
 - (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.
 - (3) The costs of any optional service component chosen by the member as described in paragraph 78.38(9)"d." Costs of the following items and services shall not be covered by the individual budget:
 1. Child care services.
 2. Clothing not related to an assessed medical need.
 3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
 4. Costs associated with shipping items to the member.
 5. Experimental and non-FDA-approved medications, therapies, or treatments.
 6. Goods or services covered by other Medicaid programs.
 7. Home furnishings.
 8. Home repairs or home maintenance.
 9. Homeopathic treatments.
 10. Insurance premiums or copayments.
 11. Items purchased on installment payments.
 12. Motorized vehicles.
 13. Nutritional supplements.
 14. Personal entertainment items.
 15. Repairs and maintenance of motor vehicles.
 16. Room and board, including rent or mortgage payments.
 17. School tuition.
 18. Service animals.
 19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
 20. Sheltered workshop services.
 21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
 22. Vacation expenses, other than the costs of approved services the member needs while on vacation.
 - (4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.
 - (5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.38(9)"d." The savings plan shall meet the requirements in paragraph 78.38(9)"f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. *Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. *Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. *Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. *Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

78.38(10) General service standards. All AIDS/HIV waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. Services must be billed in whole units.
- d. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered

nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) Direct payment. Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) Location of service. Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) Prenatal risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.41(1) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1)"f"(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

78.41(2) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.

i. Payment for respite services shall not exceed \$7,262 per the member's waiver year.

78.41(3) Personal emergency response or portable locator system.

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

- (1) The necessary components of the system are:
 1. An in-home medical communications transceiver.
 2. A remote, portable activator.
 3. A central monitoring station with backup systems staffed by trained attendants at all times.
 4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.
- (2) The service shall be identified in the member's service plan.
- (3) A unit of service is a one-time installation fee or one month of service.
- (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.
 - b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.
 - (1) The required components of the portable locator system are:
 1. A portable communications transceiver or transmitter to be worn or carried by the member.
 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
 - (2) The service shall be identified in the member's service plan.
 - (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
 - (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.

- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.
 - c. A unit of service is the completion of needed modifications or adaptations.
 - d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.
- e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.
- f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.
- g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.
- h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) Nursing services. Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

- a. A unit of service is one hour.
- b. A maximum of ten units are available per week.

78.41(6) Home health aide services. Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

- a. Services shall be included in the member's service plan.
- b. A unit is one hour.
- c. A maximum of 14 units are available per week.

78.41(7) Supported employment services. Supported employment services are 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 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 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 member's interdisciplinary team must determine that the identified services are necessary. Third, the member'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 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:

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 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 441—subrule 83.67(1). 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:

1. Developing relationships with employers and providing leads for individual members 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 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 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 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the member.
 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 member 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 member 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 members in a team of no more than eight individuals with disabilities in a teamwork or “enclave” setting.
 - (3) A unit of service is 15 minutes.
 - (4) A maximum of 160 units may be received per week.
 - c. The following requirements apply to all supported employment services:
 - (1) Employment-related adaptations required to assist the member within the performance of the member’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 members seek, obtain, or maintain employment must be persons without disabilities. 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.
 - (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 member.
 - (6) All services shall be identified in the member’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 members 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 member specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.41(8) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8)“f” and the skilled activities listed in paragraph 78.41(8)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service

component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. *Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. *Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. *Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheostomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. *Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment,

family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

- (5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.41(10) Residential-based supported community living services. Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's

stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23) "d."

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS intellectual disability waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.41(12) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.41(13) Prevocational services. Prevocational services are services that are aimed at preparing a member for paid or unpaid employment, but that are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but at more generalized habilitative goals, and are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) that are otherwise available to the member through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4.25 to 8 hours) or an hour (for up to 4 hours per day).

78.41(14) Day habilitation services.

a. **Scope.** Day habilitation services are services that assist or support the member in developing or maintaining life skills and community integration. Services must enable or enhance the member's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill

development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

b. *Family training option.* Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

c. *Unit of service.* Except as provided in paragraph 78.41(14) "b," the unit of service is 15 minutes (for up to 16 units per day) or a full day (4.25 to 8 hours per day).

d. *Exclusions.*

(1) Services shall not be provided in the member's home, except as provided in paragraph "b." For this purpose, services provided in a residential care facility where the member lives are not considered to be provided in the member's home.

(2) Services shall not include vocational or prevocational services and shall not involve paid work.

(3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(4) Services shall not be provided simultaneously with other Medicaid-funded services.

78.41(15) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disabilities waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.41(15) "b" (1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.41(15) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.41(15) "b"(3).

(6) Anticipated costs for home and vehicle modification and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.41(15) "b"(2) or the utilization adjustment factor in subparagraph 78.41(15) "b"(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Costs for home and vehicle modification and supported employment services to obtain a job may be paid to the financial management services provider in a one-time payment. Before becoming part of the individual budget, all home and vehicle modifications and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. *Required service components.* To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. *Optional service components.* A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. *Development of the individual budget.* The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.
- (3) The costs of any optional service component chosen by the member as described in paragraph 78.41(15) "d." Costs of the following items and services shall not be covered by the individual budget:
 1. Child care services.
 2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.41(15)"d." The savings plan shall meet the requirements in paragraph 78.41(15)"f."

f. *Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed

personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. *Budget authority.* The member shall have authority over the individual budget authorized by the department to perform the following tasks:

- (1) Contract with entities to provide services and supports as described in this subrule.
- (2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

- (4) Authorize payment for optional service components identified in the individual budget.
- (5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. *Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

- (1) The representative must be at least 18 years old.
- (2) The representative shall not be a current provider of service to the member.
- (3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.
- (4) The representative shall not be paid for this service.

i. *Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. *Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. *Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 4. Computing and processing other withholdings, as applicable.
 5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
 6. Preparing and issuing employee payroll checks.
 7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
 8. Processing federal advance earned income tax credit for eligible employees.
 9. Refunding over-collected FICA, when appropriate.
 10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.41(16) General service standards. All intellectual disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15]

441—78.42(249A) Pharmacies administering influenza vaccine to children. Payment will be made to a pharmacy for the administration of influenza vaccine available through the Vaccines for Children (VFC) Program administered by the department of public health if the pharmacy is enrolled in the VFC program. Payment will be made for the vaccine only if the VFC program stock has been depleted.

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

[ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.43(1) Case management services. Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

78.43(2) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management

or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2)"e"(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

78.43(4) Supported employment services. Supported employment services are 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 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 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 member's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the member'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 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:

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 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 rule 441—83.87(249A). 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:

1. Developing relationships with employers and providing leads for individual members 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 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 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the member.
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 member 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 member 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 members in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

- (3) A unit of service is 15 minutes.
- (4) A maximum of 160 units may be received per week.
 - c. The following requirements apply to all supported employment services:
 - (1) Employment-related adaptations required to assist the member within the performance of the member'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 members seek, obtain, or maintain employment must be persons without disabilities. 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.
 - (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 member.
 - (6) All services shall be identified in the member'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 members 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 member specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.43(5) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
 - (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
 - (3) Grab bars and handrails.
 - (4) Turnaround space adaptations.
 - (5) Ramps, lifts, and door, hall and window widening.
 - (6) Fire safety alarm equipment specific for disability.
 - (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
 - (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
 - (9) Keyless entry systems.
 - (10) Automatic opening device for home or vehicle door.
 - (11) Special door and window locks.
 - (12) Specialized doorknobs and handles.
 - (13) Plexiglas replacement for glass windows.
 - (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
 - (15) Motion detectors.
 - (16) Low-pile carpeting or slip-resistant flooring.
 - (17) Telecommunications device for the deaf.
 - (18) Exterior hard-surface pathways.
 - (19) New door opening.
 - (20) Pocket doors.
 - (21) Installation or relocation of controls, outlets, switches.
 - (22) Air conditioning and air filtering if medically necessary.
 - (23) Heightening of existing garage door opening to accommodate modified van.
 - (24) Bath chairs.
- c. A unit of service is the completion of needed modifications or adaptations.
- d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.
- e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker may encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
 2. A remote, portable activator.
 3. A central monitoring station with backup systems staffed by trained attendants at all times.
 4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.
- (2) The service shall be identified in the member's service plan.
- (3) A unit is a one-time installation fee or one month of service.
- (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
- (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) Specialized medical equipment.

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

- (1) Provide for health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
 - (2) Medicine dispensing devices.
 - (3) Communication devices.
 - (4) Bath aids.
 - (5) Noncovered environmental control units.
 - (6) Repair and maintenance of items purchased through the waiver.
- c. Payment of up to \$6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.
- d. The need for specialized medical equipment shall be:
- (1) Documented by a health care professional as necessary for the member's health and safety, and
 - (2) Identified in the member's service plan.
- e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.43(10) Family counseling and training services. Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) Prevocational services. Prevocational services are services which are aimed at preparing a member for paid or unpaid employment, but which are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but at more generalized habilitative goals and are reflected in a habilitative plan which 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)) which are otherwise available to the member through a state or local education agency, or

- (2) Vocational rehabilitation services which are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4.25 to 8 hours per day) or an hour (for up to 4 hours per day).

78.43(12) Behavioral programming. Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

- a. A complete assessment of both appropriate and maladaptive behaviors.
- b. Development of a structured behavioral intervention plan which should be identified in the ITP.

- c. Implementation of the behavioral intervention plan.
- d. Ongoing training and supervision to caregivers and behavioral aides.
- e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13) "f" and the skilled activities listed in paragraph 78.43(13) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. *Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. *Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. *Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheostomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. *Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

- (5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.43(15) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Specialized medical equipment.
7. Supported community living.
8. Supported employment.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.43(15) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.43(15) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.43(15) "b"(3).

(6) Anticipated costs for home and vehicle modification, specialized medical equipment, and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.43(15) "b"(2) or the utilization adjustment factor in subparagraph 78.43(15) "b"(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications, specialized medical equipment, and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker. Costs for these services may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. *Required service components.* To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled

as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.
- (3) The costs of any optional service component chosen by the member as described in paragraph 78.43(15) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.

18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.43(15)"d." The savings plan shall meet the requirements in paragraph 78.43(15)"f."

f. *Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
 2. Be medically necessary, and
 3. Be approved by the member's case manager or service worker.
- (4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. *Budget authority.* The member shall have authority over the individual budget authorized by the department to perform the following tasks:

- (1) Contract with entities to provide services and supports as described in this subrule.
- (2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits

in 441—subrule 79.1(2). The reimbursement rate for a member’s legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) “b” must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member’s legal representative provides services to the member as allowed by 441—paragraph 79.9(7) “b,” the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. *Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. *Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. *Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee’s and member’s responsibilities.

k. *Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member’s representative:

(1) Assist the member with developing the member’s initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.43(16) General service standards. All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. Services must be billed in whole units.
 - d. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) Applicability. ACT services may be provided only to a member who meets all of the following criteria:

- a. The member is at least 17 years old.
- b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:
 - (1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;
 - (2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and
 - (3) The member exhibits significant impairment in social, interpersonal, or familial functioning.
- c. The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

(2) The expected frequency and duration of each service,

(3) The location where the services will be provided,

(4) A crisis plan, and

(5) The schedule for updates of the treatment plan.

78.45(2) Services. The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. *Evaluation and medication management.*

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. *Integrated therapy and counseling for mental health and substance abuse.* This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. *Skill teaching.* Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. *Community support.* Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. *Medication monitoring.* Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. *Case management for treatment and service plan coordination.* Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. *Crisis response.* Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. *Work-related services.* Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.46(1) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1) "f" and the skilled activities listed in paragraph 78.46(1) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
 - (2) Ensure appropriate assessment, planning, implementation, and evaluation.
 - (3) Make on-site supervisory visits every two weeks with the service provider present.
- c. *Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. *Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. *Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. *Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.46(2) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker shall encumber a portion of the cost of a modification every month within

the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
- (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) Specialized medical equipment.

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

- (1) Provide for the health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.46(6) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.46(6) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.46(6) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.46(6) "b"(3).

(6) Anticipated costs for home and vehicle modification and specialized medical equipment are not subject to the average cost in subparagraph 78.46(6) "b"(2) or the utilization adjustment factor in subparagraph 78.46(6) "b"(3). Anticipated costs for home and vehicle modification and specialized medical equipment shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and specialized medical equipment may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. *Required service components.* To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.
- (3) The costs of any optional service component chosen by the member as described in paragraph 78.46(6)"d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.46(6)"d." The savings plan shall meet the requirements in paragraph 78.46(6)"f."

f. *Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. *Budget authority.* The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides

services to the member as allowed by 441—paragraph 79.9(7) “b” must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member’s legal representative provides services to the member as allowed by 441—paragraph 79.9(7) “b,” the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for waiver goods and services optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. *Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. *Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. *Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee’s and member’s responsibilities.

k. *Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member’s representative:

(1) Assist the member with developing the member’s initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.46(7) General service standards. All physical disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. Services must be billed in whole units.
 - d. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) Medicaid recipient eligibility. Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) Provider eligibility. Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

- b. Physicians shall be licensed to practice medicine.
- c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

- (1) A doctor of pharmacy degree program.
- (2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.
- (3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) Services. Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will

be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. *Initial assessment.* The initial assessment shall consist of:

- (1) A patient evaluation by the pharmacist, including:
 1. Medication history;
 2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
 3. Assessment for the presence of untreated illness; and
 4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.
- (2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. *New problem assessments.* These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. *Problem follow-up assessments.* These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. *Preventive follow-up assessments.* These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0358C, IAB 10/3/12, effective 11/7/12]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) Covered services. Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) Case management services. Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. *Definition.* "Case management" means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to

address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child's planned discharge if the child's stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child's planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child's service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

- (1) Taking the child's history;
- (2) Identifying the needs of the child;
- (3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;
- (4) Completing documentation of the information gathered and the assessment results; and
- (5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

- (1) Include the child's strengths and preferences;
 - (2) Consider the child's physical and social environment;
 - (3) Specify goals of providing services to the child; and
 - (4) Specify actions to address the child's medical, social, educational, and other service needs.
- These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are

capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.
2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.
3. Making referrals to providers for needed services.
4. Scheduling appointments for the child.
5. Facilitating the timely delivery of services.
6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.
2. Whether the services in the plan of care are adequate to meet the needs of the child.
3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. *Documentation of case management.* For each child receiving case management, case records must document:

- (1) The name of the child;
- (2) The dates of case management services;
- (3) The agency chosen by the family to provide the case management services;
- (4) The nature, content, and units of case management services received;
- (5) Whether the goals specified in the care plan have been achieved;
- (6) Whether the family has declined services in the care plan;
- (7) Time lines for providing services and reassessment; and
- (8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) Child's eligibility. Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) Delivery of services. Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) Remission of nonfederal share of costs. Payment for services shall be made only when the following conditions are met:

- a. Rescinded IAB 5/10/06, effective 7/1/06.
- b. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.
- c. The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

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

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) Covered services. Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a local education agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) Coordination services. Rescinded IAB 12/3/08, effective 2/1/09.

78.50(3) Delivery of services. Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) Remission of nonfederal share of costs. Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.52(1) General service standards. All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

78.52(2) Environmental modifications and adaptive devices.

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

- (1) Items ordinarily covered by Medicaid.
- (2) Items funded by educational or vocational rehabilitation programs.
- (3) Items provided by voluntary means.
- (4) Repair and maintenance of items purchased through the waiver.
- (5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.52(3) Family and community support services. Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

- (1) Developing and maintaining a crisis support network for the member and for the member's family.
- (2) Modeling and coaching effective coping strategies for the member's family members.
- (3) Building resilience to the stigma of serious emotional disturbance for the member and the family.
- (4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.
- (5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225C) for life situations with the member's family and in the community.
- (6) Developing medication management skills.
- (7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.
- (8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed \$1500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

- (1) Vocational services.
- (2) Prevocational services.
- (3) Supported employment services.
- (4) Room and board.
- (5) Academic services.
- (6) General supervision and care.

f. A unit of family and community support services is 15 minutes.

78.52(4) In-home family therapy. In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

78.52(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13]

441—78.53(249A) Health home services. Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible

Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

78.53(1) Covered services. Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

a. Comprehensive care management, which means:

(1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;

(2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and

(3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.

b. Care coordination, which means assisting members with:

(1) Medication adherence;

(2) Chronic disease management;

(3) Appointments, referral scheduling, and reminders; and

(4) Understanding health insurance coverage.

c. Health promotion, which means coordinating or providing behavior modification interventions aimed at:

(1) Supporting health management;

(2) Improving disease control; and

(3) Enhancing safety, disease prevention, and an overall healthy lifestyle.

d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:

(1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and

(2) Personal follow-up with the member regarding all needed follow-up after the transition.

e. Member and family support (including authorized representatives). This support may include:

(1) Communicating with and advocating for the member or family for the assessment of care decisions;

(2) Assisting with obtaining and adhering to medications and other prescribed treatments;

(3) Increasing health literacy and self-management skills; and

(4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.

f. Referral to community and social support services available in the community.

78.53(2) Members eligible for health home services.

a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:

(1) Has at least two chronic conditions;

(2) Has one chronic condition and is at risk of having a second chronic condition;

(3) Has a serious mental illness; or

(4) Has a serious emotional disturbance.

b. For purposes of this rule, the term "chronic condition" means:

(1) A mental health disorder.

(2) A substance use disorder.

(3) Asthma.

(4) Diabetes.

(5) Heart disease.

(6) Being overweight, as evidenced by:

1. Having a body mass index (BMI) over 25 for an adult, or

2. Weighing over the 85th percentile for the pediatric population.
- (7) Hypertension.
- c. For purposes of this rule, the term "serious mental illness" means:
- (1) A psychotic disorder;
- (2) Schizophrenia;
- (3) Schizoaffective disorder;
- (4) Major depression;
- (5) Bipolar disorder;
- (6) Delusional disorder; or
- (7) Obsessive-compulsive disorder.
- d. For purposes of this rule, the term "serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term "functional impairment" means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person's role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person's environment.

78.53(3) Selection of health home services provider. As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member's health home, as reported by the provider. A member must select a provider located in the member's county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

441—78.54(249A) Speech-language pathology services. Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158. [ARC 0360C, IAB 10/3/12, effective 12/1/12]

441—78.55(249A) Services rendered via telehealth. An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 653—13.11(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

This rule is intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, division V, section 12(23).

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¹ Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

³ Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

⁴ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

⁵ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

⁶ Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

⁷ July 1, 2009, effective date of amendments to 78.27(2) "d" delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

⁸ May 11, 2011, effective date of 78.34(5) "d," 78.38(5) "h," 78.41(2) "g," 78.43(3) "d," and 78.52(5) "a" delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF
MEDICAL AND REMEDIAL CARE
[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

79.1(1) Types of reimbursement.

a. *Prospective cost-related.* Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. *Retrospective cost-related.* Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. *Fee schedules.* Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. *Fee for service with cost settlement.* Providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider

during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:

1. The indirect administrative costs shall be limited to 23 percent of other costs. Other costs include: professional staff – direct salaries, other – direct salaries, benefits and payroll taxes associated with direct salaries, mileage and automobile rental, agency vehicle expense, automobile insurance, and other related transportation.

2. Mileage shall be reimbursed at a rate no greater than the state employee rate.

3. The rates a provider may charge are subject to limits established at 79.1(2).

4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. *Retrospectively limited prospective rates.* Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1) "e" (3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.

f. *Contractual rate.* Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. *Retrospectively adjusted prospective rates.* Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5) "aa" and 79.1(16) "h."

h. *Indian health service 638 facilities.* Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) Basis of reimbursement of specific provider categories.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10%. Air ambulance: Fee schedule in effect 6/30/14 plus 10%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	\$51.08 per day for each day on which a team meeting is held. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Behavioral health intervention	Fee schedule as determined by the Iowa Plan for Behavioral Health	Fee schedule in effect 7/1/13.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	<ol style="list-style-type: none"> 1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
HCBS waiver service providers, including:		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.
1. Adult day care	Fee schedule	Except as noted, limits apply to all waivers that cover the named provider.
		Effective 7/1/13, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider’s rate in effect 6/30/13 plus 3%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/13 rate: Veterans Administration contract rate or \$1.45 per 15-minute unit, \$23.24 per half day, \$46.26 per full day, or \$69.37 per extended day if no Veterans Administration contract.
2. Emergency response system:		Effective 7/1/13, for intellectual disability waiver: County contract rate or, in the absence of a contract rate, provider’s rate in effect 6/30/13 plus 3%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/13 rate, \$1.94 per 15-minute unit, \$30.96 per half day, \$61.80 per full day, or \$78.80 per extended day.
Personal response system	Fee schedule	Effective 7/1/13, provider’s rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.
Portable locator system	Fee schedule	Effective 7/1/13, provider’s rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: One equipment purchase: \$323.26. Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%.
4. Homemakers	Fee schedule	For intellectual disability waiver effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to an hourly rate.
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.20 per 15-minute unit.
6. Respite care when provided by:		For elderly waiver effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$87.12 per visit.
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	For AIDS/HIV and health and disability waivers effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$87.12 per visit.
		For AIDS/HIV and health and disability waivers effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$87.12 per visit.
		Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, not to exceed \$311.97 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, not to exceed \$311.97 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$8.87 per 15-minute unit, not to exceed \$311.97 per day.
Basic individual respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.73 per 15-minute unit, not to exceed \$311.97 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$8.87 per 15-minute unit, not to exceed \$311.97 per day.
Basic individual respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.73 per 15-minute unit, not to exceed \$311.97 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.
Adult day care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.05 per 15-minute unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
8. Home-delivered meals	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$8.10 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/13: \$1,061.11 lifetime maximum.
		For intellectual disability waiver effective 7/1/13: \$5,305.53 lifetime maximum.
10. Mental health outreach providers	Fee schedule	For brain injury, health and disability, and physical disability waivers effective 7/1/13: \$6,366.64 per year.
11. Transportation	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
12. Nutritional counseling	Fee schedule	Effective 10/1/13: The provider's nonemergency medical transportation contract rate or, in the absence of a nonemergency medical transportation contract rate, the median nonemergency medical transportation contract rate paid per mile or per trip within the member's DHS region.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/13 for non-county contract: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$8.67 per 15-minute unit.
14. Senior companion	Fee schedule	Effective 7/1/13 for non-county contract: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$1.87 per 15-minute unit.
15. Consumer-directed attendant care provided by: Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.30 per 15-minute unit, not to exceed \$122.62 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.30 per 15-minute unit, not to exceed \$122.62 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/13, \$3.54 per 15-minute unit, not to exceed \$82.53 per day. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$11.34 per 15-minute unit.
Group	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$11.33 per 15-minute unit. Rate is divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.
17. Case management	Fee for service with cost settlement. See 79.1(1)"d."	For brain injury and elderly waivers: Retrospective cost-settled rate.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	For intellectual disability and brain injury waiver effective 7/1/13: \$9.19 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3%.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$955.00 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$955.00 per unit (job placement). Maximum of two units per 12 months.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: \$9.19 per 15-minute unit. Maximum of 104 units per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: \$9.19 per 15-minute unit for all activities other than personal care and services in an enclave setting. \$5.20 per 15-minute unit for personal care. \$1.63 per 15-minute unit for services in an enclave setting. \$3,029.62 per month for total service. Maximum of 160 units per week.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$11.34 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$11.33 per 15-minute unit.
23. Prevocational services	Fee schedule	County contract rate or, in absence of a contract rate, effective 7/1/13: Lesser of provider's rate in effect 6/30/13 plus 3%, \$50.66 per day or \$13.87 per hour.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$9.19 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 3%.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: Not to exceed the maximum ICF/ID rate per day plus 3%.
26. Day habilitation	Fee schedule	Effective 7/1/13: County contract rate converted to a 15-minute or daily rate or, in the absence of a contract rate, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute or daily rate. If no 6/30/13 rate: \$3.47 per 15-minute unit or \$67.55 per day.
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$9.19 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$24.60 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$68.97 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$15.91 per hour.
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider.	\$25.75 per day.
Health home services provider	Fee schedule based on the member's qualifying health condition(s).	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	See 79.1(24) "d"	Retrospective cost-settled rate.
2. Home-based habilitation	See 79.1(24) "d"	Effective 7/1/13: \$11.68 per 15-minute unit, not to exceed \$6,083 per month, or \$200 per day.
3. Day habilitation	See 79.1(24) "d"	Effective 7/1/13: \$3.30 per 15-minute unit or \$64.29 per day.
4. Prevocational habilitation	See 79.1(24) "d"	Effective 7/1/13: \$13.47 per hour or \$48.22 per day.
5. Supported employment: Activities to obtain a job:		
Job development	See 79.1(24) "d"	\$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	See 79.1(24) "d"	\$909 per unit (job placement). Maximum of two units per 12 months.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Enhanced job search	See 79.1(24) "d"	Effective 7/1/13: Maximum of \$8.75 per 15-minute unit and 104 units per 12 months.
Supports to maintain employment	See 79.1(24) "d"	Effective 7/1/13: \$1.55 per 15-minute unit for services in an enclave setting; \$4.95 per 15-minute unit for personal care; and \$8.75 per 15-minute unit for all other services. Total not to exceed \$2,883.71 per month. Maximum of 160 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.6(11) "r."	Effective 7/1/13: Medicare LUPA rates in effect on July 1, 2013, updated July 1 every two years.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14) "d")
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1) "g" and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/13 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16) "c"	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 6/30/13 plus 1%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members. 2. Fee schedule for service provided for all other Medicaid members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate. 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/13 plus 1%.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(1)“1” and (2)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(1)“2” and (2)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 110% of the patient-day-weighted median.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(3)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(3)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See subrules 441—81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11) “r.”	Fee schedule in effect 6/30/13 plus 1%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11) “r.”	Fee schedule in effect 6/30/13 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7) “a”	Fee schedule in effect 6/30/13 plus 1%.
Anesthesia services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Qualified primary care services	See 79.1(7) “c”	Rate provided by 79.1(7) “c”

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children:		
1. Inpatient in non-state-owned facilities	Provider-specific fee schedule as determined by the Iowa Plan for Behavioral Health contractor	Effective 7/1/14: non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A)	<ol style="list-style-type: none"> 1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)“d.”	Retrospective cost-settled rate.

79.1(3) Ambulatory surgical centers.

- a. Payment is made for facility services on a fee schedule determined by the department and published on the department’s Web site. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.
- b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)“c”). This payment is made directly to the physician or dentist.

79.1(4) Durable medical equipment, prosthetic devices, medical supply dealers. Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5) “n.”

79.1(5) Reimbursement for hospitals.

a. Definitions.

“*Adolescent*” shall mean a Medicaid patient 17 years or younger.

“*Adult*” shall mean a Medicaid patient 18 years or older.

“*Average daily rate*” shall mean the hospital’s final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

“*Base year cost report*” means the hospital’s cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5) “x.” Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“*Blended base amount*” shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Blended capital costs*” shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Capital costs*” shall mean an add-on to the blended base amount, which shall compensate for Medicaid’s portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital’s base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Case-mix adjusted*” shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating

the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"*Case-mix index*" shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"*Children's hospitals*" shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

"*Cost outlier*" shall mean cases which have an extraordinarily high cost as established in 79.1(5)"f," so as to be eligible for additional payments above and beyond the initial DRG payment.

"*Critical access hospital*" or "*CAH*" means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"*Diagnosis-related group (DRG)*" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"*Direct medical education costs*" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"*Direct medical education rate*" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"*Disproportionate share payment*" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"*Disproportionate share percentage*" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate

exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5) "y"(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"*Disproportionate share rate*" shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"*DRG weight*" shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"*Final payment rate*" shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"*Full DRG transfer*" shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"*GME/DSH fund apportionment claim set*" means the hospital's applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

"*GME/DSH fund implementation year*" means 2009.

"*Graduate medical education and disproportionate share fund*" or "*GME/DSH fund*" means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

"*Indirect medical education rate*" shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"*Inlier*" shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

"*Long stay outlier*" shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5) "f."

"*Low-income utilization rate*" shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients

under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“Medicaid inpatient utilization rate” shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children’s hospitals, including hospitals qualifying for disproportionate share as a children’s hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Neonatal intensive care unit” shall mean a designated level II or level III neonatal unit.

“Net discharges” shall mean total discharges minus transfers and short stay outliers.

“Quality improvement organization” or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“Rate table listing” shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

“Rebasing” shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

“Rebasing implementation year” means 2008 and every three years thereafter.

“Recalibration” shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

“Short stay day outlier” shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5) “f.”

b. *Determination of final payment rate amount.* The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5) “r.” Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5) “r.” Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization.

The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. *Calculation of Iowa-specific weights and case-mix index.* From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.
4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.

5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. *Calculation of blended base amount.* The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical

rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. *Add-ons to the base amount.*

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. *Outlier payment policy.* Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$16,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within 30 days for same condition. Effective for dates of service on or after July 1, 2015, when an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays.

h. *Covered DRGs.* Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5) "r;" and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5) "r," which are paid per diem, as specified in paragraph 79.1(5) "i."

i. *Payment for certified physical rehabilitation hospitals and units and psychiatric units.* Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5) "r" and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5) "r" is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's base-year cost report pursuant to paragraph 79.1(5) "a." No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5) "j."

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. *Services covered by DRG payments.* Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. *Inflation factors, rebasing, and recalibration.*

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care

and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5) "y"(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph 79.1(5) "y," for dates of service prior to October 1, 2014. Out-of-state hospitals do not qualify for disproportionate share payments for dates of service on or after October 1, 2014.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5) "y."

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph "f."

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. *Determination of inpatient admission.* A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. *Inpatient admission after outpatient services.* A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. *Certification for reimbursement as a special unit or physical rehabilitation hospital.* Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)"b"(1), a neonatal intensive care unit under subparagraph 79.1(5)"b"(2), a psychiatric unit under paragraph 79.1(5)"i," or a physical rehabilitation hospital or unit under paragraph 79.1(5)"i" shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)"b"(1) if the unit's program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5) "b"(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5) "b"(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit's certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5) "i" if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5) "i" if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. *Health care access assessment inflation factor.* Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital's fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state's fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is \$26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. Non-state-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5) "y" and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity.

Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

- (1) Advertising.
- (2) Promotional items.
- (3) Feasibility studies.
- (4) Administrative travel and entertainment.
- (5) Dues, subscriptions, or membership costs.
- (6) Contributions made to other organizations.
- (7) Home office costs.
- (8) Public relations items.
- (9) Any patient convenience items.
- (10) Management fees for administrative services.
- (11) Luxury employee benefits (i.e., country club dues).
- (12) Motor vehicles for other than patient care.
- (13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals in Iowa qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is \$7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is \$13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services

to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is \$6,959,868.59. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5) "u" or 79.1(5) "v" cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age. In addition, the hospital must be a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audit and rate setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)"a" to "z" are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)"a" to "z." Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)"k."

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) *Coding.* All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code Explanation

Y The condition was present or developing at the time of the order for inpatient admission.

N The condition was not present or developing at the time of the order for inpatient admission.

U Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.

W Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

ac. *Rural hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) Qualifying criteria. A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) Source of nonfederal share. The required nonfederal share shall be funds generated from tax levy collections of the county or city in which the hospital is located, and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year shall apply.

(3) Amount of payment. The total amount of disproportionate share payments made pursuant to paragraph 79.1(5) "y" and the rural hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department, for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666.

79.1(6) Independent laboratories. The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician's Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) Physicians.

a. *Fee schedule.* The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2) "e" for the guidelines for immunization replacement.

b. *Payment reduction for services rendered in facility settings.* Rescinded IAB 10/30/13, effective 1/1/14.

c. *Payment for primary care services.* To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar year 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (4) and (6) of this paragraph (79.1(7) "c"). Primary care services furnished on or after January 1, 2015, by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (3), (5), and (7) of this paragraph (79.1(7) "c").

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7) "c") include:

1. Evaluation and management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7) "c"), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7) "c") equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7) "c"), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

(4) Primary care services rendered in calendar year 2013 or 2014. Primary care services rendered in calendar year 2013 or 2014 that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1).

(5) Primary care services rendered on or after January 1, 2015. Primary care services rendered on or after January 1, 2015, that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1), and in effect on June 30, 2014.

(6) Notwithstanding the foregoing provisions of this paragraph (79.1(7) "c"), payment for the administration of vaccines provided under the Vaccines for Children Program in calendar year 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program; or

2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

(7) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program on or after January 1, 2015, shall be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or

2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

79.1(8) Drugs. The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to May 16, 2012. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.

a. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8)“c,” whichever is later, reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph 79.1(8)“i”; or

2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph 79.1(8)“i.”

(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph 79.1(8)“i.”

(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2, plus the professional dispensing fee specified in paragraph 79.1(8)“i.”

(4) The submitted charge, representing the provider’s usual and customary charge for the drug.

b. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8)“d,” whichever is later, reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph 79.1(8)“i”; or

2. For covered specialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph 79.1(8)“i.”

(2) The submitted charge, representing the provider’s usual and customary charge for the drug.

c. Effective February 1, 2013, or upon federal approval, whichever is later, reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“k,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“j.”

(2) The maximum allowable cost (MAC), defined as the specific upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“j.”

(3) The submitted charge, representing the provider’s usual and customary charge for the drug.

d. Effective February 1, 2013, or upon federal approval, whichever is later, reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8) "k," plus the professional dispensing fee determined pursuant to paragraph 79.1(8) "j."

(2) The submitted charge, representing the provider's usual and customary charge for the drug.

e. No payment shall be made for sales tax.

f. All hospitals that wish to administer vaccines which are available through the Vaccines for Children Program to Medicaid members shall enroll in the Vaccines for Children Program. In lieu of payment, vaccines available through the Vaccines for Children Program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.

g. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8) "c," whichever is later, the basis of payment for nonprescription drugs shall be the same as specified in paragraph 79.1(8) "a" except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.

h. An additional reimbursement amount of one cent per dose shall be added to the allowable cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

i. Rescinded IAB 6/11/14, effective 8/1/14.

j. The professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries conducted every two years beginning in SFY 2014-2015.

k. For purposes of this rule, average actual acquisition cost (AAC) is defined as retail pharmacies' average prices paid to acquire drug products. Average AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department's discretion. The average AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average AAC determined by the department shall be published on the Iowa Medicaid enterprise Web site. If no current average AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average AAC.

l. For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

m. Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

n. Payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II "J" codes, as a physician service, shall be pursuant to physician payment policy under subrule 79.1(2).

79.1(9) HCBS consumer choices financial management.

a. *Monthly allocation.* A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer's individual budget amount as determined under 441—paragraph 78.34(13) "b," 78.37(16) "b," 78.38(9) "b," 78.41(15) "b," 78.43(15) "b," or 78.46(6) "b."

b. *Cost settlement.* The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall

perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

c. *Start-up grants.* A qualifying financial management service provider may be reimbursed up to \$10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

79.1(10) Prohibition against reassignment of claims. No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) Prohibition against factoring. Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) Reasonable charges for services, supplies, and equipment. For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under Part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall

be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the Part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) Copayment by member: A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than \$25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is \$25.01 to \$50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is \$50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

b. The member shall pay \$1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay \$2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay \$3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay \$1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

- (1) Placing the patient's health in serious jeopardy,
- (2) Serious impairment to bodily functions, or
- (3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

n. The member shall pay a \$3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13) "k." This \$3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

79.1(14) Reimbursement for hospice services.

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

- (1) Routine home care.
- (2) Continuous home care.
- (3) Inpatient respite care.
- (4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of

the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) HCBS retrospectively limited prospective rates. This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

a. *Reporting requirements.*

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate.

The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed \$1,570 per consumer per year for supported community living services.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed \$1,500 per child per year for family and community support services.

(9) The reasonable costs of direct care staff training shall be treated as direct care costs, rather than as indirect administrative costs.

c. Prospective rates for new providers.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph "e."

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph "d."

d. Prospective rates for established providers.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph "f."

e. Prospective rates for respite. Rescinded IAB 5/1/13, effective 7/1/13.

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) Providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 percent of the actual costs deducted from future payments.

g. *Supported community living daily rate.* For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) Outpatient reimbursement for hospitals.

a. *Definitions.*

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or "APC" means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or "APC relative weight" means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2009, means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph "g" and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following

formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

“Discount factor” means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

“Healthcare common procedures coding system” or *“HCPCS”* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

“Hospital-based clinic” means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“Modifier” means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

“Multiple significant procedure discounting” means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

“Observation services” means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

“Outpatient hospital services” means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and

2. Meets the requirements for participation in Medicare as a hospital.

“Outpatient prospective payment system” or *“OPPS”* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

“Outpatient visit” shall mean those hospital-based outpatient services which are billed on a single claim form.

“Packaged service” means a service that is secondary to other services but is considered an integral part of another service.

“Pass-through” means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

“Quality improvement organization” or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rebasing" shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

"Significant procedure" shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

"Status indicator" or *"SI"* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. *Outpatient hospital services.* Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

(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. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16) "j."

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16) "e."

2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.

3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: <ul style="list-style-type: none"> • Ambulance services. • Clinical diagnostic laboratory services. • Diagnostic mammography. • Screening mammography. • Nonimplantable prosthetic and orthotic devices. • Physical, occupational, and speech therapy. • Erythropoietin for end-stage renal dialysis (ESRD) patients. • Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital. 	For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. <ul style="list-style-type: none"> • May be paid when submitted on a different bill type other than outpatient hospital (13x). • An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	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: <ul style="list-style-type: none"> • That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or • That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or • That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or • For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid. 	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: <ul style="list-style-type: none">● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established.● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> • Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “S,” “T,” “V,” or “X.” • In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> • Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.” • In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	<p>If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.</p>
R	Blood and blood products	<p>If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
S	Significant procedure, not discounted when multiple	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
T	Significant procedure, multiple reduction applies	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
U	Brachytherapy sources	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16) "r." If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
Y	Nonimplantable durable medical equipment	For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c." For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

d. *Calculation of case-mix indices.* Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. *Calculation of the hospital-specific base APC rates.*

(1) Using the hospital's base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs "g" to "n."

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. *Calculation of statewide base APC rate.*

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n,” for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. *Cost outlier payment policy.* Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital’s cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. *Payment to critical access hospitals.* Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)“a” shall be the hospital’s line-item charge multiplied by the hospital’s Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital’s annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)“j.”

i. *Cost-reporting requirements.* Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. *Rebasing.*

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16) "v"(3).

k. *Payment to out-of-state hospitals.* Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16) "v."

l. *Preadmission, preauthorization or inappropriate services.* Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. *Health care access assessment inflation factor.* Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;

2. Recompute Medicaid payments due based on the recalculated Medicaid rates;

3. Recoup any previous overpayments; and

4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4) “d”(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

- (1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

- (2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13) “k,” payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

- (3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13) “k,” payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room and on whether the member is participating in the MediPASS program.

1. For members not participating in the MediPASS program who were referred to the emergency room by appropriate medical personnel and for members participating in the MediPASS program who were referred to the emergency room by their MediPASS primary care physician, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members not participating in the MediPASS program who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

3. For members participating in the MediPASS program who were not referred to the emergency room by their MediPASS primary care physician, no payment will be made for treatment provided in the emergency room.

s. *Limit on payments.* Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. *Government-owned facilities.* Rescinded IAB 6/30/10, effective 7/1/10.

u. *QIO review.* The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. *Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. *Final settlement for state-owned teaching hospital.*

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) Reimbursement for home- and community-based services home and vehicle modification and equipment. Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) Pharmaceutical case management services reimbursement. Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventative follow-up assessment	\$25	One per patient per 6 months

79.1(19) Reimbursement for translation and interpretation services. Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) Dentists. The dental fee schedule is based on the definitions of dental and surgical procedures given in the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association.

79.1(21) Rehabilitation agencies. Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) Medicare crossover claims for inpatient and outpatient hospital services. Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. *Definitions.* For purposes of this subrule:

“Crossover claim” means a claim for Medicaid payment for Medicare-covered inpatient or outpatient hospital services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

“Medicaid-allowed amount” means the Medicaid prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

“Medicaid reimbursement” means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

“Medicare payment amount” means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. *Reimbursement of crossover claims.* Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim shall be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim shall be the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

79.1(23) Reimbursement for remedial services. Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23) "c"(1). The unit of service may be a quarter hour, a half hour, an hour, a half day, or a day, depending on the service provided.

a. *Interim rate.* Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23) "c"(1).

b. *Cost reports.* Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

c. *Rate determination.* Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) Reimbursement for home- and community-based habilitation services. Reimbursement for case management, job development, and employer development services provided prior to July 1, 2013, is based on a fee schedule developed using the methodology described in paragraph 79.1(1) "d." Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment services provided prior to July 1, 2013, is based on a retrospective cost-related rate calculated using the methodology in paragraphs 79.1(24) "b" and "c." Reimbursement for all home- and community-based habilitation services provided on or after July 1, 2013, shall be as provided in paragraph 79.1(24) "d." All rates are subject to the upper limits established in subrule 79.1(2).

a. *Units of service.*

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

1. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.

2. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

(3) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

(4) A unit of prevocational habilitation is an hour (for up to 4 units per day) or a full day (4.25 to 8 hours).

(5) A unit of supported employment habilitation for activities to obtain a job is:

1. One job placement for job development and employer development.

2. A 15-minute unit for enhanced job search.

(6) A unit of supported employment habilitation supports to maintain employment is a 15-minute unit.

b. *Submission of cost reports.* For services provided prior to July 1, 2013, the department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed \$1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report for services provided through June 30, 2013, that meets the requirements of this paragraph, the Iowa Medicaid enterprise or the Iowa Plan for Behavioral Health contractor shall reduce the provider's rate to 76 percent of the current rate. The reduced rate shall be paid until the provider's cost report has been received by the Iowa Medicaid enterprise's provider cost audit and rate setting unit pursuant to subparagraph 79.1(24) "b" (4) but for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim

rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. *Rate determination based on cost reports.* For services provided prior to July 1, 2013, reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

d. *Reimbursement for services provided on or after July 1, 2013.*

(1) For dates of services July 1, 2013, through December 31, 2013, providers shall be reimbursed by the Iowa Plan for Behavioral Health contractor at the fee schedule or interim rate for the service and the provider in effect on June 30, 2013, with no retrospective adjustment or cost settlement. However, if a provider fails to submit a cost report for services provided prior to July 1, 2013, that meets the requirements of paragraph 79.1(24) "b," the Iowa Plan for Behavioral Health contractor shall reduce the provider's reimbursement rate to 76 percent of the rate in effect on June 30, 2013. The reduced rate shall be paid until acceptable cost reports for all services provided prior to July 1, 2013, have been received.

(2) For dates of services on or after January 1, 2014, providers shall be reimbursed by the Iowa Plan for Behavioral Health contractor at the rate negotiated by the provider and the contractor. However, if a provider fails to submit a cost report for services provided prior to July 1, 2013, that meets the requirements of paragraph 79.1(24) "b," the Iowa Plan for Behavioral Health contractor shall reduce the provider's reimbursement rate to 76 percent of the negotiated rate. The reduced rate shall be paid until acceptable cost reports for all services provided prior to July 1, 2013, have been received.

79.1(25) Reimbursement for community mental health centers (CMHCs) and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).

a. *Reimbursement methodology for providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).* Effective for services rendered on or after October 1, 2006, providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles.

b. *Reimbursement methodology for community mental health centers.* Effective for services rendered on or after July 1, 2014, community mental health centers may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services and approved by the department of human services. Once a community mental health center chooses the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services, the community mental health center may not change its elected reimbursement methodology to 100 percent of reasonable costs.

c. *Cost-based reimbursement.* For providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) and CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following.

(1) Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

d. *Reporting requirements.* All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using Form 470-4419, Financial and Statistical Report. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552-96. The following requirements apply to all required cost reports.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

79.1(26) Home health services.

a. Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

79.1(27) Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.

a. *Rate determination based on cost reports.* Reimbursement shall be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and the Iowa Medicaid enterprise (IME) may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review or audit or both by the Iowa Medicaid enterprise to determine the actual cost of services in accordance with generally accepted accounting principles, Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, subject to the exceptions and limitations in the department's administrative rules.

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. *Financial and statistical report submission and reporting requirements.*

(1) The provider shall submit the complete Financial and Statistical Report, Form 1728-94, in an electronic format approved by the department to the IME provider cost audit and rate setting unit within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to the IME provider cost audit and rate setting unit. The extension request must be received by the IME provider cost audit and rate setting unit before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to the IME provider cost audit and rate setting unit in an electronic format that can be opened using the extensionxls orxlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be e-mailed to costaudit@dhs.state.ia.us on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27) "b"(4), the department shall reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

2. The reduced rate(s) shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items which had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify the Iowa Medicaid enterprise when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

c. *Terminated home health agencies.*

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department of human services with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27) "b."

(2) For facilities that terminate activity with the Iowa Medicaid enterprise, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27) "a" shall be submitted 45 days after the date of termination, by the terminated (closed) entity.

If no report is received within 45 days, the Iowa Medicaid enterprise will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

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

[ARC 7835B, IAB 6/3/09, effective 7/8/09; ARC 7937B, IAB 7/1/09, effective 7/1/09; ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 8205B, IAB 10/7/09, effective 11/11/09; ARC 8206B, IAB 10/7/09, effective 11/11/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8647B, IAB 4/7/10, effective 3/11/10; ARC 8649B, IAB 4/7/10, effective 3/11/10; ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 8899B, IAB 6/30/10, effective 7/1/10; ARC 9046B, IAB 9/8/10, effective 8/12/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9134B, IAB 10/6/10, effective 10/1/10; ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9176B, IAB 11/3/10, effective 12/8/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 9706B, IAB 9/7/11, effective 8/17/11; ARC 9708B, IAB 9/7/11, effective 8/17/11; ARC 9710B, IAB 9/7/11, effective 8/17/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9712B, IAB 9/7/11, effective 9/1/11; ARC 9714B, IAB 9/7/11, effective 9/1/11; ARC 9719B, IAB 9/7/11, effective 9/1/11; ARC 9722B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 9886B, IAB 11/30/11, effective 1/4/12; ARC 9887B, IAB 11/30/11, effective 1/4/12; ARC 9958B, IAB 1/11/12, effective 2/15/12; ARC 9959B, IAB 1/11/12, effective 2/15/12; ARC 9960B, IAB 1/11/12, effective 2/15/12; ARC 9996B, IAB 2/8/12, effective 1/19/12; ARC 0028C, IAB 3/7/12, effective 4/11/12; ARC 0029C, IAB 3/7/12, effective 4/11/12; ARC 9959B nullified (See nullification note at end of chapter); ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0194C, IAB 7/11/12, effective 7/1/12; ARC 0196C, IAB 7/11/12, effective 7/1/12; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0355C, IAB 10/3/12, effective 12/1/12; ARC 0354C, IAB 10/3/12, effective 12/1/12; ARC 0360C, IAB 10/3/12, effective 12/1/12; ARC 0485C, IAB 12/12/12, effective 2/1/13; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0581C, IAB 2/6/13, effective 4/1/13; ARC 0585C, IAB 2/6/13, effective 1/9/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0708C, IAB 5/1/13, effective 7/1/13; ARC 0710C, IAB 5/1/13, effective 7/1/13; ARC 0713C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 0838C, IAB 7/24/13, effective 7/1/13; ARC 0840C, IAB 7/24/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 0864C, IAB 7/24/13, effective 7/1/13; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1057C, IAB 10/2/13, effective 11/6/13; ARC 1058C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1150C, IAB 10/30/13, effective 1/1/14; ARC 1152C, IAB 10/30/13, effective 1/1/14; ARC 1154C, IAB 10/30/13, effective 1/1/14; ARC 1481C, IAB 6/11/14, effective 8/1/14; ARC 1519C, IAB 7/9/14, effective 7/1/14; ARC 1521C, IAB 7/9/14, effective 7/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 1608C, IAB 9/3/14, effective 10/8/14; ARC 1609C, IAB 9/3/14, effective 10/8/14; ARC 1699C, IAB 10/29/14, effective 1/1/15; ARC 1697C, IAB 10/29/14, effective 1/1/15; ARC 1977C, IAB 4/29/15, effective 7/1/15; ARC 2026C, IAB 6/10/15, effective 8/1/15; ARC 2075C, IAB 8/5/15, effective 7/15/15; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2167C, IAB 9/30/15, effective 11/4/15]

441—79.2(249A) Sanctions.

79.2(1) Definitions.

“Affiliates” means persons having an overt or covert relationship such that any one of them directly or indirectly controls or influences or has the power to control or influence another.

“Iowa Medicaid enterprise” means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

“Person” means any individual human being or any company, firm, association, corporation, institution, or other legal entity. “Person” includes but is not limited to a provider and any affiliate of a provider.

“Probation” means a specified period of conditional participation in the medical assistance program.

“Provider” means an individual human being, firm, corporation, association, institution, or other legal entity, which is providing or has been approved to provide medical assistance to a member pursuant to the state medical assistance program.

“Suspension from participation” means an exclusion from participation for a specified period of time.

“Suspension of payments” means the temporary cessation of payments due a person until the resolution of a matter in dispute between a person and the department.

“Termination from participation” means a permanent exclusion from participation in the medical assistance program.

“Withholding of payments” means a reduction or adjustment of the amounts paid to a person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.

79.2(2) Grounds for sanctions. The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include, but are not limited to, the following:

- a. Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.
- b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.
- c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.
- d. Upon lawful demand, failing to disclose or make available to the department, the department's authorized agent, any law enforcement or peace officer, any agent of the department of inspections and appeals' Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.
- e. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, "quality services" means services provided in accordance with the applicable rules and regulations governing the services.
- f. Engaging in a course of conduct or performing an act which is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.
- g. Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department's representative or to any other publicly or privately funded health care program.
- h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.
- i. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.
- j. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.
- k. Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.
- l. Breaching any settlement or similar agreement with the department, or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.
- m. Failing to meet standards required by state or federal law for participation, including but not limited to licensure.
- n. Exclusion from Medicare or any other state or federally funded medical assistance program.
- o. Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.
- p. Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.
- q. Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.
- r. Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.
- s. Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime

of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.

- t. Violation of a condition of probation, suspension of payments, or other sanction.
- u. Loss, restriction, or lack of hospital privileges for cause.
- v. Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.
- w. Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.
- x. Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.
- y. Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) Sanctions.

- a. The department may impose any of the following sanctions on any person:
 - (1) A term of probation for participation in the medical assistance program.
 - (2) Termination from participation in the medical assistance program.
 - (3) Suspension from participation in the medical assistance program.
 - (4) Suspension of payments in whole or in part.
 - (5) Prior authorization of services.
 - (6) Review of claims prior to payment.
- b. The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.
- c. Mandatory suspensions and terminations.
 - (1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program shall be retroactive to the date established by the Centers for Medicare and Medicaid Services or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.
 - (2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.
 - (3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.
 - (4) Upon notification from the U.S. Department of Justice, the Iowa department of justice, the department of inspections and appeals, or a similar agency, that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department shall immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension shall end upon notification that the person has responded to the demand in full.

79.2(4) Imposition and extent of sanction. The department shall consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include, but are not limited to:

- a. Seriousness of the offense.
- b. Extent of violations.
- c. History of prior violations.
- d. Prior imposition of sanctions.
- e. Prior provision of provider education (technical assistance).
- f. Provider willingness to obey program rules.
- g. Whether a lesser sanction will be sufficient to remedy the problem.
- h. Actions taken or recommended by peer review groups or licensing boards.

79.2(5) Scope of sanction.

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

79.2(6) Notice to third parties. When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR § 1002.212, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members, as provided in 42 CFR §§ 1001.2005 and 1001.2006, whenever the department initiates an exclusion under 42 CFR § 1002.210.

79.2(7) Notice of violation.

a. Any order of sanction shall be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction shall also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider. The department of inspections and appeals is not required to comply with the additional notification provisions of 441—paragraph 7.10(7) "c" for appeals certified for hearing under this chapter.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, the provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken. If the provider fails to do so, the sanction shall remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the appeals section. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5) "c."

79.2(8) Suspension or withholding of payments. The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it shall notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

79.2(9) Civil monetary penalties and interest. Civil monetary penalties and interest assessed in accordance with 2013 Iowa Acts, Senate File 357, section 5 or section 11, are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance shall the department reimburse a person for such civil monetary penalties or interest.

79.2(10) Report and return of identified overpayment.

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

c. An overpayment required to be reported under 2013 Iowa Acts, Senate File 357, section 3, must be made in writing, addressed to the Program Integrity Unit of the Iowa Medicaid Enterprise, and contain all of the following:

- (1) Person's name.

- (2) Person's tax identification number.
 - (3) How the error was discovered.
 - (4) The reason for the overpayment.
 - (5) Claim number(s), as appropriate.
 - (6) Date(s) of service.
 - (7) Member identification number(s).
 - (8) National provider identification (NPI) number.
 - (9) Description of the corrective action plan to ensure the error does not occur again, if applicable.
 - (10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.
 - (11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.
 - (12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.
 - (13) A refund in the amount of the overpayment.
- This rule is intended to implement Iowa Code section 249A.4.
[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15]

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request shall result in claim denial or recoupment.

79.3(1) *Financial (fiscal) records.*

- a. A provider of service shall maintain records as necessary to:
 - (1) Support the determination of the provider's reimbursement rate under the medical assistance program; and
 - (2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.
- b. A financial record does not constitute a medical record.

79.3(2) *Medical (clinical) records.* A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. *Definition.* "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

- (1) The provision of each service and each activity billed to the program; and
- (2) First and last name of the member receiving the service.

b. *Purpose.* The medical record shall provide evidence that the service provided is:

- (1) Medically necessary;
- (2) Consistent with the diagnosis of the member's condition; and
- (3) Consistent with professionally recognized standards of care.

c. *Components.*

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2) "d." The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity

and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)“c” or “d,” 441—paragraph 77.33(6)“d,” 441—paragraph 77.34(5)“d,” 441—paragraph 77.37(15)“d,” 441—paragraph 77.39(13)“e,” 441—paragraph 77.39(14)“d,” or 441—paragraph 77.46(5)“i,” or 441—subparagraph 78.9(10)“a”(1).
5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Any supplies dispensed as part of the service.
7. The first and last name and professional credentials, if any, of the person providing the service.
8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.
9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2)“b.”)

- (1) Physician (MD and DO) services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.

- (2) Pharmacy services:
 - 1. Prescriptions.
 - 2. Nursing facility physician order.
 - 3. Telephone order.
 - 4. Pharmacy notes.
 - 5. Prior authorization documentation.
- (3) Dentist services:
 - 1. Treatment notes.
 - 2. Anesthesia notes and records.
 - 3. Prescriptions.
- (4) Podiatrist services:
 - 1. Service or office notes or narratives.
 - 2. Certifying physician statement.
 - 3. Prescription or order form.
- (5) Certified registered nurse anesthetist services:
 - 1. Service notes or narratives.
 - 2. Preanesthesia physical examination report.
 - 3. Operative report.
 - 4. Anesthesia record.
 - 5. Prescriptions.
- (6) Other advanced registered nurse practitioner services:
 - 1. Service or office notes or narratives.
 - 2. Procedure, laboratory, or test orders and results.
- (7) Optometrist and optician services:
 - 1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
 - 2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
 - 3. Prior authorization documentation.
- (8) Psychologist services:
 - 1. Service or office psychotherapy notes or narratives.
 - 2. Psychological examination report and notes.
- (9) Clinic services:
 - 1. Service or office notes or narratives.
 - 2. Procedure, laboratory, or test orders and results.
 - 3. Nurses' notes.
 - 4. Prescriptions.
 - 5. Medication administration records.
- (10) Services provided by rural health clinics or federally qualified health centers:
 - 1. Service or office notes or narratives.
 - 2. Form 470-2942, Prenatal Risk Assessment.
 - 3. Procedure, laboratory, or test orders and results.
 - 4. Immunization records.
- (11) Services provided by community mental health centers:
 - 1. Service referral documentation.
 - 2. Initial evaluation.
 - 3. Individual treatment plan.
 - 4. Service or office notes or narratives.
 - 5. Narratives related to the peer review process and peer review activities related to a member's treatment.
 - 6. Written plan for accessing emergency services.
- (12) Screening center services:
 - 1. Service or office notes or narratives.
 - 2. Immunization records.

3. Laboratory reports.
 4. Results of health, vision, or hearing screenings.
- (13) Family planning services:
1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Immunization records.
 5. Consent forms.
 6. Prescriptions.
 7. Medication administration records.
- (14) Maternal health center services:
1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Form 470-2942, Prenatal Risk Assessment.
- (15) Birthing center services:
1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
- (16) Ambulatory surgical center services:
1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 2. Physician orders.
 3. Consent forms.
 4. Anesthesia records.
 5. Pathology reports.
 6. Laboratory and X-ray reports.
- (17) Hospital services:
1. Physician orders.
 2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 3. Progress or status notes.
 4. Diagnostic procedures, including laboratory and X-ray reports.
 5. Pathology reports.
 6. Anesthesia records.
 7. Medication administration records.
- (18) State mental hospital services:
1. Service referral documentation.
 2. Resident assessment and initial evaluation.
 3. Individual comprehensive treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
1. Physician orders.
 2. Progress or status notes.
 3. Service notes or narratives.
 4. Procedure, laboratory, or test orders and results.
 5. Nurses' notes.
 6. Physical therapy, occupational therapy, and speech therapy notes.
 7. Medication administration records.
 8. Form 470-0042, Case Activity Report.
- (20) Services provided by intermediate care facilities for persons with mental retardation:

1. Physician orders.
 2. Progress or status notes.
 3. Preliminary evaluation.
 4. Comprehensive functional assessment.
 5. Individual program plan.
 6. Form 470-0374, Resident Care Agreement.
 7. Program documentation.
 8. Medication administration records.
 9. Nurses' notes.
 10. Form 470-0042, Case Activity Report.
- (21) Services provided by psychiatric medical institutions for children:
1. Physician orders or court orders.
 2. Independent assessment.
 3. Individual treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (22) Hospice services:
1. Physician certifications for hospice care.
 2. Form 470-2618, Election of Medicaid Hospice Benefit.
 3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
 4. Plan of care.
 5. Physician orders.
 6. Progress or status notes.
 7. Service notes or narratives.
 8. Medication administration records.
 9. Prescriptions.
- (23) Services provided by rehabilitation agencies:
1. Physician orders.
 2. Initial certification, recertifications, and treatment plans.
 3. Narratives from treatment sessions.
 4. Treatment and daily progress or status notes and forms.
- (24) Home- and community-based habilitation services:
1. Notice of decision for service authorization.
 2. Service plan (initial and subsequent).
 3. Service notes or narratives.
- (25) Behavioral health intervention:
1. Order for services.
 2. Comprehensive treatment or service plan (initial and subsequent).
 3. Service notes or narratives.
- (26) Services provided by area education agencies and local education agencies:
1. Service notes or narratives.
 2. Individualized education program (IEP).
 3. Individual health plan (IHP).
 4. Behavioral intervention plan.
- (27) Home health agency services:
1. Plan of care or plan of treatment.
 2. Certifications and recertifications.
 3. Service notes or narratives.
 4. Physician orders or medical orders.
- (28) Services provided by independent laboratories:
1. Laboratory reports.

2. Physician order for each laboratory test.
- (29) Ambulance services:
1. Documentation on the claim or run report supporting medical necessity of the transport.
 2. Documentation supporting mileage billed.
- (30) Services of lead investigation agencies:
1. Service notes or narratives.
 2. Child's lead level logs (including laboratory results).
 3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
 4. Health education notes, including follow-up notes.
- (31) Medical supplies:
1. Prescriptions.
 2. Certificate of medical necessity.
 3. Prior authorization documentation.
 4. Medical equipment invoice or receipt.
- (32) Orthopedic shoe dealer services:
1. Service notes or narratives.
 2. Prescriptions.
 3. Certifying physician's statement.
- (33) Case management services, including HCBS case management services:
1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
 2. Notice of decision for service authorization.
 3. Service notes or narratives.
 4. Social history.
 5. Comprehensive service plan.
 6. Reassessment of member needs.
 7. Incident reports in accordance with 441—subrule 24.4(5).
- (34) Early access service coordinator services:
1. Individualized family service plan (IFSP).
 2. Service notes or narratives.
- (35) Home- and community-based waiver services, other than case management:
1. Notice of decision for service authorization.
 2. Service plan.
 3. Service logs, notes, or narratives.
 4. Mileage and transportation logs.
 5. Log of meal delivery.
 6. Invoices or receipts.
 7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.
- (36) Physical therapist services:
1. Physician order for physical therapy.
 2. Initial physical therapy certification, recertifications, and treatment plans.
 3. Treatment notes and forms.
 4. Progress or status notes.
- (37) Chiropractor services:
1. Service or office notes or narratives.
 2. X-ray results.
- (38) Hearing aid dealer and audiologist services:
1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
 2. Documentation of hearing aid evaluation and selection (Form 470-0828).
 3. Waiver of informed consent.

4. Prior authorization documentation.
 5. Service or office notes or narratives.
- (39) Behavioral health services:
1. Assessment.
 2. Individual treatment plan.
 3. Service or office notes or narratives.
- (40) Health home services:
1. Comprehensive care management plan.
 2. Care coordination and health promotion plan.
 3. Comprehensive transitional care plan, including appropriate follow-up, from inpatient to other settings.
4. Documentation of member and family support (including authorized representatives).
 5. Documentation of referral to community and social support services, if relevant.
- (41) Services of public health agencies:
1. Service or office notes or narratives.
 2. Immunization records.
 3. Results of communicable disease testing.
- e. *Corrections.* A provider may correct the medical record before submitting a claim for reimbursement.
- (1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.
 - (2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.
 - (3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.
 - (4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

- 79.3(3) Maintenance requirement.** The provider shall maintain records as required by this rule:
- a. During the time the member is receiving services from the provider.
 - b. For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.
 - c. As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

79.3(4) Availability. Rescinded IAB 1/30/08, effective 4/1/08.
This rule is intended to implement Iowa Code section 249A.4.
[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 8262B, IAB 11/4/09, effective 12/9/09; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0711C, IAB 5/1/13, effective 7/1/13; ARC 1695C, IAB 10/29/14, effective 1/1/15]

441—79.4(249A) Reviews and audits.

79.4(1) Definitions.

“*Authorized representative,*” within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

“*Claim*” means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

“*Clinical record*” means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

“Confidence level” means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

“Customary and prevailing fee” means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

“Extrapolation” means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

“Fiscal record” means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

“Overpayment” means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

“Procedure code” means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

“Random sample” means a statistically valid random sample for which the probability of selection for every item in the universe is known.

“Underpayment” means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

“Universe” means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) Audit or review of clinical and fiscal records by the department. Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records to determine whether:

- (1) The department has correctly paid claims for goods or services.
- (2) The provider has furnished the services to Medicaid members.
- (3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.
- (4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise program integrity unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“d” to document the basis for services or activities provided.

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) Audit or review procedures. The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph “b.”

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider’s designee. The request must:

1. Establish good cause for the delay in submitting the records; and
 2. Be received by the department before the date the records are due to be submitted.
- (2) For purposes of these rules, “good cause” has the same meaning as in Iowa Rule of Civil Procedure 1.977.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute *prima facie* evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

79.4(4) Preliminary report of audit or review findings. If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) Disagreement with audit or review findings. If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. *Reevaluation request.* A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. *Additional information.* A provider that has made a reevaluation request pursuant to paragraph "a" of this subrule may submit clarifying information or supplemental documentation that was not

previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph "c" of this subrule.

c. Disagreement with sampling results. When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:

- (1) Be arranged and paid for by the provider.
- (2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.
- (3) Be conducted by a certified public accountant if the issues relate to fiscal records.
- (4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.
- (5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) Finding and order for repayment. Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) Appeal by provider of care. A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) shall not be admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0712C, IAB 5/1/13, effective 7/1/13; ARC 1155C, IAB 10/30/13, effective 1/1/14]

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

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

441—79.7(249A) Medical assistance advisory council.

79.7(1) Officers. Officers shall be a chairperson and a vice-chairperson.

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) Membership. The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2 and 3.

79.7(3) Expenses, staff support, and technical assistance. Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

79.7(4) Meetings. The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting.

Each notice shall include an agenda for the meeting.

79.7(5) Procedures.

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.

d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) Duties.

a. *Executive committee.* Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

(1) Recommendations on the reimbursement for medical services rendered by providers of services.

(2) Identification of unmet medical needs and maintenance needs which affect health.

(3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

(4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

(5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. *Council.* The medical assistance advisory council shall:

- (1) Advise the professional groups and business entities represented and act as liaison between them and the department.
- (2) Report at least annually to the professional groups and business entities represented.
- (3) Perform other functions as may be provided by state or federal law or regulation.
- (4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) Responsibilities.

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

(1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and

(2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members on the council and executive committee.

[ARC 8263B, IAB 11/4/09, effective 12/9/09]

441—79.8(249A) Requests for prior authorization. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

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

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

79.9(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

79.9(7) Incorrect payment.

a. Except as provided in paragraph 79.9(7) "b," medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7) "a," medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, "legal representative" means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

79.9(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2014 Iowa Acts, Senate File 2320.
[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical

procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.12(249A) Advance directives. “Advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person’s admission as an inpatient, a home health care provider in advance of a person’s coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person’s rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider’s policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person’s medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

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

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

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

441—79.14(249A) Provider enrollment.

79.14(1) Application request. Iowa Medicaid providers other than managed care organizations and Medicaid fiscal agents shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise Web site.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.

c. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

d. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to the Iowa Medicaid enterprise provider services unit by personal delivery, by e-mail, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

a. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

b. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C).

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under 2013 Iowa Acts, Senate File 357, section 12.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

- (5) Exempt providers. The following providers shall not be required to submit an application fee:
 1. Individual physicians or nonphysician practitioners.
 2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.
 3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR § 455.460.

79.14(3) Program integrity information requirements.

a. All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

- (1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;
- (2) Has been or is subject to a payment suspension under a federally funded health care program;
- (3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;
- (4) Has had its billing privileges denied or revoked;
- (5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or
- (6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3) "a"(1), (2), (3), (4), or (5).

b. The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. The Iowa Medicaid enterprise shall deny enrollment to or shall immediately disenroll any person that the Iowa Medicaid enterprise, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and shall deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3) "c." Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

c. For purposes of this rule, the term "direct or indirect affiliation" includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

- (1) A compensation arrangement;
- (2) An ownership arrangement;
- (3) Managerial authority over any member of the affiliation;
- (4) The ability of one member of the affiliation to control or influence any other; or
- (5) The ability of a third party to control or influence any member of the affiliation.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years,

pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

79.14(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

a. For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

b. Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450.

c. Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state’s Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

79.14(5) Notification. A provider shall be notified of the decision on the provider’s application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.

79.14(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

79.14(7) Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by the Iowa Medicaid enterprise provider services unit.

79.14(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(9) No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise’s approval of an application.

79.14(10) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(11) An amendment to an application shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(13) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include, but are not

limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

b. When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

79.14(14) Provider termination or denial of enrollment. The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

79.14(15) Temporary moratoria. The Iowa Medicaid enterprise must impose any temporary moratorium pursuant to 2013 Iowa Acts, Senate File 357, section 12.

79.14(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.14(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 1153C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15]

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least \$5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) Policy requirements. Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

- b. Include in any employee handbook a specific discussion of:
 - (1) The laws described in paragraph 79.15(1) "a";
 - (2) The rights of employees to be protected as whistle blowers; and
 - (3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) Reporting requirements.

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

- (1) The name, address, and national provider identification numbers under which the entity receives payment;
 - (2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and
 - (3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.
- b. The information may be provided by:
- (1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or
 - (2) Faxing the information to (515)725-1354.

79.15(3) Enforcement. Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) State elections. In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as amended to September 4, 2012. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term "hospital-based eligible professional (EP)" as set forth in 42 CFR Section 495.4 as amended to September 4, 2012, the department elects the calendar year preceding the payment year as the period used to gather data to determine whether or not an eligible professional is "hospital-based" for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to September 4, 2012, the department has elected that eligible providers may use either:

- (1) The patient encounter methodology found in 42 CFR Section 495.306(c) as amended to September 4, 2012, or
- (2) The patient panel methodology found in 42 CFR Section 495.306(d) as amended to September 4, 2012.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to September 4, 2012, the "12-month period selected by the state" shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to September 4, 2012, the "12-month period selected by the state" shall mean the hospital fiscal year.

79.16(2) Eligible providers. To be deemed an "eligible provider" for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

- a. The provider must be currently enrolled as an Iowa Medicaid provider.
- b. The provider must be one of the following:

- (1) An eligible professional, listed as:
 1. A physician,
 2. A dentist,
 3. A certified nurse midwife,
 4. A nurse practitioner, or
 5. A physician assistant practicing in a federally qualified health center or a rural health clinic when the physician assistant is the primary provider, clinical or medical director, or owner of the site.
- (2) An acute care hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.
- (3) A children's hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.
 - c. For the year for which the provider is applying for an incentive payment:
- (1) An acute care hospital must have 10 percent Medicaid patient volume.
- (2) An eligible professional must have at least 30 percent of the professional's patient volume enrolled in Medicaid, except that:
 1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a "pediatrician" is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.
 2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) Application and agreement. Any eligible provider that intends to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the CMS Registration and Attestation Web site, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the Iowa EHR Medicaid incentive payment administration Web site at www.imeincentives.com. The applicant shall use the Web site to:

- (1) Attest to the applicant's qualifications to receive the incentive payment, and
- (2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, eligible providers must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) Payment. The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the CMS Registration and Attestation Web site.

a. The primary communication channel from the department to the provider will be the Iowa EHR Medicaid incentive payment administration Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

- (1) Eligibility,
- (2) Purchase of certified electronic health record technology, and
- (3) Meaningful use of electronic health record technology.

79.16(5) Administrative appeal. Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

- a. Provider eligibility determination.
- b. Incentive payments.
- c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

[ARC 9254B, IAB 12/1/10, effective 1/1/11; ARC 9531B, IAB 6/1/11, effective 5/12/11; ARC 0824C, IAB 7/10/13, effective 9/1/13]

441—79.17(249A) 2013 reimbursement rate increases. Rescinded **ARC 1056C**, IAB 10/2/13, effective 11/6/13.

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- ◊ Two or more ARCs
- ¹ Effective date of 79.1(2) and 79.1(5) "t" delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.
- ² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.
- ³ Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.
- ⁴ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.
- ⁵ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.
- ⁶ Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.
- ⁷ July 1, 2009, effective date of amendments to 79.1(1) "d," 79.1(2), and 79.1(24) "a"(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- ⁸ See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7) "b" (ARC 9959B, IAB 1/11/12).

CHAPTER 80
PROCEDURE AND METHOD OF PAYMENT
[Prior to 7/1/83, Social Services[770] Ch 80]

441—80.1(249A) The fiscal agent function in medical assistance. Rescinded IAB 5/25/05, effective 7/1/05.

441—80.2(249A) Submission of claims. Providers of medical and remedial care participating in the program shall submit claims for services rendered to the Iowa Medicaid enterprise on at least a monthly basis. All nursing facilities and providers of home- and community-based services shall submit claims for services after end of the calendar month in which the services are provided. Following audit of the claim, the Iowa Medicaid enterprise will make payment to the provider of care.

80.2(1) Electronic submission. Providers are encouraged to submit claims electronically whenever possible.

a. Ambulance service providers may bill electronically only when the procedures performed are identified by codes based on the ones that Medicare recognizes as emergency and support medical necessity without a review by the Iowa Medicaid enterprise.

b. When filing electronic claims, pharmacies shall use the format prescribed by the National Council for Prescription Drug Programs.

c. Claims submitted electronically after implementation of the Health Insurance Portability and Accountability Act of 1996 shall be filed on the Accredited Standards Committee (ASC) X12N 837 transaction, Health Care Claim. The department shall send all providers written notice when the Act is implemented.

(1) Providers listed as filing claims on Form CMS-1500 or on the Claim for Targeted Medical Care shall file claims on the professional version of the Health Care Claim.

(2) Providers listed as filing claims on Form CMS-1450 or on the Iowa Medicaid Long-Term Care Claim shall file the institutional version of the Health Care Claim.

(3) Dentists shall file the dental version of the Health Care Claim.

(4) Pharmacists providing drugs and injections shall use the format prescribed by the National Council for Prescription Drug Programs.

d. If a claim submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3969, Claim Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3969 the attachment control number submitted on the ASC X12N 837 electronic transaction.

80.2(2) Claim forms. Claims for payment for services provided recipients shall be submitted on Form CMS-1500, Health Insurance Claim Form, except as noted below.

a. The following providers shall submit claims on Form UB-04, CMS-1450:

(1) Home health agencies providing services other than home- and community-based services.

(2) Hospitals providing inpatient care or outpatient services, including inpatient psychiatric hospitals.

(3) Psychiatric medical institutions for children.

(4) Rehabilitation agencies.

(5) Hospice providers.

(6) Medicare-certified nursing facilities.

(7) Nursing facilities for the mentally ill.

(8) Special population nursing facilities as defined in rule 441—81.6(249A).

(9) Out-of-state nursing facilities.

b. All other nursing facilities and intermediate care facilities for the mentally retarded shall file claims on Form 470-0039, Iowa Medicaid Long-Term Care Claim.

c. Pharmacies shall submit claims on the Universal Pharmacy Claim Form when filing paper claims.

d. Dentists shall submit claims on the dental claim form approved by the American Dental Association.

e. Rescinded IAB 8/1/07, effective 9/5/07.

f. Providers of home- and community-based waiver services, including home health agencies, shall submit claims on Form 470-2486, Claim for Targeted Medical Care. In the event of the death of the member, the case manager or service worker shall sign and date the claim form if the services were delivered.

g. Case management providers shall submit claims on Form 470-2486, Claim for Targeted Medical Care, for services provided pursuant to 441—Chapter 90 and on FACS-generated claims for services provided pursuant to 441—Chapter 186.

h. Providers billing claims for Medicare beneficiaries that do not cross over electronically to the Iowa Medicaid enterprise shall submit:

(1) Form 470-4707, Medicare Crossover Invoice (Institutional), along with the Explanation of Medicare Benefits (EOMB) for institutional services.

(2) Form 470-4708, Medicare Crossover Invoice (Professional), along with the Explanation of Medicare Benefits (EOMB) for professional services.

80.2(3) Providers shall purchase their supplies of forms CMS-1450 and CMS-1500 for use in billing.

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

[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9724B, IAB 9/7/11, effective 9/1/11; ARC 9889B, IAB 11/30/11, effective 1/4/12; ARC 2165C, IAB 9/30/15, effective 12/1/15]

441—80.3(249A) Payment from other sources.

80.3(1) Payments deducted. The amount of any payment made directly to the provider of care by the recipient, relatives, or any source shall be deducted from the established cost standard for the service provided to establish the amount of payment to be made by Iowa Medicaid.

80.3(2) Third-party liability. When a third-party liability for medical expenses exists, this resource shall be utilized before the Medicaid program makes payment unless:

a. The department pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third party. This “pay and chase” provision applies to claims for:

- (1) Prenatal care,
 - (2) Preventive pediatric services, and
 - (3) All services provided to a person for whom there is court-ordered medical support.
- b. Otherwise authorized by the department.

80.3(3) Recovery from third parties legally responsible to pay for health care. Parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall:

a. Respond to any inquiry by the state regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of the item or service.

b. Agree not to deny any claim submitted by the state solely because of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim, if both of the following conditions are met:

(1) The claim is submitted to the entity by the state within the three-year period beginning on the date on which the item or service was furnished.

(2) Any action by the state to enforce its rights with respect to the claim is commenced within six years of the date that the claim was submitted by the state.

c. Reimburse the Medicaid program within 90 days of the request for repayment.

This rule is intended to implement Iowa Code chapter 249A.

[ARC 7547B, IAB 2/11/09, effective 3/18/09]

441—80.4(249A) Time limit for submission of claims and claim adjustments.

80.4(1) *Submission of claims.* Payment will not be made on any claim when the amount of time that has elapsed between the date the service was rendered and the date the initial claim is received by the Iowa Medicaid enterprise exceeds 365 days. The department shall consider claims submitted beyond the 365-day limit for payment only if retroactive eligibility on newly approved cases is made that exceeds 365 days or if attempts to collect from a third-party payer delay the submission of a claim. In the case of retroactive eligibility, the claim must be received within 365 days of the first notice of eligibility by the department.

80.4(2) *Claim adjustments and resubmissions.* A provider's request for an adjustment to a paid claim or resubmission of a denied claim must be received by the Iowa Medicaid enterprise within 365 days from the date the claim was last adjudicated in order to have the adjustment or resubmission considered. In no case will a claim be paid if the claim is received beyond two years from the date of service.

80.4(3) *Definition.* For purposes of this rule, a claim is "received" when entered into the department's payment system with an action of pay, deny, or suspend. Any claim returned to the provider without such action is not "received."

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.
[ARC 1155C, IAB 10/30/13, effective 1/1/14]

441—80.5(249A) Authorization process.

80.5(1) *Identification cards.* The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to members for use in securing medical and health services available under the program except as provided in 441—76.6(249A).

a. The department shall issue the Medical Assistance Eligibility Card:

- (1) When the member's eligibility is initially determined.
- (2) Annually thereafter.
- (3) Upon the member's request for replacement of a lost, stolen, or damaged card.

b. The Medical Assistance Eligibility Card is valid only for months in which the member has established eligibility, as indicated on the department's eligibility verification system (ELVS). Payment will be made for services provided to an ineligible person when ELVS indicates that the person was eligible for the period in which the service was provided.

80.5(2) *Third-party liability.* Rescinded IAB 2/11/09, effective 3/18/09.
[ARC 7547B, IAB 2/11/09, effective 3/18/09]

441—80.6(249A) Payment to provider—exception. Payments for medical services may be made only to the provider of the services except as provided below:

80.6(1) *Medical assistance corrective payments.* Payment may be made to the client or county relief agency in accordance with rule 441—75.8(249A).

80.6(2) *Assignment.* Payment may be made in accordance with an assignment to a county for medical services received while the recipient was receiving interim assistance or while an appeal of a denial of medical assistance was pending.

80.6(3) *Business agent of provider.* Payment may be made to a business agent that furnishes statements and receives payments in the name of the provider if the agent's compensation is:

- a. Related to the cost of processing the billing.
- b. Not related on a percentage or other basis to the amount that is billed or collected.
- c. Not dependent upon the collection of the payment.

441—80.7(249A) Health care data match program. As a condition of doing business in Iowa, health insurers shall provide, upon the request of the state, information with respect to individuals who are eligible for or are provided medical assistance under the state's medical assistance state plan to determine (1) during what period the member or the member's spouse or dependents may be or may have been covered by a health insurer and (2) the nature of the coverage that is or was provided by the health insurer. This requirement applies to self-insured plans, group health plans as defined in the federal Employee Retirement Income Security Act of 1974 (Public Law 93-406), service benefit plans, managed care

organizations, pharmacy benefits managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

80.7(1) Agreement required. The parties shall sign a data use agreement for the purposes of this rule. The agreement shall prescribe the manner in which information shall be provided to the department of human services and the acceptable uses of the information provided.

a. The initial provision of data shall include the data necessary to enable the department to match covered persons and identify third-party payers for the two-year period before the initial provision of the data. The data shall include the name, address, and identifying number of the plan.

b. Ongoing monthly matches may be limited to changes in the data previously provided, including additional covered persons, with the effective dates of the changes.

80.7(2) Agreement form.

a. An agreement with the department shall be in substantially the same form as Form 470-4415, Agreement for Use of Data.

b. An agreement with the department's designee shall be in a form approved by the designee, which shall include privacy protections equivalent to those provided in Form 470-4415, Agreement for Use of Data.

80.7(3) Confidentiality of data. The exchange of information carried out under this rule shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to:

a. The federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191; and

b. Regulations promulgated in accordance with that Act and published in 45 CFR Parts 160 through 164.

[ARC 1070C, IAB 10/2/13, effective 10/1/13]

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

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◊ Two or more ARCs

CHAPTER 83 MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in medical institutions. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

441—83.1(249A) Definitions.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Blind individual*” means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

“*Client participation*” means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Deeming*” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“*Disabled person*” means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

“*Financial participation*” means client participation and medical payments from a third party including veterans’ aid and attendance.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*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 persons with an intellectual disability which has been approved as a Medicaid vendor.

“*Medical intervention*” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“*Medical monitoring*” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“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.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.2(249A) Eligibility. To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) Eligibility criteria.

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act.

b. The person must be ineligible for Supplemental Security Income (SSI) if the person is 21 years of age or older, except that persons who are receiving health and disability waiver services upon reaching the age of 21 may continue to be eligible regardless of SSI eligibility until they reach the age of 25.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent’s(s’) income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse’s income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person’s income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care.

(3) Health and disability waiver services will not be provided when the person 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 or a physician assistant.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)“b” and 75.5(4)“c” shall be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) Need for services.

a. The member shall have a service plan approved by the department which is developed by the service worker or targeted case manager identified by the county of residence. This service plan must be completed prior to services provision and annually thereafter.

The service worker or targeted case manager shall establish the interdisciplinary team for the member and, with the team, identify the member's need for service based on the member's needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan shall be based, in part, on information in the completed Service Worker Comprehensive Assessment, Form 470-5044. Form 470-5044 shall be completed annually. The service worker or targeted case manager shall have a face-to-face visit with the member 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 or targeted case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the member's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>	<u>ICF/ID</u>
\$2,765	\$950	\$3,365

(1) For members eligible for SSI who remain eligible for health and disability waiver services until the age of 25 because they are receiving health and disability waiver services upon reaching the age of 21, these amounts shall be increased by the cost of services for which the member would be eligible under 441—subrule 78.9(10) if still under 21 years of age.

(2) If more than \$505 is paid for home and vehicle modification services, the service worker or targeted case manager shall encumber up to \$505 per month within the monthly dollar cap allowed for the member 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 or targeted case manager. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) “b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14]

441—83.3(249A) Application.

83.3(1) Application for HCBS health and disability waiver services. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.3(2) Application and services program limit. The number of persons who may be approved for the HCBS health and disability waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant’s name shall be placed on a waiting list maintained by the bureau of long-term care.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the department shall enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2) “a”(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program

is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available.

(5) Once a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The county department office shall notify the bureau of long-term care within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) Approval of application.

a. Applications for the HCBS health and disability waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information which is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, has been submitted to the IME medical services unit.

(5) The application is pending because the assessment, Form 470-4392, 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 470-4392, or service plan, the application shall be denied.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the client case plan are completed.

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) Effective date of eligibility.

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations 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 health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4) "a" and "c" do not apply is the date on which the income eligibility and level of care determinations and the case plan are completed.

c. Eligibility for persons covered under subparagraph 83.2(1) "c" (3) shall exist on the date the income and resource eligibility and level of care determinations 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 member has been in a medical institution for 30 consecutive days for other than respite care. Members who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through Form 470-0602, Notice of Decision. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

83.4(1) Maintenance needs of the individual. The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.4(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid shall make no payments to health and disability waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

83.4(3) Maintenance needs of spouse and other dependents. Rescinded IAB 4/9/97, effective 6/1/97.
[ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person's situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).

[ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.6(249A) Allowable services. Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).

[ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with 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 health and disability waiver services and the types of providers who will deliver the services.

83.7(2) The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the member; and
- b. The financial management service selected by the member.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.

[ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.

- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the aggregate monthly costs established in 83.2(2) "b," or are not met by the services provided.

- d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) "a," "b," "c," "g," or "h" apply.
- b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in 83.2(2) "b."

- c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 30 days in any one stay for purposes other than respite care.

- d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member's own home as determined by the service worker or targeted case manager.

- e. Service providers are not available.

83.8(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs "a" and "b."

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13]

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 based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

e. Determined to need services as described in subrule 83.22(2).

f. Rescinded IAB 10/11/06, effective 10/1/06.

g. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

83.22(2) Need for services, service plan, and cost.

a. *Case management.* Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to 441—subrule 77.33(21). Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. *Interdisciplinary team.* The case manager shall establish an interdisciplinary team for the consumer.

(1) *Composition.* The interdisciplinary team shall include the case manager and the consumer and, if appropriate, the consumer’s legal representative, family, service providers, and others directly involved in the consumer’s care.

(2) *Role.* The team shall identify:

1. The consumer’s need for services based on the consumer’s needs and desires.

2. Available and appropriate services to meet the consumer’s needs.

3. Health and safety issues for the consumer that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.

4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the consumer’s needs change.

c. *Service plan.* An applicant for elderly waiver services shall have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan shall be appropriate to the problems and specific needs or disabilities of the consumer.

(2) Services must be the least costly available to meet the service needs of the member. The total monthly cost of the elderly waiver services exclusive of case management services shall not exceed

the established monthly cost of the level of care. Aggregate monthly costs, excluding the cost of case management and home and vehicle modifications, are limited as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>
\$2,765	\$1,339

- (3) The service plan must be completed before services are provided.
- (4) The service plan must be reviewed at least annually and when there is any significant change in the consumer's needs.
 - d. *Content of service plan.* The service plan shall include the following information based on the consumer's current assessment and service needs:
 - (1) Observable or measurable individual goals.
 - (2) Interventions and supports needed to meet those goals.
 - (3) Incremental action steps, as appropriate.
 - (4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.
 - (5) The desired individual outcomes.
 - (6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.
 - (7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.
 - (8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:
 - 1. The name of the service provider responsible for providing the service.
 - 2. The funding source for the service.
 - 3. The amount of service that the consumer is to receive.
 - (9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.
 - (10) The determination that the services authorized in the service plan are the least costly.
 - (11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:
 - 1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.
 - 2. The emergency backup support and crisis response system identified by the interdisciplinary team.
 - 3. Emergency, backup staff designated by providers for applicable services.

83.22(3) Providers—standards. Rescinded IAB 10/11/06, effective 10/1/06.
 [ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14]

441—83.23(249A) Application.

83.23(1) Application for HCBS elderly waiver. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.23(2) Application for services. Rescinded IAB 12/6/95, effective 2/1/96.

83.23(3) Approval of application.

a. Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-4694, Case Management Comprehensive Assessment, indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(4) Effective date of eligibility.

a. The effective date of eligibility 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.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

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).

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person's primary diagnosis will determine which services shall be used.

441—83.31(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.32 to 83.40 Reserved.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

"*AIDS*" means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," August 14, 1987, Vol. 36, No. 1S issue of "Morbidity and Mortality Weekly Report."

"*Attorney in fact under a durable power of attorney for health care*" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"*Basic individual respite*" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Client participation” means the amount of the recipient’s income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

“Deeming” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“Financial participation” means client participation and medical payments from a third party including veterans’ aid and attendance.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“HIV” means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

“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 based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care.

(3) AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) Need for services.

a. The department service 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 Service Worker Comprehensive Assessment, Form 470-5044. Form 470-5044 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 \$1,840.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13]

441—83.43(249A) Application.

83.43(1) Application for HCBS AIDS/HIV waiver services. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.43(2) Application for services. Rescinded IAB 12/6/95, effective 2/1/96.

83.43(3) Approval of application.

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, has been submitted to the IME medical services unit.

(3) Rescinded IAB 3/7/01, effective 5/1/01.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the consumer service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(4) Effective date of eligibility.

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations 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.
[ARC 0306C, IAB 9/5/12, effective 11/1/12]

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).

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.50(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

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

441—83.51 to 83.59 Reserved.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

441—83.60(249A) Definitions.

“*Adaptive*” means age-appropriate skills related to taking care of one’s self and one’s ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

“*Adult*” means a person with an intellectual disability aged 18 or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Behavior*” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Case management services*” means those services established pursuant to Iowa Code chapter 225C.

“*Child*” means a person with an intellectual disability aged 17 or under.

“*Client participation*” means the posteligibility amount of the consumer’s income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

“*Counseling*” means face-to-face mental health services provided to the consumer and caregiver by a qualified intellectual disability professional (QIDP) to facilitate home management of the consumer and prevent institutionalization.

“*Deemed status*” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

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

“Direct service” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“Fiscal accountability” means the development and maintenance of budgets and independent fiscal review.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Health” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“Immediate jeopardy” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“Intellectual disability” means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which shall be made only when the onset of the person’s condition was during the developmental period and shall be based on an assessment of the person’s intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person’s adaptive skills. The diagnosis shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association.

“Intermediate care facility for persons with an intellectual disability (ICF/ID)” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“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 persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Natural supports” means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

“Organization” means the entity being certified.

“Organizational outcome” means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

“Outcome” means an action or event that follows as a result or consequence of the provision of a service or support.

“Procedures” means the steps to be taken to implement a policy.

“Process” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“Qualified intellectual disability professional” means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master’s degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor’s degree in recreation or in a specialty area such as art, dance, music or physical education.
9. A professional dietitian who is eligible for registration by the American Dietetics Association.
10. A human services professional who must have at least a bachelor’s degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

“Related condition” means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.
2. It is manifested before the age of 22.
3. It is likely to continue indefinitely.
4. It results in substantial functional limitations in three or more of the following areas of major life activity:
 - Self-care.
 - Understanding and use of language.
 - Learning.
 - Mobility.
 - Self-direction.
 - Capacity for independent living.

“Service plan” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“SIS assessment” means the Supports Intensity Scale® assessment developed and licensed by the American Association on Intellectual and Developmental Disabilities for use in the assessment of the support and service needs of individuals.

“Specialized respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“Staff” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“Third-party payments” means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

“Usual caregiver” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15]

441—83.61(249A) Eligibility. To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) Eligibility criteria. All of the following criteria must be met. The person must:

a. Have a diagnosis of intellectual disability as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of intellectual disability as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 years and above	Current psychological documentation substantiating a diagnosis of intellectual disability if the last testing date was (1) more than six years ago for an applicant with a diagnosis of mild or unspecified severity, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound level of severity	Psychological documentation substantiating a diagnosis of intellectual disability made since the member reached 22 years of age	Psychological documentation substantiating a diagnosis of intellectual disability every six years and whenever a significant change occurs

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF>ID. The IME medical services unit shall be responsible for annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

(1) to (3) Rescinded IAB 3/7/01, effective 5/1/01.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For supported employment services:

- (1) Be at least age 16.
- (2) Rescinded IAB 7/1/98, effective 7/1/98.

(3) Not be eligible for supported employment service funding under Public Law 94-142 or for the Rehabilitation Act of 1973.

(4) Not reside in a medical institution.

h. Choose HCBS intellectual disability waiver services rather than ICF/ID services.

i. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

j. Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).

k. For residential-based supported community living services, meet all of the following additional criteria:

(1) Be less than 18 years of age.

(2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:

1. Social history;

2. Case history that includes previous placements and service programs;

3. Medical history that includes major illnesses and current medications;

4. Current psychological evaluations and consultations;

5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;

6. Any current court orders in effect regarding the child;

7. Any legal history;

8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;

9. Whether the proposed placement would be safe for the child and for other children living in that setting; and

10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:

1. Be residing in an ICF/ID;

2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2) "a"; or

3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

l. For day habilitation, be 16 years of age or older.

m. For the consumer choices option as set forth in 441—subrule 78.41(5), not be living in a residential care facility.

83.61(2) Need for services.

a. Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange an SIS assessment.

b. Applicants not receiving services as set forth in paragraph 83.61(2) "a" shall have a department service worker or case manager:

- (1) Arrange an SIS assessment for the initial level of care determination;
- (2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and
- (3) With the initial interdisciplinary team, identify the applicant's needs and desires as well as the availability and appropriateness of services.

c. Applicants meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

d. Services shall not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The case manager shall coordinate with the department to arrange an SIS assessment for the initial level of care determination within 30 days from the date of the HCBS application unless the worker can document difficulty in locating information necessary to arrange the SIS assessment or other circumstances beyond the worker's control.

g. At initial enrollment, the case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing identification of need for services:

(1) The assessment shall be based on the results of the most recent SIS assessment or of the SIS contractor's off-year review.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care. The service worker, department QIDP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) "b"(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) HCBS intellectual disability waiver program limit. The number of persons receiving HCBS intellectual disability waiver services in the state shall be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots shall be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list shall be sent to the person by the department.

83.61(4) Securing a payment slot. The department shall determine if a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department shall give written notice to the applicant.

(2) The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the applicant shall be placed on a statewide priority waiting list. The department shall assess each applicant to determine the applicant's priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county on September 30, 2011, and for all new applications received on or after October 1, 2011.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4) "b"(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.61(4) "b"(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15]

441—83.62(249A) Application.

83.62(1) Application for HCBS intellectual disability waiver services. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.62(2) Rescinded IAB 6/5/96, effective 8/1/96.

83.62(3) Approval of application.

a. Applications for the HCBS intellectual disability waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF>ID care. The case manager or worker shall have the consumer or legal representative indicate the consumer's choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

g. Rescinded IAB 5/6/09, effective 7/1/09.

83.62(4) Effective date of eligibility.

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in

rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 30 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

83.62(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2168C, IAB 9/30/15, effective 11/4/15]

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months. In years in which an SIS assessment is not completed, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous SIS or other full assessment.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 2168C, IAB 9/30/15, effective 11/4/15]

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.67(249A) Service plan. A service plan shall be prepared for each HCBS intellectual disability waiver consumer.

83.67(1) Development. The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved.

83.67(2) Retention. The service plan shall be stored by the case manager for a minimum of three years.

83.67(3) Interdisciplinary team meeting. The interdisciplinary team meeting shall be conducted before the current service plan expires.

83.67(4) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of the consumer's rights including, but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
 - d. The name of the service provider responsible for providing each service.
 - e. The service funding source.
 - f. The amount of the service to be received by the consumer.
 - g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
 - h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.67(5) Documentation. The Medicaid case manager shall ensure that the consumer's case file contains the consumer's service plan and documentation supporting the diagnosis of mental retardation.

83.67(6) Approval of plan. The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

- a. Services must be authorized and entered into ISIS before the plan implementation date.
- b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.
- c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department has final authority regarding the services and service cost.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

441—83.68(249A) Adverse service actions.

83.68(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The applicant is not eligible for the services.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.
- g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “*a*” or “*b*,” apply.

83.68(3) Termination. A particular service may be terminated when the department determines that:

- a.* The provisions of 441—subrule 130.5(2) paragraph “*d*,” “*g*,” or “*h*,” apply.
- b.* Needed services are not available or received from qualifying providers.
- c.* No HCBS intellectual disability waiver service is identified in the member’s annual service plan.
- d.* Service needs are not met by the services provided.
- e.* Services needed exceed the service unit or reimbursement maximums.
- f.* Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.
- g.* The consumer receives services from other Medicaid waiver programs.
- h.* The consumer or legal representative through the interdisciplinary process requests termination from the services.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.69(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

441—83.70(249A) County reimbursement. Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

441—83.71(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

441—83.72(249A) Rent subsidy program. Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. See 265—Chapter 24.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.73 to 83.80 Reserved.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

“*Adaptive*” means age appropriate skills related to taking care of one’s self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“*Adult*” means a person with a brain injury aged 18 years or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“*Assessment*” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Behavior*” means skills related to regulating one’s own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Brain injury" means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

- Malignant neoplasms of brain, cerebrum.
 - Malignant neoplasms of brain, frontal lobe.
 - Malignant neoplasms of brain, temporal lobe.
 - Malignant neoplasms of brain, parietal lobe.
 - Malignant neoplasms of brain, occipital lobe.
 - Malignant neoplasms of brain, ventricles.
 - Malignant neoplasms of brain, cerebellum.
 - Malignant neoplasms of brain, brain stem.
 - Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.
 - Malignant neoplasms of brain, cerebral meninges.
 - Malignant neoplasms of brain, cranial nerves.
 - Secondary malignant neoplasm of brain.
 - Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
 - Benign neoplasm of brain and other parts of the nervous system, brain.
 - Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
 - Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
 - Encephalitis, myelitis and encephalomyelitis.
 - Intracranial and intraspinal abscess.
 - Anoxic brain damage.
 - Subarachnoid hemorrhage.
 - Intracerebral hemorrhage.
 - Other and unspecified intracranial hemorrhage.
 - Occlusion and stenosis of precerebral arteries.
 - Occlusion of cerebral arteries.
 - Transient cerebral ischemia.
 - Acute, but ill-defined, cerebrovascular disease.
 - Other and ill-defined cerebrovascular diseases.
 - Fracture of vault of skull.
 - Fracture of base of skull.
 - Other and unqualified skull fractures.
 - Multiple fractures involving skull or face with other bones.
 - Concussion.
 - Cerebral laceration and contusion.
 - 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 persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Natural supports” means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

“Organization” means the entity being certified.

“Organizational outcome” means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

“Outcome” means an action or event that follows as a result or consequence of the provision of a service or support.

“Procedures” means the steps to be taken to implement a policy.

“Process” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“Qualified brain injury professional” means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years’ experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in psychology, sociology, or public health or rehabilitation services.

“Service coordination” means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

“Service plan” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“Specialized respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“Staff” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“Third-party payments” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“Usual caregiver” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a diagnosis of brain injury.
- b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.
- c. Be at least one month of age.
- d. Be a U.S. citizen and Iowa resident.
- e. Rescinded IAB 7/11/01, effective 7/1/01.
- f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF>ID), skilled nursing, or ICF level of care.
- g. Be assessed by the IME medical services unit as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.
- h. At a minimum, receive a waiver service each quarter in addition to case management.
- i. Choose HCBS.
- j. To be eligible for interim medical monitoring and treatment services the consumer must be:
 - (1) Under the age of 21;
 - (2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);
 - (3) Residing in the consumer’s family home or foster family home; and
 - (4) In need of interim medical monitoring and treatment as ordered by a physician.
- k. Receive services in a community, not an institutional, setting.
- l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.
- m. For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.

83.82(2) Need for services.

- a. The applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the applicant and, with the team, identify the applicant’s need for service based on the applicant’s needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the IME medical services unit.

(2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.

(4) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) “b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person’s needs as a precondition of eligibility for the HCBS BI waiver.

d. The total cost of brain injury waiver services, excluding the cost of case management and home and vehicle modifications, shall not exceed \$2,954 per month.

83.82(3) HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care. Rescinded IAB 7/11/01, effective 7/1/01.

83.82(4) Securing a state payment slot.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department shall enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14]

441—83.83(249A) Application.

83.83(1) Application for financial eligibility. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.83(2) Approval of application for eligibility.

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application or the case manager. The discharge planner or case manager shall provide to the IME medical services unit all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IME medical services unit shall inform the discharge planner or case manager on behalf of the consumer or the consumer's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall complete and sign Form 470-4694, Case Management Comprehensive Assessment, indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, shall contact the 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.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.84(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, consumer-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

441—83.87(249A) Service plan. A service plan shall be prepared and utilized for each HCBS BI waiver consumer. The service plan shall be developed by an interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The service plan shall be stored by the case manager for a minimum of three years. The service plan staffing shall be conducted before the current service plan expires.

83.87(1) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:

- (1) The consumer's living environment at the time of waiver enrollment.
- (2) The number of hours per day of on-site staff supervision needed by the consumer.
- (3) The number of other waiver consumers who will live with the consumer in the living unit.
 - c. An identification and justification of any restriction of a consumer's rights including, but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
 - d. The names of all providers responsible for providing all services.
 - e. All service funding sources.
 - f. The amount of the service to be received by the consumer.
 - g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
 - h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.87(2) Use of nonwaiver services. Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) Annual assessment. The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed Form 470-4694, Case Management Comprehensive Assessment, and supporting documentation as needed.

83.87(4) Service file. The Medicaid case manager must ensure that the consumer service file contains the consumer's service plan.

a. to d. Rescinded IAB 8/7/02, effective 10/1/02.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

441—83.88(249A) Adverse service actions.

83.88(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The brain injury waiver service is not identified in the consumer's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g. The consumer receives services from other Medicaid waiver providers.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph "a" or "b," apply.

83.88(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph "d," "g," or "h," apply.
- b. Needed services are not available or received from qualifying providers.
- c. The brain injury waiver service is not identified in the consumer's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.

- f. Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.
- g. The consumer receives services from other Medicaid providers.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.89(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

441—83.90(249A) County reimbursement. Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

441—83.91(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.92 to 83.100 Reserved.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

“*Adaptive*” means age-appropriate skills related to taking care of one’s self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“*Adult*” means a person with a physical disability aged 18 years to 64 years.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“*Assessment*” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Behavior*” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Client participation*” means the amount of the consumer’s income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

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

“*Guardian*” means a guardian appointed in probate court for an adult.

“*Medical institution*” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“*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.
[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a physical disability.
- b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act or the disability guidelines for the Medicaid employed people with disabilities coverage group.
- c. Be ineligible for the HCBS intellectual disability waiver.
- d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.
- e. Be eligible for Medicaid under 441—Chapter 75.
- f. Be aged 18 years to 64 years.
- g. Rescinded IAB 2/7/01, effective 2/1/01.
- h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care.

(2) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

(3) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

- i. Choose HCBS.
- j. Use a minimum of one unit of service per calendar quarter under this program.
- k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) Need for services.

a. The applicant shall have a service plan which is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The service worker shall identify the need for service based on the needs of the applicant, as documented in Form 470-5044, Service Worker Comprehensive Assessment, as well as the availability and appropriateness of services.

(2) The service worker shall have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, shall not exceed \$692 per month.

83.102(3) Slots. The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

83.102(4) County payment slots for persons requiring the ICF/MR level of care. Rescinded IAB 10/6/99, effective 10/1/99.

83.102(5) Securing a slot.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no slot is available, the department shall enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(6) Securing a county payment slot. Rescinded IAB 10/6/99, effective 10/1/99.

83.102(7) HCBS physical disability waiver waiting list. When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14]

441—83.103(249A) Application.

83.103(1) Application for financial eligibility. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

83.103(2) Approval of application for eligibility.

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall have the applicant's primary care provider complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the discharge planner of the IME medical services unit's decision.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's primary care provider shall complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the 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.
[ARC 0306C, IAB 9/5/12, effective 11/1/12]

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 member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1) "h" and the appeal process at rule 441—83.109(249A), based on the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, and supporting documentation as needed.

83.107(3) Case file. Rescinded IAB 8/7/02, effective 10/1/02.
[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.108(249A) Adverse service actions.

83.108(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. All of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The physical disability waiver service is not identified in the consumer's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g. The consumer receives services from other Medicaid waiver providers.
- h. The consumer or legal representative requests termination from the services.

83.108(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

83.108(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.
- b. Needed services are not available or received from qualifying providers.
- c. The physical disability waiver service is not identified in the consumer’s annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.
- g. The consumer receives services from other Medicaid providers.
- h. The consumer or legal representative requests termination from the services.

441—83.109(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

83.109(1) Appeal to county. Rescinded IAB 2/7/01, effective 2/1/01.

83.109(2) Reconsideration request to IME medical services unit. Rescinded IAB 9/5/12, effective 11/1/12.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.110(249A) County reimbursement. Rescinded IAB 10/6/99, effective 10/1/99.

441—83.111(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.112 to 83.120 Reserved.

DIVISION VII—HCBS CHILDREN’S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

“*Assessment*” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, abilities, desires, and goals.

“*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 persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

“Mental health professional” means a person who meets all of the following conditions:

1. Holds at least a master’s degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

“Serious emotional disturbance” means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer’s role or functioning in family, school, or community activities. “Serious emotional disturbance” shall not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as “other conditions that may be a focus of clinical attention,” unless these conditions co-occur with another diagnosable serious emotional disturbance.

“Service plan” means a written, consumer-centered, outcome-based plan of services developed by the consumer’s interdisciplinary team that addresses all relevant services and supports being provided. The service plan may involve more than one provider.

“Skill development” means that the service provided is habilitative and is intended to impart an ability or capacity to the consumer. Supervision without habilitation is not skill development.

“Targeted case management” means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for consumers eligible for the children’s mental health waiver.

“Waiver year” for the children’s mental health waiver means a 12-month period commencing on July 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—83.122(249A) Eligibility. To be eligible for children’s mental health waiver services, a consumer must meet all of the following requirements:

83.122(1) Age. The consumer must be under 18 years of age.

83.122(2) Diagnosis. The consumer must be diagnosed with a serious emotional disturbance.

a. *Initial certification.* For initial application to the HCBS children’s mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

b. *Ongoing certification.* A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) Level of care. The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit shall certify the applicant’s level of care annually based on Form 470-4694, Case Management Comprehensive 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 applicant must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the applicant's parent or legal guardian on Form 470-4694, Case Management Comprehensive 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 member's needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, may not exceed \$1,967 per month.
- c. At a minimum, each consumer must receive one billable unit of a children's mental health waiver service per calendar quarter.
- d. A consumer may not receive children's mental health waiver services and foster family care services under 441—Chapter 202 at the same time.
- e. A consumer may be enrolled in only one HCBS waiver program at a time.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14]

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 470-4694, Case Management Comprehensive 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 applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department;

(2) The names of Medicaid members shall be added to the waiting list on the date as specified in paragraph 83.123(1) "a."

(3) In the event that more than one application is received at one time, the names of consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

d. Consumers whose names are on the waiting list shall be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved consumers on the program is maintained.

(1) Once a payment slot is assigned, the department shall give written notice to the consumer within five working days.

(2) The department shall hold the payment slot for 30 days for the consumer to file a new application.

(3) If an application has not been filed within 30 days, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer originally assigned the slot must reapply for a new slot.

83.123(2) Approval of waiver eligibility.

a. *Time limit.* Applications for the HCBS children's mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal Supplemental Security Income (SSI) benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the consumer or the department.

(3) The application is pending because the assessment 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.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

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 470-4694, Case Management Comprehensive 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.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

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).

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

These rules are intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

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CHAPTER 88
MANAGED HEALTH CARE PROVIDERS
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter contains rules governing the delivery of managed health care under the Medicaid program. These rules make provision for the following managed health care options: health maintenance organizations (HMOs), prepaid health plans (PHPs), patient management, known as Medicaid Patient Access to Service System (MediPASS), the managed care plan for the delivery of mental health and substance abuse services (Iowa Plan for Behavioral Health), and programs of all-inclusive care for the elderly (PACE). The rules cover eligibility of a provider to participate, reimbursement methodologies, record-keeping requirements, grievance procedures, and member enrollment and disenrollment procedures. Services covered or requiring authorization and member access to services are specified.

DIVISION I
HEALTH MAINTENANCE ORGANIZATION

441—88.1(249A) Definitions.

“*Capitation rate*” shall mean the fee the department pays monthly to an HMO for each enrolled recipient for the provision of covered medical and health services whether or not the enrolled recipient received services during the month for which the fee is intended.

“*Contract*” shall mean a contract between the department and an HMO for the provision of medical and health services to Medicaid recipients in which the HMO assumes a risk as defined in the contract. These contracts shall meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996.

“*Covered services*” shall mean all or a part of those medical and health services set forth in 441—Chapter 78 and covered in the contract between the department and an HMO.

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

“*Emergency care*” shall mean those medical services rendered for an emergent medical condition or protection of the public health.

“*Emergent medical condition*” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect it to result in:

1. Placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

The determination of whether an emergent medical condition exists shall be decided by a medical professional and shall be based on the patient’s medical condition, including presenting symptoms and medical history (as related to severe pain) prior to treatment.

In cases where the above criteria are satisfied, no prior authorization procedures are allowed.

“*Enrolled recipient*” shall mean a Medicaid recipient who is eligible for HMO enrollment as defined at subrule 88.2(4) and has been enrolled with an HMO as defined at subrule 88.3(2) or 88.3(7).

“*Enrollment area*” shall mean the county or counties or region or regions in which an HMO is licensed to operate by the state of Iowa and in which service capability exists as defined by the department and set forth in the contract. An enrollment area shall not be less than an entire county but may be less than a region. Regions shall be established by the department and outlined in the contract with the HMO.

“*Extended-participation program*” shall mean a mandatory six-month enrollment period with a managed care entity.

“*Federally qualified HMO*” shall mean an HMO qualified under Section 1315(a) of the Public Health Service Act as determined by the U.S. Public Health Service.

“Grievance” shall mean an incident, complaint, or concern which cannot be resolved in a manner satisfactory to enrolled recipients by the immediate response, verbal or otherwise, of the HMO staff member receiving the complaint or any complaint received in writing.

“Health maintenance organization (HMO)” shall mean a public or private organization which is licensed as an HMO under commerce department rules 191—Chapter 40.

“Managed care entity” shall mean either a managed care organization licensed by the department of insurance (e.g., HMO or PHP) or a primary care case management program (i.e., MediPASS).

“Managed health care” shall mean any one of the alternative deliveries of regular fee-for-service Medicaid such as defined in subrules dealing with health maintenance organizations (HMOs), prepaid health plans (PHPs), or Medicaid Patient Access to Service System (MediPASS).

“Managed health care review committee” shall mean a committee composed of representatives from the department. The committee shall review and render a decision on all requests for disenrollment which are not automatically approvable.

“Mandatory enrollment” shall mean mandatory participation in managed health care as specified in subrule 88.3(3).

“Mandatory project county” shall mean a county where the department has contracts with more than one managed care entity, one of which may be primary care case management (MediPASS) in cases where the number of MediPASS providers willing to serve as patient managers is sufficient to meet the needs and makeup of the recipient population in the county, or where the department has implemented the MediPASS program alone in the county.

“Noncovered services” shall mean services covered under Medicaid which are not included in the HMO’s contract with the department. Payment for these services will be made under regular Medicaid procedures.

“Participating providers” shall mean the providers of covered medical and health services who subcontract with or who are employed by an HMO.

“Recipient” shall mean any person determined by the department to be eligible for Medicaid and for HMO enrollment. See subrule 88.2(4) for a list of Medicaid eligibles who are not eligible for HMO enrollment.

“Region” shall mean an area consisting of two or more contiguous counties, as established by the department and specified in contracts with health maintenance organizations.

“Routine care” shall mean medical care which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment without risk of permanent damage to the patient’s life or health status. The condition requiring routine care is not likely to substantially worsen without immediate clinical intervention.

“Urgent care” shall mean those medical services rendered for an urgent medical condition or protection of the public health.

“Urgent medical condition” shall mean a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy.
2. Impairment to bodily functions, or
3. Dysfunction of any bodily organ or part.

441—88.2(249A) Participation.

88.2(1) Contracts with HMOs. The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with an HMO licensed under the provisions of commerce department rules of the insurance division, 191—Chapter 40. The department may also include the scope of services described in 441—Chapter 74, known as the Iowa Health and Wellness Plan, or part thereof, in contracts with HMOs.

- a. The department must determine that the HMO meets the following additional requirements:

(1) It shall make the services it provides to its Medicaid enrollees at least as accessible to them (in terms of timeliness, duration and scope) as those services are accessible to nonenrolled Medicaid recipients in the area served by the HMO.

(2) It shall provide satisfaction to the department against the risk of insolvency and assure that Medicaid recipients shall not be responsible for its debts if it does become insolvent. Compliance shall exist with commerce department rules regarding deposit requirements at 191—40.12(514B) and reporting requirements at 191—40.14(514B).

(3) For any contract executed or extended to be in effect on or after July 1, 2002, an HMO must have accreditation by the National Committee on Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

b. The contract shall meet the following minimum requirements. The contract shall:

- (1) Be in writing.
- (2) Be renewable by mutual consent for a period of up to three years.
- (3) List the services covered.
- (4) Describe information access and disclosure.
- (5) List conditions for nonrenewal, termination, suspension, and modification.
- (6) Specify the method and rate of reimbursement.
- (7) Provide for disclosure of ownership and subcontractor relationship.
- (8) Be made with the licensee by the department.

(9) Specify the enrollment area which shall be at least a county and effective July 1, 1998, a region of two or more contiguous counties.

c. Any protests to the award of contracts shall be in writing and submitted to the director of the department. Prior to termination or suspension of a contract, the department shall send a notice to cure to the HMO, specifying the number of days the HMO has to correct the problems. Failure to correct the problems in the time given shall then result in termination or suspension. The HMO may appeal the decision of the department in writing to the director of the department or to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, if the appeal documents state violations of federal law or regulation.

88.2(2) Method of selection of HMO. In those counties served by a single HMO, the department shall attempt to negotiate a contract. In those counties served by two or more HMOs, the department shall initiate communication and attempt to negotiate as many contracts as are cost-effective and administratively feasible. The department reserves the right to contract with more than one HMO serving any enrollment area.

a. *Request for proposal.* Rescinded IAB 11/10/93, effective 11/1/93.

b. *Minimum contract requirements.* Rescinded IAB 11/10/93, effective 11/1/93.

88.2(3) Termination of contract. The department and an HMO may by mutual consent terminate a contract by either party giving 60 days' written notice to the other party. The department may terminate or suspend a contract if the contract is determined by the department to be inconsistent with the overall goals and objectives of the Medicaid program. The determination shall be based on factors including, but not limited to, the following:

a. The HMO's delivery system does not ensure Medicaid recipients adequate access to medical services.

b. The HMO's delivery system does not ensure the availability of all services covered under the contract.

c. There are not proper assurances of financial solvency on the part of the HMO.

d. There is not substantial compliance with all provisions of the contract.

e. The HMO has discriminated against persons eligible to be covered under the contract on the basis of age, race, sex, religion, national origin, creed, color, physical or mental disability, political belief, health status, or the need for health services.

88.2(4) Recipients eligible to enroll. Any Medicaid-eligible recipient is eligible to enroll in a contracting HMO except for the following:

a. Recipients who are medically needy as defined at 441—subrule 75.1(35).

- b. Recipients over the age of 65 and under the age of 21 in psychiatric institutions as defined at 441—Chapter 85.
 - c. Recipients who are supplemental security income-related case members.
 - d. Rescinded IAB 10/3/01, effective 12/1/01.
 - e. Recipients whose eligibility is in the process of automatic redetermination as defined at rule 441—76.11(249A).
 - f. Recipients who are foster care and subsidized adoption-related case members.
 - g. Recipients who are Medicare beneficiaries.
 - h. Recipients who are pregnant women and who are deemed to be presumptively eligible as defined at 441—subrule 75.1(30).
 - i. Recipients who are Native American Indians or Alaskan natives.
 - j. Recipients who are receiving services from a Title V provider.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—88.3(249A) Enrollment.

88.3(1) Enrollment area. Counties in an HMO enrollment area shall be designated as either voluntary or mandatory. In voluntary counties enrollment is not required but eligible recipients may choose to join the HMO. See subrule 88.3(2) for information about voluntary enrollment. In mandatory counties enrollment is required for eligible recipients. See subrule 88.3(3) for information about mandatory enrollment.

88.3(2) Voluntary enrollment. When only one HMO in any county has a contract with the department, and the county is not a mandatory project county for Medicaid Patient Management (MediPASS) under subrule 88.43(1), enrollment by Medicaid recipients in the HMO is voluntary. The state encourages recipients to enroll in an HMO. Applicants and recipients eligible for HMO enrollment as set forth in subrule 88.2(4) are offered the option of HMO enrollment. Persons who enroll with the HMO shall have the right to request disenrollment at any time as defined at subrule 88.4(3).

Applicants or recipients can designate their choices on a form designated by the managed health care contractor or in writing to or with a verbal request to the Medicaid managed health care contractor. The form shall be available through the county office, provider offices, the HMO office, the managed health care contractor, or other locations at the department's discretion. If the HMO (or any entity listed above other than the managed health care contractor) receives the form, it shall be forwarded to the managed health care contractor within three working days.

Recipients shall be accepted by the HMO in the order in which they enroll without restrictions.

Recipients who choose not to enroll in an HMO shall be covered under regular Medicaid.

88.3(3) Mandatory enrollment. Participation in managed health care, if available, is required as specified in this subrule for covered eligibles who reside in a mandatory project county. The department shall require, whenever administratively feasible, that all eligible recipients enroll with a managed care entity. Administrative feasibility is determined by whether a freedom-of-choice waiver or state plan amendment has been approved by the Centers for Medicare and Medicaid Services and whether the managed care entities demonstrate sufficient access to and quality of services.

88.3(4) Effective date. The effective date of enrollment shall be no later than the first day of the second month subsequent to the date on which the managed health care contractor receives the designated managed health care choice form or written or verbal request except as defined at 88.4(4) "b." The recipients shall be entitled to regular Medicaid until the effective date of HMO enrollment which shall always be the first day of the month. The effective date shall be earlier than the second subsequent month where computer cutoff allows.

88.3(5) Identification card. The HMO may issue an appropriate identification card to the enrollee or request the department to do it on its behalf. The identification card shall be issued so the recipient receives it prior to the effective date of enrollment.

88.3(6) Limitations on enrollment. Contracting managed care entities may specify in a contract a limit to the number of recipients who can be assigned under subrule 88.3(7). If a limit is specified, the contracting entity must still provide services to all enrolled recipients who voluntarily select enrollment

in that option. If a specified limitation is reached, the remaining assignment needs in that county shall be met by the other managed care entities who are contracting with the department in that county.

88.3(7) Enrollment procedures. In mandatory enrollment counties, recipients shall be required to choose their managed care entity. When no choice is made by the recipient, the recipient shall be assigned to a contracting health maintenance organization (HMO) serving the recipient's county of residence when an HMO is available or to a MediPASS patient manager on a rotating basis to ensure an equitable distribution between the HMO and MediPASS programs based on the number of managed health care options (MediPASS and HMOs) available in the county. In the event there is no contracting HMO serving the recipient's county of residence in a mandatory enrollment county, the recipient shall be assigned to a MediPASS patient manager.

Within the MediPASS option, recipients shall be assigned according to age appropriateness. Whenever possible, family units shall be assigned to the same provider that an enrolled family member has selected, if that provider is appropriate according to age parameters. If not, the household shall be assigned to another physician. MediPASS patient managers shall not be assigned more recipients than their self-imposed maximum or the maximum described in subrule 88.46(5), whichever is lower.

Recipients who are assigned a managed care entity as described in this subrule shall have at least ten days in which to request enrollment in a different available entity. The change is subject to provisions in subrule 88.4(2) dealing with the effective date.

a. *Timely notice.* Recipients shall be sent timely notice of the managed care entity assignment. The recipient shall have a minimum of ten days in which a change to the assigned managed care entity can be made. The notice shall include the name of the managed care entity to whom the recipient shall be assigned if the recipient does not make a different selection by the date specified in the notice. If the covered eligible does not make a selection before the due date, the recipient shall be enrolled with the managed care entity listed on the notice.

b. *Enrollment.* Enrollment in managed health care shall be discussed during the face-to-face interview with all applicants for Medicaid under covered categories of assistance in mandatory or voluntary enrollment areas. The applicant shall be shown an informational videotape and encouraged to make a selection of a managed care entity. Applicants in mandatory enrollment areas shall be informed that should the applicant become eligible for a managed health care selection, one shall be assigned. Covered eligibles who are not enrolled shall be sent a notice of their managed health care assignment when the recipient:

- (1) Attains initial eligibility for a covered category of service in a mandatory project county.
- (2) Changes from an excluded category of assistance to a covered category of assistance in a mandatory project county.
- (3) Is receiving a covered category of assistance and moves from a county where no managed health care is available or from a voluntary project county to a mandatory project county.
- (4) Reattains eligibility.
- (5) Has a new member of the household receiving a covered category of assistance.

c. *Selection of a managed health care provider.* A list of health care providers participating in managed care entities serving the county shall be available to recipients for use in selecting a provider. If the recipient wishes to request an exception to the list of available managed health care providers, the managed health care review committee shall make a determination on the exception request. While the determination is being made, the recipient's enrollment shall be placed in a pending status.

d. *Request to change enrollment.* An enrolled recipient may, within 90 days from timely notice, request to change enrollment from one managed health care provider to another or one managed care entity to another. The request may be made on a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department. Changes are subject to the provisions of subrule 88.4(2) dealing with effective date.

e. *Managed care entity extended-participation program (EPP).* After the initial 90 days from timely notice, recipients will remain enrolled with the chosen entity for the following six months, with three exceptions:

- (1) A request for disenrollment by recipient for good cause pursuant to paragraph 88.4(3) "a."

(2) A request for disenrollment by provider for good cause pursuant to paragraph 88.4(3) "b."

(3) Availability of a new, previously unavailable, managed care entity. In this instance recipients will be allowed to select that entity for the remainder of the current EPP period.

f. *Enrollment cycle.* Prior to the end of any EPP period, recipients shall be notified of their ability to enroll with a different managed care option. A change in enrollment or failure to change enrollment will begin a new EPP enrollment period at the end of the current EPP.

441—88.4(249A) Disenrollment.

88.4(1) Disenrollment request. Rescinded IAB 5/6/98, effective 7/1/98.

88.4(2) Effective date. Disenrollment will be effective no later than the first day of the second calendar month after the month in which the department receives a request for disenrollment. The recipient will remain enrolled in the HMO and the HMO will be responsible for services covered under the contract until the effective date of disenrollment which will always be the first day of a month.

88.4(3) Disenrollment process. The recipient may complete the form designated by the managed health care contractor which can be obtained through the locations described in subrule 88.3(2). The recipient may also make a verbal or written request through the managed health care contractor. If the HMO or any other entity described in subrule 88.3(2) receives a request to disenroll from the recipient, the request shall be forwarded to the Medicaid managed health care contractor office within three working days. If the recipient must show good cause for disenrollment or if the HMO is requesting disenrollment, the determination as to whether disenrollment shall occur shall be made by the managed health care review committee within 30 days. If the recipient or HMO disagrees with the decision of the review committee, an appeal may be filed under the provisions of 441—Chapter 7. The HMO may request disenrollment of a recipient by showing good cause and completing Form 470-2169, Managed Health Care Provider Request for Disenrollment. If the county office receives a completed Form 470-2169 from the managed health care provider, the county office shall forward the form to the managed health care review committee within three days.

a. *Request for disenrollment by the recipient.* The enrolled recipient may request disenrollment by completing a choice form designated by the managed health care contractor, in writing or by telephone call to the toll-free recipient managed health care telephone line maintained by the department at any time prior to enrollment with a managed health care entity and within the 90 days from timely notice date. After this time period, a recipient may be disenrolled for good cause when the recipient can demonstrate that services were untimely, inaccessible, of insufficient quality or inadequately provided. In a mandatory county, a disenrollment request must be accompanied by a choice for another managed health care provider.

b. *Request for disenrollment by the HMO.* With prior approval of the DHS/HMO Review Committee a recipient may be disenrolled when:

(1) There is evidence of fraud or forgery in the use of HMO services or in the application for HMO coverage.

(2) There is evidence of unauthorized use of the HMO identification card.

(3) Upon documentation that the HMO has been unable after reasonable efforts to establish or maintain a satisfactory physician-patient relationship with the recipient. Examples include, but are not limited to, repeated failure to follow a prescribed treatment plan, disruptive or abusive behavior with office or clinic staff, documented pattern of missed appointments or "drop-in" requests for service without making appointments.

88.4(4) Disenrollments by the department. Disenrollments will occur when:

a. The contract between the department and the HMO is terminated.

b. The recipient becomes ineligible for Medicaid. If the recipient becomes ineligible and is later reinstated to Medicaid, enrollment in the HMO will also be reinstated.

c. The recipient permanently moves outside the HMO's enrollment area.

d. The recipient transfers to an eligibility group excluded from HMO enrollment. See definition of recipient in rule 441—88.1(249A).

e. The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

f. The department has determined that the recipient's enrollment in the recipient lock-in program, as defined in rule 441—76.9(249A), would be more cost-effective for the department.

88.4(5) No disenrollment for health reasons. No recipient will be disenrolled from an HMO because of an adverse change in health status.

441—88.5(249A) Covered services.

88.5(1) Amount, duration, and scope of services. Except as provided for in the contract, HMOs shall cover as a minimum all services covered by the Medicaid program as set forth in 441—Chapter 78.

a. The recipient shall be issued Form 470-1911, Medical Assistance Eligibility Card, and information about those services not covered by the HMO.

b. To the maximum extent possible, the HMO shall make enrolled recipients aware of alternate providers for services not covered by the HMO.

88.5(2) Required services.

a. The HMO shall cover as a minimum the following services:

- (1) Inpatient hospital services.
- (2) Outpatient hospital services.
- (3) Physician services.
- (4) Family planning services.
- (5) Home health agency services.
- (6) Early periodic screening, diagnosis and treatment for individuals under the age of 21.
- (7) Laboratory and X-ray services.
- (8) Rural health clinic services (where available).
- (9) Advanced registered nurse practitioners.
- (10) Optometric and ophthalmology services.
- (11) Clinic services.
- (12) Ambulance services.
- (13) Rescinded IAB 11/5/97, effective 1/1/98.
- (14) Other practitioner services (e.g., speech therapy, audiology, physical therapy, and occupational therapy).

(15) Rehabilitation agencies.

b. HMOs shall attempt to subcontract with all local family planning clinics funded by Title X moneys and maternal and child health centers funded by Title V moneys. The attempt to contract by the HMO is expected to be a reasonable and good faith effort. The determination of whether or not a good faith effort was made shall be completed by the department.

88.5(3) Excluded services. Unless specifically included in the contract, HMOs will not be required to cover:

a. Long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state hospital schools, or intermediate care facilities for the mentally retarded).

b. Inpatient psychiatric care provided at state-administered mental health institutes.

c. Services provided by the area education agencies.

d. Services provided at psychiatric medical institutions for children.

e. Dental services.

f. Hospice services.

g. Mental health services as defined in rule 441—88.65(249A).

h. Rescinded IAB 8/1/07, effective 9/5/07.

i. Psychiatric services.

j. Infant and toddler program services.

k. Local education agency services.

Reimbursement to recipients for nonemergency medical transportation as described at rule 441—78.13(249A) will not be covered by the HMO. The department will continue to reimburse as it currently does for this service.

88.5(4) Restrictions and limitations. If the HMO covers a type of service which is also covered under Medicaid, the HMO shall offer the same scope of procedures available under regular Medicaid as described in the provisions at 441—Chapter 78. The HMO may not impose limitations on days of service or length of stay not pertinent to regular Medicaid. The HMO may, however, require the use of certain providers, as defined in subrule 88.5(5); require preauthorization for services other than those meeting the definition of emergency, as defined in rule 441—88.1(249A); direct enrollees to the appropriate level of care for receipt of covered services; and deny payment if these enrollment requirements are not met by the enrollee. The HMO may at its discretion offer services to recipients beyond the scope of Medicaid as defined in 441—Chapter 78.

88.5(5) Recipient use of HMO services. A recipient enrolled in an HMO must use HMO providers of service, unless the HMO has authorized a referral to a provider outside the HMO for provision of a service or treatment plan. Payment shall be denied by the HMO on claims for services provided by non-HMO providers if the same service is covered by the HMO under its contract with the department except as provided in rule 441—88.6(249A), as allowed for by a referral to a non-HMO provider, or as an additional service permitted by subrule 88.5(4).

441—88.6(249A) Emergency and urgent care services.

88.6(1) Availability of services. The HMO shall ensure that emergency services are available on an emergency basis 24 hours a day, seven days a week, either through the HMO's own providers or through arrangements with other providers. In addition the HMO must provide payment to nonparticipating providers within 60 days of receipt of the bill for all contracted services furnished by providers which do not have arrangements with the HMO to provide services but were provided because they were needed immediately as defined at rule 441—88.1(249A) and in which cases the medical emergency does not permit a choice of provider.

88.6(2) HMO payment liability. HMO payment liability on account of injury or emergency illness is limited to emergency care as defined in rule 441—88.1(249A). If an ambulance is medically necessary to transport the recipient to follow-up treatment the HMO shall be financially liable. The HMO may require that follow-up treatment to an emergency be provided by HMO-participating providers.

If a recipient is injured or becomes ill and receives emergency services while temporarily outside the HMO's enrollment area, the HMO shall pay the facility or person who rendered the emergency care for emergency medical services and medical services, for inpatient hospital services in a general hospital as a result of the emergency, and for emergency ambulance service.

88.6(3) Notification and claim filing time spans. The HMO may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers. However, failure to give notice or file claims within those time limitations will not invalidate any claim if it can be shown not to have been reasonably possible to give such notice and that notice was in fact given as soon as was reasonably possible.

88.6(4) Provision of urgent care. If the recipient is assigned to a patient manager by the HMO, the patient manager shall arrange for urgent care within 24 hours by either providing it or referring to and authorizing another appropriate provider to provide care.

441—88.7(249A) Access to service.

88.7(1) Choice of provider. Recipients will have the opportunity to choose their health care professionals to the extent possible and medically appropriate from any of the HMO providers participating in the Medicaid project.

88.7(2) Medical service delivery sites. Medical service delivery sites must have the following specific characteristics:

- a. Be located within 30 miles of and accessible from the personal residences of enrolled recipients.

b. Have sufficient staff resources to adequately provide the medical services contracted for by the site including physicians with privileges at one or more participating acute care hospitals.

c. Have arrangements for services to be provided by other providers where in-house capability to serve specific medical needs does not exist.

d. Meet the applicable standards for participating in the Medicaid program.

e. Be in compliance with all applicable local, state, and federal standards related to the service provided as well as those for fire and safety.

88.7(3) Adequate appointment system. The HMO shall have procedures for the scheduling of patient appointments which are appropriate to the reason for the visit as follows:

a. Patients with urgent symptoms shall be seen within one day of contacting their HMO provider at an HMO medical service delivery site.

b. Patients with persistent symptoms shall be seen within 48 hours of reporting of the onset of the persistent symptoms.

c. Patient routine visits shall be scheduled within four to six weeks of the date the patient requests the appointment.

d. Scheduling of appointments shall be by specific time intervals and not on a block basis.

88.7(4) Adequate after hours call-in coverage. The HMO must have in effect the following arrangements which provide for adequate after hours call-in coverage.

a. Twenty-four-hour-a-day phone coverage shall exist.

b. If a physician does not respond to the initial telephone call there must be a written protocol specifying when a physician must be consulted. Calls requiring a medical decision shall be forwarded to the on-call physician and a response to each call which requires a medical decision must be provided by the physician within 30 minutes.

c. Notations shall be made in the patient's medical record of relevant information related to an after-hours call.

88.7(5) Adequate referral system. The HMO must effect the following arrangements which provide for an adequate referral system:

a. A network of referral sources for all services which are covered in the contract and not provided by the HMO directly.

b. Procedures for the return of relevant medical information from referral sources including review of information by the referring physician, entry of information into the patient's medical record, and arrangements for periodic reports from ongoing referral arrangements.

c. A notation for hospitalized patients in the medical record indicating the reason, date, and duration of hospitalization and entry of pertinent reports from the hospitalization and discharge planning in the medical record.

441—88.8(249A) Grievance procedures.

88.8(1) Written procedure. The HMO must have a written procedure by which enrolled recipients may express grievances, complaints, concerns, or recommendations, either individually or as a class and which:

a. Is approved by the department prior to use.

b. Acknowledges receipt of a grievance to the grievant.

c. Sets time frames for resolution including emergency procedures which are appropriate to the nature of the grievance and which require that all grievances shall be resolved within 30 days.

d. Ensures the participation of persons with authority to require corrective action.

e. Includes at least one level of appeal.

f. Ensures the confidentiality of the grievant.

g. Ensures issuance of a departmentally approved notice of decision for each adverse action and for each decision on requests for HMO reconsideration. These notices shall contain the enrollee's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

88.8(2) Written record. All grievances, including informal or verbal complaints, which must be referred or researched for resolution must be recorded in writing. A log of the grievances must be maintained and made available at the time of audit and must include progress notes and resolutions.

88.8(3) Information concerning grievance procedures. The HMO's written grievance procedure must be provided to each newly covered recipient not later than the effective date of coverage.

88.8(4) Appeals to the department. A recipient shall exhaust the established grievance procedure of the HMO before appealing the issue to the department under the provisions of 441—Chapter 7. The HMO appeal process shall not be more stringent in requirements and time frames than the department's appeal process. The HMO shall issue a written notice stating the outcome of all appeals.

88.8(5) Periodic report to the department. The HMO must make quarterly reports to the department summarizing grievances and resolutions as specified in the contract.

88.8(6) Consent for state fair hearing. Network providers which are contracted and in good standing with a medical managed care organization (MCO) may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member. The network provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the network provider submits a document providing such member's approval of the request for a state fair hearing. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

[ARC 0583C, IAB 2/6/13, effective 4/1/13]

441—88.9(249A) Records and reports.

88.9(1) Medical records system. The HMO shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition the HMO must maintain a medical records system which:

- a. Identifies each medical record by state identification number.
- b. Identifies the location of every medical record.
- c. Places medical records in a given order and location.
- d. Provides a specific medical record on demand.
- e. Maintains the confidentiality of medical records information and releases the information only in accordance with established policy pursuant to subrule 88.9(3).
- f. Maintains inactive medical records in a specific place.
- g. Permits effective professional review in medical audit processes.
- h. Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.
- i. Meets state and federal reporting requirements applicable to HMOs.

88.9(2) Content of individual medical record. The HMO must have in effect arrangements which provide for an adequate medical record-keeping system which includes a complete medical record for each enrolled recipient in accordance with provisions set forth in the contract.

88.9(3) Confidentiality of records. HMOs must maintain the confidentiality of medical record information and release the information only in the following manner:

- a. All medical records of enrolled recipients shall be confidential and shall not be released without the written consent of the enrolled recipients or responsible party.
- b. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities who are providing services to enrolled recipients under a subcontract with the HMO. This provision also applies to specialty providers who are retained by the HMO to provide

services which are infrequently used, provide a support system service to the operation of the HMO, or are of an unusual nature. This provision is also intended to waive the need for written consent for department staff assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the HMO itself, and other subcontractors which require information as described under paragraph "e" of this subrule.

c. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 441—88.6(249A).

d. Written consent is required for the transmission of the medical record information of a former enrolled recipient to any physician not connected with the HMO.

e. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a "need to know" on the part of the practitioner or a facility requesting the information.

f. Medical records maintained by subcontractors must meet the requirements of this rule.

88.9(4) Reports to the department. Each HMO shall submit reports to the department as follows:

a. Annual audited financial statements no later than 120 days after the close of the HMO's fiscal year or other additional terms as specified by the contract.

b. Periodic financial, utilization, and statistical reports as required by the department under the contract.

c. Time-specific reports required by the contract which define activity for child health care, grievances, and other designated activities which may, at the department's discretion, vary among HMOs, depending on the services covered and other contractual differences.

88.9(5) Audits. The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the HMO. The department or HHS may audit and inspect any records of an HMO, or the subcontractor of the HMO that pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee or HHS may request.

441—88.10(249A) Marketing.

88.10(1) General requirements. An HMO may not distribute directly or through any agent or independent contractor any marketing materials, without the prior approval of the department, and may not distribute marketing materials that contain false or materially misleading information.

a. *Service market.* An HMO shall distribute any marketing materials to its entire service area or region.

b. *Prohibition of tie-ins.* An HMO, or any agency of the entity, may not seek to influence an individual's enrollment with the HMO in conjunction with the sale of any other insurance.

c. *Prohibiting marketing fraud.* Each HMO shall comply with the procedures and conditions the department prescribes in the contract in order to ensure that, before an individual is enrolled with the HMO, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll.

d. *Prohibition of "cold-call" marketing.* HMOs shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing of enrollment.

88.10(2) Marketing representatives. Marketing representatives utilized to market Medicaid recipients must be sufficiently trained and capable of performing marketing activities within the requirements of the contract. The HMO's marketing representatives must represent the HMO in an honest and straightforward manner. In its marketing presentations the HMO must include information which ensures that the marketing representative is not mistaken for a state or county employee.

88.10(3) Marketing presentations. The HMO may make marketing presentations in the local offices of the department or otherwise include the department in their marketing efforts at the discretion of the department.

88.10(4) Marketing materials. Written material must include a marketing brochure or a member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to Medicaid recipients as specified in the contract.

441—88.11(249A) Patient education.

88.11(1) Health education procedures. The HMO will have written procedures for health education designed to prepare patients for participation in and reaction to specific medical procedures and to instruct patients in self-management of medical problems and in disease prevention. This service may be provided by any health practitioner or by any other person approved by the HMO.

88.11(2) Use of services. The HMO will have procedures in effect to orient covered persons in the use of all services provided. This includes but is not limited to written instructions regarding appropriate use of the referral system, grievance procedure, after hours call-in system, and provisions for emergency treatment.

88.11(3) Patient rights and responsibilities. The HMO shall have in effect a written statement of patient rights and responsibilities which is available to patients upon request and which is sent to all new enrolled recipients. The rights of the recipient to request disenrollment shall be included.

441—88.12(249A) Reimbursement.

88.12(1) Capitation rate. In consideration for all services rendered by an HMO under a contract with the department, the HMO will receive a payment each month for each enrolled recipient. This capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled recipients under the contract.

A portion of any increase in capitation payments may be reserved for an incentive payment to be paid based on the percentage of counties in a region included in an HMO's enrollment area. Incentive payments shall be made retroactively to the beginning of a state fiscal year if an HMO increases the percentage of counties in a region included in its enrollment area.

88.12(2) Determination of rate. The capitation rate is actuarially determined for the beginning of each new fiscal year using statistics and data about Medicaid fee-for-service expenses for HMO-covered services to a similar population during a base fiscal year. The capitation rate shall not exceed the cost to the department of providing the same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. HMOs electing to share risk with the department shall have their payment rates reduced by an amount reflecting the department's experience for high cost fee-for-service recipients.

88.12(3) Amounts not included in rate. The capitation rate does not include any amounts for the recoupment of losses suffered by the HMO for risks assumed under the contract or any previous risk contract. Any savings realized by the HMO due to the expenditure for necessary health services by the enrolled population being less than the capitation rate paid by the department will be wholly retained by the HMO.

88.12(4) Third-party liability. If an enrolled recipient has health insurance coverage or a responsible party other than the Medicaid program available for payment of medical expenses it is the right and responsibility of the HMO to investigate these third-party resources and attempt to obtain payment. The HMO will retain all funds collected for third-party resources. A complete record of all income from these sources must be maintained and made available to the department on request.

441—88.13(249A) Quality assurance. The HMO shall have in effect an internal quality assurance system that meets the requirements of 42 CFR 434.44 as amended to December 31, 1996, and a system of periodic medical audits meeting the requirements of 42 CFR 434.53 as amended to December 13, 1990.

441—88.14(249A) Contracts with federally qualified health centers (FQHCs) and rural health clinics (RHCs). In the case of services provided pursuant to a contract between an FQHC or RHC and a managed care organization, the organization shall provide payment to the FQHC or RHC that is not less than the amount of payment that it would make for the services if furnished by a provider other

than an FQHC or RHC. The payment from the managed care organization to the FQHC or RHC shall be supplemented by a direct payment from the department to the FQHC or RHC to provide reimbursement at 100 percent of reasonable cost as determined by Medicare cost reimbursement principles. FQHCs and RHCs shall be required to submit Form 470-3495, Managed Care Wraparound Payment Request Form, to the Iowa Medicaid enterprise provider audits and rate setting unit to document Medicaid encounters and differences between payments by the managed care organization and 100 percent of reasonable cost as determined by Medicare cost reimbursement principles.

441—88.15 to 88.20 Reserved.

**DIVISION II
PREPAID HEALTH PLANS**

441—88.21(249A) Definitions.

“*Capitation rate*” shall mean the fee the department pays monthly to a PHP for each enrolled recipient for the provision of covered medical services whether or not the enrolled recipient received services during the month for which the fee is intended.

“*Contract*” shall mean a contract between the department and a PHP for the provision of medical services to enrolled Medicaid recipients for whom the PHP assumes a risk as defined in the contract. These contracts shall meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996.

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

“*Emergency service*” shall mean those medical services rendered under unforeseen conditions which require hospitalization for the treatment of accidental injury and relief of acute pain, which, if not immediately diagnosed and treated, would result in risk of permanent danger to the patient’s health.

“*Enrollment area*” shall mean the county or counties which the PHP has capability to serve and is defined in the contract with the department. An enrollment area shall not be less than an entire county.

“*Grievance*” shall mean an incident, complaint, or concern which cannot be resolved in a manner satisfactory to enrolled recipients by the immediate response, verbal or otherwise, of the PHP staff member receiving the complaint or any complaint received in writing.

“*Managed health care*” shall mean any one of the alternative deliveries of regular, fee-for-service Medicaid such as defined in subrules dealing with health maintenance organizations (HMOs), or prepaid health plans (PHPs), or Medicaid Patient Access to Service System (MediPASS).

“*Managed health care review committee*” shall mean a committee composed of representatives from the department. The committee shall review and render a decision on all requests for disenrollment which are not automatically approvable.

“*Managed services*” shall mean all or part of those medical services set forth in 441—Chapter 78 and covered in the contract between the department and a PHP.

“*Nonmanaged services*” shall mean medical services covered under regular Medicaid, but which are not covered in the PHP’s contract with the department. Payment for nonmanaged services incurred by an enrolled recipient shall be made under regular Medicaid procedures.

“*Participating providers*” shall mean the providers of covered medical services who subcontract with or who are employed by the PHP.

“*Prepaid health plan (PHP)*” shall mean an entity defined in Section 1903(m)(2)(B)(iii) of the Social Security Act and considered to be a PHP by the department based upon criteria set forth in the Code of Federal Regulations at Title 42, Part 434.20(a)(3) as amended to March 31, 1991.

“*Recipient*” shall mean any person determined by the department to be eligible for Medicaid and for PHP enrollment. See subrule 88.22(4) for a list of Medicaid eligibles who are not eligible for PHP enrollment.

“*Routine care*” shall mean medical care which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment without risk of permanent damage to the patient’s life or

health status. The condition requiring routine care is not likely to substantially worsen without immediate clinical intervention.

“Urgent, nonemergency need” shall mean the existence of conditions due to an illness or injury which are not life threatening but which require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention.

441—88.22(249A) Participation.

88.22(1) Contracts with PHPs. The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with a PHP which has verified to the department that the criteria set forth in the Social Security Act have been met. This verification shall be reviewed by Centers for Medicare and Medicaid Services (CMS) staff to ensure that the status of PHP is rightfully conferred. The department may also include the scope of services described in 441—Chapter 74, known as the Iowa Health and Wellness Plan, or part thereof, in contracts with PHPs.

a. The department shall also determine that the PHP meets the following additional requirements:

(1) The PHP shall make the services it provides to enrolled recipients at least as accessible (in terms of timeliness, duration, and scope) to them as those services are accessible to recipients in the enrollment area who are not enrolled.

(2) The PHP shall provide satisfaction to the department that insolvency is not likely to occur and that enrolled Medicaid recipients shall not be responsible for its debts if the PHP should become insolvent.

b. The contract shall meet the following minimum requirements. The contract shall:

- (1) Be in writing.
- (2) Be renewable by mutual consent for a period of up to three years.
- (3) List the services covered.
- (4) Describe information access and disclosure.
- (5) List conditions for nonrenewal, termination, suspension, and modification.
- (6) Specify the method and rate of reimbursement.
- (7) Provide for disclosure of ownership and subcontractor relationship.
- (8) Be made with the licensee by the department.

c. Any protests to the award of contracts shall be in writing and submitted to the director of the department. Prior to termination or suspension of a contract, the department shall send a notice to cure to the PHP, specifying the number of days the PHP has to correct the problems. Failure to correct the problems in the time given shall then result in termination or suspension. The PHP may appeal the decision of the department in writing to the director of the department or to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, if the appeal documents state violations of federal law or regulation.

88.22(2) Method of selection of PHP. In counties served by a single prospective PHP, the department shall attempt to negotiate directly with the PHP. In counties where two or more prospective PHPs exist, the department shall initiate communication and attempt to negotiate as many contracts as are administratively feasible.

88.22(3) Termination of contract. Either party may, by mutual consent, terminate a contract. Either party may give 60 days written notice to the other party. The effective date of termination must be the first day of a month. The department may terminate or suspend a contract if the contract is determined by the department to be inconsistent with the overall goals and objectives of the Medicaid program. The determination shall be based upon, but not limited to, the following:

a. The PHP’s delivery system does not ensure enrolled recipients adequate access to medical services.

b. The PHP’s delivery system does not ensure the availability of all services covered under the contract.

c. There are not proper assurances of solvency on the part of the PHP.

d. There is not substantial compliance with all provisions of the contract.

e. The PHP has discriminated against persons eligible to be covered under the contract on the basis of age, race, sex, religion, national origin, creed, color, physical or mental disability, political belief, health status, or the need for health services.

88.22(4) Recipients eligible to enroll. Any Medicaid-eligible recipient is eligible to enroll in a contracting PHP except for the following:

- a. Recipients who are medically needy as defined at 441—subrule 75.1(35).
- b. Recipients over the age of 65 and under the age of 21 in psychiatric institutions as defined at 441—Chapter 85.
- c. Recipients who are supplemental security income-related case members.
- d. Rescinded IAB 10/3/01, effective 12/1/01.
- e. Recipients whose eligibility is in the process of automatic redetermination as defined at rule 441—76.11(249A).
- f. Recipients who are foster care and subsidized adoption-related case members.
- g. Recipients who are Medicare beneficiaries.
- h. Recipients who are pregnant women and who are deemed to be presumptively eligible as defined at 441—subrule 75.1(30).
- i. Recipients who are Native American Indians or Alaskan natives.
- j. Recipients who are receiving services from a Title V provider.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—88.23(249A) Enrollment.

88.23(1) Enrollment area. Counties in a PHP enrollment area shall be designated as voluntary or mandatory. In voluntary counties, enrollment is not required but eligible recipients may choose to join the PHP. Recipients not excluded in rule 441—88.21(249A) may volunteer to enroll in the PHP. In mandatory counties, enrollment in managed health care is required for eligible recipients.

88.23(2) Voluntary enrollment. When only one managed health care option is providing service in a county, enrollment by recipients is voluntary. The department encourages recipients to enroll in a managed health care option. Applicants and recipients are offered the option of managed health care enrollment or regular Medicaid coverage. Applicants and recipients who do not choose one option or the other shall be assigned to a managed health care provider as defined in subrule 88.23(6). These persons shall have the right to request disenrollment at any time as defined in subrule 88.24(3).

Applicants or recipients may designate their choices of providers on a form designated by the managed health care contractor or in writing to or through a verbal request to the managed health care contractor. The form shall be available through the county office, the PHP office, provider offices, the managed health care contractor, or other locations at the department's discretion. If the PHP (or any entity listed above other than the managed health care contractor) receives the form, it shall be forwarded to the managed health care contractor within three working days.

Recipients shall be accepted by the PHP as they are enrolled by the department unless a maximum limit has been specified in the contract.

Recipients who choose not to enroll in a PHP shall be covered under regular Medicaid.

88.23(3) Mandatory enrollment. In a county where the department has a contract with more than one PHP, HMO, or other managed health care provider, the department shall require whenever it is administratively feasible that all eligible recipients enroll with a managed health care provider of their own choosing. Administrative feasibility is determined by whether the managed health care providers have the capacity to adequately serve all potential enrolled recipients. Recipients may enroll by completing the choice form designated by the managed health care contractor, in writing to or through verbal request to the managed health care offices. Recipients may also contact the managed health care contractor by the publicized toll-free telephone number for enrollment assistance.

88.23(4) Effective date. The effective date of enrollment shall be no later than the first day of the second month subsequent to the date on which the managed health care contractor receives the form designated by the managed health care contractor.

88.23(5) Identification card. The PHP may issue an appropriate identification card to the enrolled recipient or request the department to do so on its behalf. The identification card shall be issued so that the recipient receives it prior to the effective date of enrollment.

88.23(6) Assignment methodology. When no choice is made, the recipient shall be systematically assigned to, between, or among the contracting managed health care providers.

a. *Notification.* Recipients who are assigned to a managed health care provider shall receive notification of the assignment and the name of the provider in a timely fashion prior to the effective date of enrollment.

b. *Limitations.* Contracting providers may specify in the contract a limit to the number of recipients who can be assigned under this subrule. If a specified limitation is attained, the remaining assignment needs in that county shall be met by the other managed health care providers who are contracting with the department in that county.

c. *Household member enrollment.* Inasmuch as persons within a household are allowed to make individual decisions about choosing enrollment in managed health care, it is possible that a case may exist where some household members have made a choice and some have not (so that assignment is required). In these instances, a systematic search of household member choices regarding managed health care option shall be completed. Assignment of those who have made no choice shall be made whenever possible to the managed health care provider with whom the first household member is already enrolled.

d. *Assigned recipients who desire another choice.* Recipients who are assigned to a managed health care provider as described in this subrule shall have at least 30 days in which to request enrollment in a different available managed health care plan. The change of plan is subject to provisions in subrules 88.23(4) and 88.24(2) dealing with effective date.

441—88.24(249A) Disenrollment.

88.24(1) Disenrollment request. An enrolled recipient may request disenrollment at any time. In voluntary counties, this request shall be approved and acted upon within ten days of receipt without requiring the recipient to demonstrate good cause. In mandatory counties as defined at subrule 88.23(3), the disenrollment shall not be acted upon by the health care contractor unless the request includes an alternate choice of managed health care.

88.24(2) Effective date. Disenrollment will be effective no later than the first day of the second calendar month after the month in which the department receives a request for disenrollment. The recipient will remain enrolled in the PHP and the PHP will be responsible for services covered under the contract until the effective date of disenrollment which will always be the first day of a month.

88.24(3) Disenrollment process. If the recipient is requesting disenrollment, the recipient shall complete the choice form designated by the managed health care contractor which can be obtained through the PHP, the county office, or the managed health care contractor. If the PHP receives a request from the recipient, the PHP shall forward the form to the managed health care contractor within three working days. If the recipient must show good cause for disenrollment, the determination as to whether disenrollment shall occur shall be made by the managed health care review committee within 30 days. If the recipient or the PHP disagrees with the decision of the review committee, an appeal may be filed under the provisions of 441—Chapter 7. If the PHP is requesting disenrollment, the PHP shall complete Form 470-2169, Managed Health Care Provider Request for Disenrollment. If the county office receives a completed Form 470-2169 from the managed health care provider, the county office shall forward the form to the managed health care review committee within three working days.

a. *Request for disenrollment by the recipient.* In voluntary counties, the request shall be approved and acted upon within ten days of receipt by the managed health care contractor. In mandatory counties, a request for disenrollment shall be denied unless a choice of another managed health care provider is requested simultaneously or good cause can be demonstrated to the review committee. Examples of good cause include services received which were untimely, inaccessible, of insufficient quality, or inadequately provided by all of the contracting managed health care providers in the recipient's county of residence. If the recipient has not experienced the above conditions in all the other available managed health care

programs, enrollment in one of the alternative managed health care programs shall be a condition of approving disenrollment.

b. *Request for disenrollment by the PHP.* With prior approval of the managed health care review committee, a request for disenrollment of an enrolled recipient may be approved when:

- (1) There is evidence of fraud or forgery in the use of PHP services or in the choice for PHP services.
- (2) There is evidence of unauthorized use of the PHP identification card.
- (3) Upon documentation, the PHP has been unable after reasonable efforts to establish or maintain a satisfactory physician-patient relationship with the recipient.

88.24(4) Disenrollments by the department. Disenrollments will occur when:

- a. The contract between the department and the PHP is terminated.
- b. The recipient becomes ineligible for Medicaid. If the recipient becomes ineligible and is later reinstated to Medicaid, enrollment in the PHP will also be reinstated.
- c. The recipient permanently moves outside the PHP's enrollment area.
- d. The recipient transfers to an eligibility group excluded from PHP enrollment. See definition of recipient in rule 441—88.21(249A).
- e. The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

88.24(5) No disenrollment for health reasons. No recipient shall be disenrolled from a PHP because of an adverse change in health status.

441—88.25(249A) Covered services.

88.25(1) Amount, duration, and scope of services. Except as provided for in the contract, PHPs shall cover as a minimum all services covered by the Medicaid program as set forth in 441—Chapter 78.

88.25(2) Mandatory services.

a. Although the contract may specify additional services covered (with the exception of those defined in 88.25(3)), the PHP shall cover as a minimum the following services:

- (1) Inpatient hospital services.
- (2) Outpatient hospital services.
- (3) Physician services.
- (4) Family planning services.
- (5) Home health agency services.
- (6) Laboratory and X-ray services.
- (7) Early periodic screening, diagnosis and treatment for persons under age 21.
- (8) Rural health clinic services (where available).
- (9) Advanced registered nurse practitioners.

b. PHPs shall attempt to subcontract with all local family planning clinics funded by Title X moneys and all maternal and child health centers funded by Title V moneys.

c. According to the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, recipients enrolled in managed health care options (including PHPs) may seek family planning services anywhere without referral, even if they are minors. The PHP must pay any claims submitted by a provider of family planning services when the service has been provided to a recipient in a month for which a capitation rate has been paid on the recipient's behalf to the PHP by the department.

88.25(3) Excluded services. Unless specifically included in the contract, PHPs will not be required to cover long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state resource centers, or intermediate care facilities for the mentally retarded), inpatient psychiatric care provided at the state-administered mental health institutes, services provided by the area education agencies, services provided at specialized adolescent psychiatric facilities, day treatment and partial hospitalization services for persons aged 20 or under, or the enhanced services provided to certain eligible recipients. Reimbursement to recipients for nonemergency medical transportation as described at rule 441—78.13(249A) will not be covered by the PHP; the department will continue to reimburse through its fee-for-service methodology for this service.

88.25(4) Restrictions and limitations. If the PHP covers a type of service which is also covered under Medicaid, the PHP may not impose any restrictions or limitations on that service more stringent than those applicable in Medicaid according to the provisions at 441—Chapter 78. The PHP may, at its discretion, offer services to its enrolled recipients beyond the scope of Medicaid as defined at 441—Chapter 78.

88.25(5) Recipient use of PHP services. An enrolled recipient must utilize PHP participating providers of service. No payment by the PHP will be made for services provided by non-PHP providers if the same type of service is available through the PHP under its contract with the department except as provided in subrule 88.25(2) "c," and rule 441—88.26(249A).

441—88.26(249A) Emergency services.

88.26(1) Availability of services. The PHP will ensure that the services of a primary care physician are available on an emergency basis 24 hours a day, seven days a week, either through the PHP's own providers or through arrangements with other providers. In addition, the PHP must provide payment to nonparticipating providers within 60 days of receipt of the bill for all contracted services furnished by providers which do not have contractual arrangements with the PHP to provide services but which were needed immediately because of an injury or illness and in which case the illness or injury did not permit a choice of provider.

88.26(2) PHP payment liability. PHP payment liability on account of injury or emergency illness is limited to emergency care required before the recipient can, without medically harmful consequences, return to the enrollment area or to the care of a provider with whom the PHP has arrangements to provide services. If an ambulance is necessary to transport the recipient to follow-up treatment, the PHP shall be financially liable. Benefits for continuing the follow-up treatment are provided only in the PHP's enrollment area.

If an enrolled recipient is injured or becomes ill and receives emergency services outside the PHP's enrollment area, the PHP shall pay the facility or person who provided the emergency care for emergency medical services and medical services, for inpatient hospital services in a general hospital as a result of the emergency, and for emergency ambulance service.

88.26(3) Notification and claim filing time span. The PHP may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers. However, failure to give notice or to file claims within those time limitations will not invalidate any claim if it can be shown that it was not reasonably possible to give the notice and that notice was, in fact, given as soon as was reasonably possible.

441—88.27(249A) Access to service.

88.27(1) Choice of provider. Recipients will have the opportunity to choose their health care professionals to the extent possible and medically appropriate from any of the PHP providers participating in the Medicaid contract.

88.27(2) Medical service delivery sites. Medical service delivery sites shall have the following specific characteristics:

- a. Be located within 30 miles of and be accessible from the personal residences of enrolled recipients.
- b. Have sufficient staff resources to adequately provide the medical services for which the contract is in effect including physicians with privileges at one or more acute care hospitals.
- c. Have arrangements for services to be provided by other providers where in-house capability to serve specific medical needs does not exist.
- d. Meet the applicable standards for participating in the Medicaid program.
- e. Be in compliance with all applicable local, state, and federal standards related to the service provided as well as those for fire and safety.

88.27(3) Adequate appointment system. The PHP shall have procedures for the scheduling of patient appointments which are appropriate to the reason for the visit as follows:

a. Patients with urgent nonemergency needs shall be seen within one hour of presentation at a PHP medical service delivery site.

b. Patients with persistent symptoms shall be seen within 48 hours of reporting of the onset of the persistent symptoms.

c. Patient routine visits shall be scheduled within four to six weeks of the date the patient requests the appointment.

d. Scheduling of appointments shall be by specific time intervals and not on a block basis.

88.27(4) Adequate after hours call-in coverage. The PHP must have in effect the following arrangements which provide for adequate after hours call-in coverage:

a. Twenty-four-hour-a-day telephone coverage shall exist.

b. If a physician does not respond to the initial telephone call, there must be a written protocol specifying when a physician must be consulted. Calls requiring a medical decision shall be forwarded to the on-call physician and a response to each call which requires a medical decision must be provided within 30 minutes.

c. Notations shall be made in the patient's medical record of relevant information related to an after-hours call.

88.27(5) Adequate referral system. The PHP must effect the following arrangements which provide for an adequate referral system:

a. A network of referral sources for all services which are covered in the contract, but not directly provided by the PHP.

b. Procedures for the return of relevant medical information from referral sources including review of information by the referring physicians, entry of information into the patient's medical record, and arrangements for periodic reports from ongoing referral arrangements.

c. A notation in the medical record for hospitals' patients indicating the reason, date, and duration of hospitalization and entry of pertinent reports from the hospitalization and discharge planning in the medical record.

441—88.28(249A) Grievance procedures.

88.28(1) Written procedure. The PHP must have a written procedure by which enrolled recipients may express grievances, complaints, or recommendations, either individually or as a class and which:

a. Is approved by the department prior to use.

b. Acknowledges receipt of a grievance to the grievant.

c. Sets time frames for resolution including emergency procedures which are appropriate to the nature of the grievance and which require that all grievances shall be resolved within 30 days.

d. Ensures the participation of persons with authority to require corrective action.

e. Includes at least one level of appeal.

f. Ensures the confidentiality of the grievant.

88.28(2) Written record. All grievances, including all informal or verbal complaints, which must be referred or researched for resolution must be recorded in writing. A log of the grievances must be retained and made available at the time of audit and must include progress notes and method of resolution.

88.28(3) Information concerning grievance procedures. The PHP's written grievance procedure must be provided to each newly enrolled recipient not later than the effective date of coverage.

88.28(4) Appeals to the department. A recipient who has exhausted the grievance procedure of the PHP may appeal the issue to the department under the provisions of 441—Chapter 7. Instances where the substance of the grievance relates to department policy shall be appealed directly to the department.

88.28(5) Periodic report to the department. The PHP shall make quarterly reports to the department summarizing grievances and resolutions as specified in the contract.

441—88.29(249A) Records and reports.

88.29(1) Medical records system. The PHP shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and, in addition, the PHP must maintain a medical record system which:

- a. Identifies each medical record by the departmentally assigned state identification number.
- b. Identifies the location of every medical record.
- c. Places medical records in a given order and location.
- d. Provides a specific medical record on demand.
- e. Maintains the confidentiality of medical records information and releases the information only in accordance with established policy pursuant to subrule 88.29(3).
 - f. Maintains inactive medical records in a specific place.
 - g. Permits effective professional review in medical audit processes.
 - h. Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.
 - i. Meets state and federal reporting requirements applicable to PHPs.

88.29(2) Content of individual medical record. The PHP must have in effect arrangements which provide for an adequate medical record-keeping system which includes a complete medical record for each enrolled recipient in accordance with provisions set forth in the contract.

88.29(3) Confidentiality of records. PHPs must maintain the confidentiality of medical record information and release the information only in the following manner:

- a. All medical records of enrolled recipients shall be confidential and shall not be released without the written consent of the enrolled recipients or the responsible party acting on behalf of the enrolled recipient.
- b. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities which are providing services to enrolled recipients under a subcontract with the PHP. This provision also applies to specialty providers who are retained by the PHP to provide services which are infrequently used or are of an unusual nature.
- c. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 441—89.26(249A).
- d. Written consent is required for the transmission of medical record information of a former enrolled recipient to any medical provider not connected with the PHP.
- e. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a “need to know” on the part of the practitioner or facility requesting the information.
- f. Medical records maintained by subcontracting providers must meet the requirements of this rule.

88.29(4) Reports to the department. Each PHP shall submit reports to the department as follows:

- a. Annual audited financial statements no later than 120 days after the close of the PHP's fiscal year.
- b. Periodic financial, utilization, and statistical reports as required by the department under the contract.

88.29(5) Audits. The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means, the quality, appropriateness, and timeliness of services performed by the PHP. The department or HHS may audit and inspect any records of a PHP, or the subcontractors of a PHP, which pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee, or HHS may request.

441—88.30(249A) Marketing.

88.30(1) Marketing procedures. All marketing plans, procedures, and materials used by the PHP must be approved in writing by the department prior to use. Random door-to-door marketing of low-income families or the offering of financial incentives will not be approved.

88.30(2) Marketing representatives. Marketing representatives utilized to market Medicaid recipients must be sufficiently trained and capable of performing marketing activities within the requirements of the contract. The PHP's marketing representatives must represent the PHP in an honest and straightforward manner. In its marketing presentations, the PHP must include information which

ensures that the representative is not mistaken for a department employee. Marketing presentations which intentionally belittle or maliciously downplay the benefit package, services, or providers of another participating managed health care option will not be approved.

88.30(3) Marketing presentations. The PHP may make marketing presentations in the local office(s) of the department or otherwise include the department in marketing efforts at the discretion of the department.

88.30(4) Marketing materials. Written material must include a marketing brochure or a member handbook which fully explains the services available, how and when to obtain them, and special factors applicable to enrolled recipients as specified in the contract.

441—88.31(249A) Patient education.

88.31(1) Use of services. The PHP shall have procedures in effect to orient enrolled recipients in the use of services the PHP is contracting to provide. This includes what to do if the recipient requires medical care while out of the enrollment area, a 24-hour-a-day telephone number, appropriate use of the referral system, grievance procedures, and how emergency treatment is to be provided.

88.31(2) Patient rights and responsibilities. The PHP shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrolled recipients. This statement may be part of an informational brochure provided to all new enrollees. The right of the enrolled recipient to request disenrollment must be included.

441—88.32(249A) Payment to the PHP.

88.32(1) Capitation rate. In consideration for all services rendered by a PHP under a contract with the department, the PHP will receive a payment each month for each enrolled recipient. This capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled recipients under the contract.

88.32(2) Determination of rate. The capitation rate is actuarially determined by the department for the beginning of the new fiscal year using statistics and data about Medicaid fee-for-service expenses for PHP-covered services to a similar population during the preceding fiscal year. (For example, fiscal year 1990 rates are predicted with fiscal year 1988 dates of service for Medicaid fee-for-service expenditures.) The capitation rate may not exceed the cost to the department of providing the same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. A 1 percent incentive will be available to PHPs who contract to cover all services except those specified in subrule 88.25(3). PHPs electing to share risk with the department will have their payment rates reduced by an amount reflecting the department's experience for high cost fee-for-service recipients.

88.32(3) Amounts not included in rate. The capitation rate does not include any amounts for the recoupment of losses suffered by the PHP for risks assumed under the current or any previous contract. The PHP accepts the rate as payment in full for the contracted services. Any savings realized by the PHP due to lower utilization from a less frequent incidence of health problems among the enrolled population shall be wholly retained by the PHP.

88.32(4) Third-party liability. If an enrolled recipient has health coverage or a responsible party other than the Medicaid program available for purposes of payment for medical expenses, it is the right and responsibility of the PHP to investigate these third-party resources and attempt to obtain payment. The PHP shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

441—88.33(249A) Quality assurance. The PHP shall have in effect an internal quality assurance system that meets the requirements of 42 CFR 434.44 as amended to December 31, 1996, and a system of periodic medical audits meeting the requirements of 42 CFR 434.53 as amended to December 13, 1990.

441—88.34 to 88.40 Reserved.

DIVISION III
MEDICAID PATIENT MANAGEMENT

441—88.41(249A) Definitions.

“*Contract*” shall mean a contract between the department and a Medicaid-participating provider or clinic as specified in rule 441—88.44(249A) and subrule 88.45(1) for the purpose of providing patient management to enrolled recipients.

“*Covered eligibles*” shall mean those groups of Medicaid-eligible recipients specified in subrule 88.42(1) who are eligible to receive services under patient management.

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

“*Designee*” shall mean an organization designated by the department of human services to act on behalf of the department in the administration of Medicaid managed health care.

“*Eligible providers*” shall mean those providers specified in rule 441—88.44(249A) and subrule 88.45(1) with whom the department may contract to be patient managers.

“*Emergency care*” shall mean those medical services rendered for an emergent medical condition or protection of the public health.

“*Emergent medical condition*” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect it to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

The determination of whether an emergent medical condition exists shall be decided by a medical professional and shall be based on the patient’s medical condition including presenting symptoms and medical history (as related to severe pain) prior to treatment.

In cases where the above criteria are satisfied, no prior authorization procedures are allowed.

“*Enrolled recipient*” shall mean a covered eligible who has been enrolled with a patient manager according to procedures set forth in rule 441—88.46(249A).

“*Extended-participation program*” shall mean mandatory six-month enrollment period with a managed care entity.

“*Grievance*” shall mean a complaint expressed verbally or in writing by an enrolled recipient or provider relative to services under patient management. A grievance at the informal level is one which can be resolved by short-term intervention on the part of the department or its designee via the toll-free managed health care telephone line or through informational correspondence. A formal grievance is one which must be taken to another level for quality of care or policy determination.

“*Managed care entity*” shall mean either a managed care organization licensed by the department of insurance (e.g., HMO or PHP) or a primary care case management program (i.e., MediPASS).

“*Managed health care*” shall mean any of the options for alternative delivery of Medicaid services that provides coordinated delivery of health care. The current options offered by the department are Medicaid patient management, known as MediPASS, health maintenance organization (HMO) enrollment and prepaid health plan (PHP) enrollment.

“*Managed health care review committee*” shall mean a committee composed of representatives from the department and its designee. The committee shall review and render decisions on all requests for disenrollment from managed health care that are not automatically approvable, all requests for exception to eligible provider provisions, and other exceptions to managed health care procedures.

“*Mandatory enrollment*” shall mean a mandatory participation in managed health care as specified in subrule 88.46(1).

“*Mandatory project county*” shall mean a county where the department has contracts with more than one managed care entity, one of which may be primary care case management (MediPASS) in cases where the number of MediPASS providers willing to serve as patient managers is sufficient to meet the

needs and makeup of the recipient population in the county, or where the department has implemented the MediPASS program alone in the county.

“Managed services” shall mean services as specified in subrule 88.48(1) that require preauthorization from the patient manager in order to be payable by Medicaid.

“Medical service area” means a geographic area within which recipients must reside in order to enroll in the managed health care MediPASS option.

“MediPASS” shall mean Medicaid patient access to service system and shall be the acronym used to identify the Medicaid patient management program.

“Nonmanaged services” shall mean services as specified in subrule 88.48(2) that do not require authorization by the patient manager in order to be payable by Medicaid.

“Patient management” shall mean the provision of services to enrolled recipients by a patient manager in accordance with the contract.

“Patient manager” shall mean an eligible provider who has signed a contract with the department to perform patient management for enrolled recipients.

“Urgent care” shall mean those medical services rendered for an urgent medical condition or protection of the public health.

“Urgent medical condition” shall mean a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy,
2. Impairment to bodily functions, or
3. Dysfunction of any bodily organ or part.

If the recipient is assigned to a patient manager (e.g., MediPASS or HMO), the patient manager shall arrange for necessary care within 24 hours by either providing it or referring and authorizing another appropriate provider to provide care.

441—88.42(249A) Eligible recipients.

88.42(1) Included categories of assistance. All categories of Medicaid-eligible recipients except those specified as excluded in subrule 88.42(2) are required to participate in Medicaid managed health care if they reside in a mandatory project county as described in subrule 88.43(1). Recipients who reside in a voluntary project county as described in subrule 88.43(2) may participate if they so choose.

A choice to enroll in any other form of Medicaid managed health care available in the recipient's county of residence shall fulfill the requirements to participate in mandatory project counties.

88.42(2) Excluded categories of assistance. The following categories of Medicaid-eligible recipients shall not be allowed to participate in Medicaid patient management in either mandatory or voluntary project counties:

- a. Medically needy recipients as defined in 441—subrule 75.1(35).
- b. Recipients over age 65 and under age 21 in psychiatric institutions as defined in 441—Chapter 85.
- c. Recipients who are supplemental security income-related case members.
- d. Rescinded IAB 10/3/01, effective 12/1/01.
- e. Automatic redetermination recipients as defined in rule 441—76.11(249A).
- f. Recipients who are foster care and subsidized adoption-related case members.
- g. Recipients who are Medicare beneficiaries.
- h. Pregnant women who are determined presumptively eligible in accordance with provisions in 441—subrule 75.1(30).
 - i. Recipients who are Native American Indians or Alaskan natives.
 - j. Recipients who are receiving services from a Title V provider.

441—88.43(249A) Project area.

88.43(1) Designation as a mandatory project county. The department shall designate mandatory enrollment counties included in the project. In order for a county to be considered a mandatory project county, the number of MediPASS providers willing to serve as patient managers shall be sufficient to meet the needs of the size and makeup of the recipient population in the county, and the county shall be included in the department's freedom of choice waiver from the Centers for Medicare and Medicaid Services.

88.43(2) Voluntary project counties. The department shall designate voluntary enrollment counties included in the project. A county may be voluntary where provider participation is not sufficient to be designated mandatory but providers may choose to participate on a voluntary enrollment basis.

88.43(3) Expansion to other counties. Rescinded IAB 11/10/93, effective 11/1/93.

441—88.44(249A) Eligible providers.

88.44(1) Specialties allowed. Providers shall be allowed to contract with the department to provide patient management to enrolled recipients as long as the provider:

a. Is a licensed doctor of medicine or osteopathy or an advanced registered nurse practitioner licensed pursuant to Iowa Code chapter 152 and possessing evidence of certification pursuant to board of nursing rules under 655—Chapter 7 in a specialty area listed in paragraph 88.44(1) "d."

b. Is otherwise eligible to enroll as an Iowa Medicaid provider.

c. Is a provider in good standing with the Medicaid agency as defined in subrule 88.45(1).

d. Is practicing in one of the following specialties in the medical services area:

(1) Family practice.

(2) General practice.

(3) Pediatrics.

(4) Internal medicine.

(5) Obstetrics and gynecology.

88.44(2) Clinic or group practice participation. A provider may participate as an individual practitioner or as a partner or employee of a clinic or group practice. The clinic or group shall be the contractor. Federally qualified health centers and rural health clinics that employ providers in the specialties specified in subrule 88.44(1) may contract. However, each provider participating within the clinic, group, federally qualified health center, or rural health clinic shall sign and be bound by the terms of the clinic or group contract as if the provider was in individual practice.

88.44(3) Exceptions. Other providers licensed as doctors of medicine or osteopathy or as advanced registered nurse practitioners may request exception to subrule 88.44(1) for specific individual patients in accordance with the procedures set forth in this subrule.

a. If the request is being made in order to allow a different type of specialist to be a patient manager, or to allow a provider practicing outside the recipient's medical service area to serve the recipient, the provider shall make a written request to the department.

(1) The request shall identify the provider by name, address, telephone number, specialty, and Medicaid provider number, indicating the practice location, or date of application to be a Medicaid provider. The request shall specify the members in question and state agreement to provide primary care and patient management as specified in subrule 88.45(2) to those members.

(2) If the request comes initially from the recipients as specified in paragraph 88.46(2) "c," the department shall contact the provider in question to offer the provider the opportunity to request the exception.

b. Rescinded IAB 11/10/93, effective 11/1/93.

c. Rescinded IAB 11/10/93, effective 11/1/93.

d. The managed health care review committee shall consider the request and respond within ten working days of receipt of the request. If the request is approved, a contract will be forwarded to the physician and procedures for contracting with a physician as specified in rule 441—88.45(249A) shall be followed.

e. The following factors shall be taken into account when considering the physician's request:

- (1) Mutual agreement between physician and patient regarding the arrangement.
- (2) Existence of an already established physician-patient relationship.
- (3) Transportation barriers, if requesting a patient manager outside the medical service area.
- (4) Customary practice by the specialist to provide primary care.
- (5) A new medical condition which necessitates the proposed physician-patient relationship.

441—88.45(249A) Contracting for the provision of patient management.

88.45(1) Eligibility to contract. Only Medicaid-participating providers and clinics in good standing shall be eligible to contract with the department to provide patient management.

88.45(2) Contract provisions. The department shall enter into a contract arrangement with all providers who are eligible as specified in rule 441—88.44(249A) and who wish to provide patient management. Form 470-2615, Agreement for Participation as a Primary Care Physician Patient Manager in the Medicaid Patient Access to Service System, shall be the form designated as the contract. At a minimum, the contract shall include provisions as follows:

- a. The patient manager shall provide managed health care to enrolled recipients by providing primary health care and providing or referring the patient appropriately and authorizing payment for all other care covered under the program as specified in subrule 88.48(1). The patient manager is also responsible for monitoring and coordinating all covered care.
- b. The patient manager shall provide or arrange for 24-hour-per-day, seven-day-per-week provider availability to enrolled recipients.
- c. The patient manager shall maintain records that at a minimum:
 - (1) Identify the patient as a patient management recipient.
 - (2) Document all authorizations for medical services provided by other providers and the extent of those authorizations.
 - (3) Contain the name, state identification number, age, sex and address of the patient.
 - (4) Document services provided and where and by whom they are provided.
 - (5) Contain medical diagnosis, treatment, therapy and drugs prescribed or administered.
 - (6) Contain the name of the person making the entry and the date of the contact.
- d. The patient manager shall review and take action upon periodic utilization review reports, according to instructions that the department will provide each patient manager.
- e. The department shall specify the fees and method of payment to patient managers.
- f. The department shall specify the manner in which providers shall be notified of the recipients enrolled with them.

88.45(3) Contract compliance. The department shall put into place procedures for the monitoring of contract compliance on the part of patient managers to ensure appropriate access to adequate quality care. Those procedures may include, but are not limited to, on-site review of medical records by appropriate professional medical personnel and review of utilization patterns of participating patient managers. The procedures shall also include establishment of a grievance procedure defined in rule 441—88.49(249A).

88.45(4) Corrective action and sanctions. The department shall establish procedures for corrective action and sanctions when monitoring activities reveal possible contract noncompliance.

88.45(5) Termination of contract. The contract may be terminated in any of the following ways:

- a. The patient manager may terminate the contract or a clinic may remove a provider from a clinic contract by providing the department with written notice of the desire to terminate the contract 60 days in advance of the desired date of termination in order to allow the department or its designee time to disenroll and reenroll the MediPASS patients with other patient managers.
 - (1) In no situation shall the provider stop providing patient management or primary care to the patient until the patient can be reenrolled with another provider except as specified in subrule 88.48(4).
 - (2) Failure to provide the specified period of notice or failure to continue providing patient management or primary care before the reenrollment shall result in forfeiture of all remaining patient management fees that would otherwise have been due the patient manager.
- b. The department may terminate the contract with the patient manager with 60 days' advance notice for any of the following reasons:

- (1) The department has imposed any sanction described at 441—subrule 79.2(3).
- (2) Recommendations of contract termination made in accordance with the procedures described in rule 441—88.51(249A), after opportunity for corrective action has been unsuccessful or rejected by the patient manager in question.

Sixty days' advance notice is not required for situations described in subrule 88.48(4).

- c. Any patient manager who has had a contract terminated by the department shall have the right to appeal the termination as provided in 441—Chapter 7.

441—88.46(249A) Enrollment and changes in enrollment.

88.46(1) Mandatory enrollment. Participation in managed health care, if available, is required for covered eligibles as specified in subrule 88.42(1) who reside in a mandatory project county. The department shall require, whenever administratively feasible, that all eligible recipients enroll with a managed care entity. Administrative feasibility is determined by whether a freedom-of-choice waiver or state plan amendment has been approved by the Centers for Medicare and Medicaid Services and whether the managed care entities demonstrate sufficient access to and quality of services.

88.46(2) Enrollment procedures. In mandatory enrollment counties, recipients shall be required to choose their managed health care provider. When no choice is made by the recipient, the recipient will be assigned to a contracting health maintenance organization (HMO) serving the recipient's county of residence when an HMO is available or to a MediPASS patient manager on a rotating basis to ensure an equitable distribution between the HMO and MediPASS programs based on the number of managed health care options (MediPASS and HMOs) available in the county. In the event there is no contracting HMO serving the recipient's county of residence in a mandatory enrollment county, the recipient shall be assigned to a MediPASS patient manager.

Within the MediPASS option, recipients shall be assigned according to age appropriateness. Whenever possible, family units shall be assigned to the same provider that an enrolled family member has selected, if that provider is appropriate according to age parameters. MediPass patient managers shall not be assigned more recipients than their self-imposed maximum or the maximum described in subrule 88.46(5), whichever is lower.

Recipients who are assigned a managed care entity as described in this subrule shall have at least ten days in which to request enrollment in a different available entity. The change is subject to provisions in subrule 88.46(4) dealing with the effective date.

a. *Timely notice.* Recipients shall be sent timely notice of the managed health care assignment. The recipient shall have a minimum of ten days in which a change to the assigned managed care entity can be made. The notice shall include the name of the managed care entity to whom the recipient shall be assigned if the recipient does not make a different selection by the date specified in the notice. If the covered eligible does not make a selection before the due date, the recipient shall be enrolled with the managed care entity listed on the notice.

b. *Enrollment.* Enrollment in managed health care shall be discussed during the face-to-face interview with all applicants for Medicaid under covered categories of assistance in mandatory or voluntary enrollment areas. The applicant shall be shown an informational videotape and encouraged to make a selection of a managed care entity. Applicants in mandatory enrollment areas shall be informed that should the applicant become eligible for a managed health care selection, one shall be assigned. Covered eligibles who are not enrolled shall be sent a notice of their managed health care assignment when the recipient:

- (1) Attains initial eligibility for a covered category of service in a mandatory project county.
- (2) Changes from an excluded category of assistance to a covered category of assistance in a mandatory project county.
- (3) Is receiving a covered category of assistance and moves from a county where no managed health care is available or voluntary project county to a mandatory project county.
- (4) Reattains eligibility.
- (5) Has a new member of the household receiving a covered category of assistance.

If the covered eligible in a mandatory project county does not make another selection before the due date specified in the notice, the covered eligible shall be enrolled with the managed health care provider listed on the notice.

c. *Selection of a managed health care provider.* A list of managed health care providers participating in managed care entities serving the county shall be available to recipients for use in selecting a provider. If the recipient wishes to request an exception to the list of available managed health care providers as described in subrule 88.44(3), the managed health care review committee shall make a determination on the exception request. While the determination is being made, the recipient's enrollment shall be placed in a pending status.

d. Rescinded IAB 5/7/97, effective 7/1/97.

e. *Request to change enrollment.* An enrolled recipient may, within 90 days from timely notice, request to change enrollment from one managed health care provider to another or one managed care entity to another. The request shall be made on a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department. Changes are subject to the provisions of subrule 88.46(3) dealing with effective date.

f. *Managed care entity extended-participation program (EPP).* After the initial 90 days from timely notice, recipients will remain enrolled with the chosen provider for the following six months, with three exceptions:

- (1) A request for disenrollment by recipient for good cause pursuant to paragraph 88.4(3) "a."
- (2) A request for disenrollment by provider for good cause pursuant to paragraph 88.4(3) "b."
- (3) Availability of a new, previously unavailable, managed care entity. In this instance recipients will be allowed to select that entity for the remainder of the current EPP period.

g. *Enrollment cycle.* Prior to the end of any extended-participation program (EPP) period, recipients will be notified of their ability to enroll with a different managed care option. A change in enrollment or failure to change enrollment will begin a new EPP enrollment period at the end of the current EPP.

88.46(3) Voluntary enrollment procedures. Voluntary enrollment procedures shall be the same guidelines as mandatory enrollment procedures except:

- a. Recipients shall not be informed at the face-to-face interview that enrollment is required.
- b. Notice to recipient shall not include assignment language.
- c. Recipients shall not be assigned if no selection is made voluntarily.
- d. A managed health care provider must be available for enrollment.

88.46(4) Effective date. Enrollment or changes in enrollment shall always be effective on the first day of a month. The effective date of enrollment shall be no later than the first day of the second month subsequent to the date the department or its designee receives a choice as specified in subrules 88.46(1) and 88.46(2) or the deadline given a recipient to indicate the recipient's managed health care choice, whichever is applicable. The effective date shall be earlier where computer cutoff allows.

88.46(5) Identification card. The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to all enrolled recipients.

Providers of medical services shall access the department's eligibility verification system (ELVS) via telephone or access the department's secure Web site at the time of service in order to establish that the patient is Medicaid-eligible and whether the services being provided require the authorization of the patient manager.

88.46(6) Enrollment limits.

a. Unless one or more of the following special situations exist, enrollment shall be limited to 1500 enrollees per full-time patient manager with an additional 300 enrollees allowed for each full-time nurse practitioner or physician's assistant employed by the MediPASS provider or clinic:

- (1) The provider treats a disproportionate share of Medicaid patients in the provider's current practice.
- (2) A special group practice arrangement exists with a demonstrated ability to manage a large number of enrollees.

(3) Other exceptional situations may be considered as special demonstration projects on a case-by-case basis.

b. Patient managers wishing to receive consideration for one of these special situations must make a request for consideration in writing to the department and provide sufficient documentation that they fit one or more of the special situations.

c. Providers or clinics may set a lower self-imposed maximum number of enrollees at the time they sign the initial contract and may revise that number by notifying the department or its designee in writing.

(1) If the patient manager decreases the patient manager's own maximum to a number below which the patient manager currently has enrolled, the patient manager must continue to serve those recipients until normal disenrollments put the provider below the provider's new maximum.

(2) No minimum number of enrollees shall be required.

88.46(7) Reinstatement of patient management status. When an enrolled recipient loses Medicaid eligibility and is subsequently reinstated before the effective date of cancellation, the enrollment in patient management will also be reinstated.

441—88.47(249A) Disenrollment.

88.47(1) Disenrollment request. An enrolled recipient may be disenrolled from a patient manager in one of three ways:

a. The enrolled recipient may request disenrollment by completing a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department at any time prior to enrollment with a managed health care entity and within the 90 days from the date of the enrollment notice. After this time period, a recipient may be disenrolled for good cause when the recipient can demonstrate that services were untimely, inaccessible, of insufficient quality, or inadequately provided. If the recipient is a covered eligible specified in subrule 88.42(1) as a mandatory participant, the recipient's disenrollment request shall not be approved until another patient manager or managed health care option is chosen.

b. The patient manager may request that an enrolled recipient be disenrolled by completing Form 470-2169, Managed Health Care Provider Request for Recipient Disenrollment.

(1) Disenrollment may be approved for good cause, such as but not limited to inability after reasonable effort to establish or maintain a satisfactory provider-patient relationship with the recipient. Documentation of the reason for disenrollment shall be included with or attached to the disenrollment request.

(2) The department shall respond within 30 days as to whether the disenrollment request is approved.

(3) If the request is approved, the patient manager shall continue to serve a mandatory recipient until the recipient can be enrolled with another patient manager or another managed health care option. In no case shall that time exceed 60 days from the date of receipt of the form.

c. The department may disenroll an enrolled recipient in the following situations:

(1) The contract with the patient manager is terminated.

(2) The patient manager dies, retires or leaves the medical service area.

(3) The recipient loses Medicaid eligibility. If the recipient regains eligibility as specified in subrule 88.46(7), the enrollment to patient management will be automatically reinstated.

(4) The recipient moves to a nonproject county.

(5) The recipient's eligibility changes to a category of assistance as specified in subrule 88.42(2) that is excluded from participation in patient management.

(6) The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

(7) The department has determined that the recipient's enrollment in the recipient lock-in program, as defined in 441—Chapter 76, would be more cost-effective for the department.

The department shall request that recipients whose participation is mandatory as specified in subrule 88.42(1) select a new patient manager or other managed health care option if disenrollment is for reasons listed in 88.47(1) "c" (1) or (2). If the recipient does not make the selection the recipient will be assigned a new patient manager by the department.

88.47(2) Effective date. Disenrollment shall always be effective on the first day of a month. The effective date of disenrollment shall be no later than the first day of the second month subsequent to the date the department or its designee receives an enrollment change request as specified in subrule 88.47(1) or the date the department approves a disenrollment request from a physician or the date the department becomes aware of an event which causes the department to disenroll an enrolled recipient, whichever is applicable. The effective date shall be earlier whenever possible.

441—88.48(249A) Services.

88.48(1) Managed services. Provision of the following services by any provider other than the patient manager requires authorization from the patient manager in order to be payable by Medicaid except that mental health and substance abuse services for all managed health care recipients are provided under the Iowa Plan program and do not require authorization (see rule 441—88.61(249A)):

- a. Inpatient hospital.
- b. Outpatient hospital.
- c. Home health.
- d. Physician (except services provided by an ophthalmologist).
- e. Clinic (rural health clinic, federally qualified health center, maternal health center, ambulatory surgical center, birthing center).
- f. Laboratory, X-ray.
- g. Medical supplies.
- h. Physical therapy, audiology, rehabilitation agency, advanced registered nurse practitioner.
- i. Rescinded IAB 11/5/97, effective 1/1/98.
- j. Podiatric.

These services require authorization even if the need for the service is considered urgent. However, in case of urgent medical conditions, the patient manager shall arrange for necessary care within 24 hours by either providing it or referring to and authorizing another appropriate provider to provide care.

Services or parts thereof described in 441—Chapter 74, known as the Iowa Health and Wellness Plan, require authorization by the patient manager as otherwise required by this division.

88.48(2) Nonmanaged services. Provision of any services not listed in subrule 88.48(1) does not require authorization from the patient manager in order to be payable by Medicaid.

88.48(3) Authorizing managed services. The patient manager may make referrals to another provider for specialty care or for primary care during the patient manager's absence or nonavailability.

a. No special authorization or referral form is required, and referrals should occur in accordance with accepted practice in the medical community. To ensure that payment is made for properly authorized services, the patient manager shall provide the specialist or other provider with the patient manager's Medicaid provider number (the national provider identifier number or Iowa-specific provider identifier number), which must be entered on the billing form to signify that the service has been authorized.

b. After the patient manager's initial referral of a patient to a specialist for ongoing treatment, the specialist shall not be required to receive further specific authorizations for the duration of the illness, or at the discretion of the patient manager, for a period of time specified by the patient manager.

c. The referral shall include necessary services rendered by the specialist and referrals for related services made by the specialist. With the patient manager's approval, the patient manager's number may be relayed by the referred specialist to other providers considered necessary for proper treatment of the patient. All authorizations and referrals shall be documented by both the patient manager and the referred-to provider in the patient's medical record.

d. Emergency services are excluded from the authorization requirement, even though these services may be ones customarily requiring authorization under patient management. Urgent care requires authorization in order for Medicaid services to be paid. The unauthorized use of a patient

manager's authorization number shall be considered to be a false or fraudulent claim submission and may subject the provider to recoupment or to sanctions described at 441—subrule 79.2(3).

88.48(4) Special authorizations. Special authorization for the provision of managed services shall be given to providers by the department in situations such as, but not limited to, the death of the enrolled recipient's patient manager, the patient manager has left medical practice, moved from the medical service area or has been removed as a Medicaid provider and the department has not yet been able to establish a new patient manager or other managed health care option for the recipient. The procedure for obtaining this special authorization shall be specified in the provider handbook. The special authorization procedures shall only be used until the department is able to enroll the recipient with another patient manager or managed health care option. Additionally, special authorizations may be given when contracting patient managers fail to comply with contract provisions such as, but not limited to, failure to maintain 24-hour access as specified in subrule 88.45(2), paragraph "b." [ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—88.49(249A) Grievance procedure. The department shall establish a procedure whereby enrolled recipients or providers may express complaints or concerns either verbally or in writing specific to managed health care services.

88.49(1) Written record. The department or its designee shall maintain a written record of all grievances. A log shall be maintained that includes the date of the grievance, member name and state identification number, provider name and national provider identifier number or Iowa-specific provider identifier number, nature of complaint, resolution and date of resolution.

88.49(2) Formal grievance resolution and response. The department or its designee shall record the facts involved in all grievances. Pertinent facts shall be obtained, as necessary and appropriate, from interviews with involved parties, on-site visits and consultation with professional medical consultants or an education and review committee. The department or its designee shall respond to all grievances within 15 working days of receipt. The response shall be in writing and copies shall be provided to the recipient, the provider and to the department's patient manager file. Appeal rights shall be included in the response.

88.49(3) Repeated grievances. Providers or recipients who file repeated grievances, or providers or recipients against whom repeated grievances are filed, will be reviewed in-depth and a possible on-site visit will be made to resolve any misunderstandings as to patient management policies and procedures.

88.49(4) Quality of care grievances. In grievances involving quality of care, the case shall be referred to appropriate persons or agencies, including the board of medicine, for investigation.

88.49(5) Information concerning grievance procedures. The department grievance procedure shall be published on appropriate forms and brochures for the information of recipients and in provider handbooks for the information of patient managers and other providers.

88.49(6) Appeals to the department. A recipient who has exhausted the formal grievance procedure may appeal the issue to the department under the provisions of 441—Chapter 7.

441—88.50(249A) Payment.

88.50(1) Fee. Patient managers shall be paid a monthly fee of \$2 per enrolled recipient for the provision of patient management, including referrals. Payment for other services rendered shall be reimbursed in accordance with rules governing Medicaid payment. Providers such as federally qualified health centers who are reimbursed on a 100 percent of cost basis are not eligible to receive patient management fees separate from other reimbursement.

88.50(2) Basis for payment. Payment shall be based on the number of recipients enrolled with the patient manager as of automated benefit calculation system cutoff day in the month for which payment is being calculated.

88.50(3) Mode of payment. The provider shall be paid individually unless a clinic or group practice elects to receive payment for all providers participating under the clinic or group contract. The same mode of payment must be used for both patient management and regular Medicaid claims.

88.50(4) Payment limit. Payment shall be limited to \$3000 per month per patient manager no matter how many recipients are enrolled with the patient manager.

441—88.51(249A) Utilization review and quality assessment. Patient managers shall be monitored to ensure that recipients are able to access quality care and that utilization patterns and costs fall within acceptable standards. If overutilization or underutilization is apparent or quality of management service is inadequate, efforts shall be made to determine the reason and resolve problems, as necessary.

88.51(1) Measured services. Cost and units of service data will be reviewed for selected categories of service. This data shall be used to monitor overall utilization patterns and compare peer utilization patterns.

88.51(2) Reports to patient managers. Utilization information shall be provided on a periodic basis to patient managers to enable them to review their own utilization patterns and to review utilization by their enrollees. Patient managers will be responsible for reporting any discrepancies detected in this information to the department. The patient manager will be responsible for attempting to correct utilization behavior of recipients who appear from utilization reports to be inappropriate utilizers of medical services.

88.51(3) Managed health care advisory committee. Participating managed health care providers will be invited to assist the department or its agent in establishing and assessing goals of the state's Medicaid managed health care program. The department shall form a managed health care advisory committee made up of persons deemed appropriate by the department to review, advise and plan managed care goals with the department. Members may include representatives of MediPASS providers, HMO providers, FQHC providers, RHC providers, association representatives, and other public agencies as deemed appropriate by the department. The committee's functions may include, but are not limited to, the following:

- a. Assist the department in developing procedures and parameters for utilization review and conduct further review of the utilization of patient managers whose pattern of utilization falls outside established parameters.
- b. Assist the department in establishing options for managed health care quality assessment.
- c. Assist the department in reviewing and making recommendations for action on quality of service-related grievances under the grievance procedure outlined in rule 441—88.49(249A).
- d. Assist the department in developing corrective action steps and recommendations for managed health care providers who have identifiable utilization or quality of management service deficiencies.
- e. Assist the department in developing standards and procedures for managed health care providers to use in performing review functions.
- f. Prepare or provide educational or informative articles to be used for patient education and health promotion.

441—88.52(249A) Marketing. A MediPASS provider may not distribute directly or through any agent or independent contractor marketing materials without the prior approval of the department, and may not distribute marketing materials that contain false or materially misleading information.

88.52(1) Service market. A MediPASS provider shall distribute any marketing materials to the entire service area or region.

88.52(2) Prohibition of “cold-call” marketing. MediPASS providers shall not, directly or indirectly, conduct door-to-door, telephonic, or other “cold-call” marketing of enrollment.

441—88.53 to 88.60 Reserved.

DIVISION IV
IOWA PLAN FOR BEHAVIORAL HEALTH

441—88.61(249A) Definitions.

“Accredited” shall mean an entity approved by the division of mental health and disability services of the department to provide mental health services.

“Appeal” shall mean the process defined in 441—Chapter 7 by which a Medicaid member, or the member’s designee, may request review of a certain decision made by the department or the contractor.

“ASAM-PPC” shall mean the current version of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Addictive, Substance-Related, and Co-Occurring Conditions published by the American Society of Addiction Medicine.

“Assertive community treatment (ACT) program” shall mean a program of comprehensive outpatient services provided in the community directed toward the amelioration of symptoms and the rehabilitation of behavioral, functional, and social deficits of persons with severe and persistent mental disorders and persons with complex symptomatology who require multiple mental health and supportive services to live in the community.

“Capitation rate” shall mean the fee the department pays monthly to the contractor for each enrolled Medicaid member for the provision of covered, required, and optional services, whether or not the enrollee received services during the month for which the fee is paid.

“Certification” shall mean the process of determining that a facility, equipment or an individual meets the requirements of federal or state law.

“Clinical decision review” shall mean the process by which enrollees and participating and nonparticipating providers may request a review by the contractor of a decision made by an employee of the contractor regarding the prior authorization, denial, or payment for services.

“Contract” shall mean the contract between the department and the entity or entities selected by the department to implement the Iowa Plan. Contract sections related to Medicaid-funded services shall be interpreted to meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996. The department of public health also shall be party to the contracts in relationship to the provision of substance abuse services to non-Medicaid persons served through the Iowa Plan.

“Contractor” shall mean each entity with whom the department contracts to provide covered, required and optional services for those members enrolled in the Iowa Plan.

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

“Covered services” shall mean mental health and substance abuse treatment services reimbursable based on provisions of the Medicaid state plan and paid through the fee-for-service payment system administered by the Iowa Medicaid enterprise.

“Department” shall mean the Iowa department of human services acting in cooperation with the department of public health for governance of the contract.

“Designee” shall mean an organization, person, or group of persons designated by the director to act on behalf of the department in the review or evaluation of services provided through the Iowa Plan.

“Director” shall mean the director of the Iowa department of human services.

“Disenrollment” shall mean the removal of an enrollee from the contractor’s enrollment list either through loss of eligibility or some other cause.

“Emergency services” shall mean those services required to meet the needs of an enrollee who is experiencing an acute crisis of a level of severity requiring immediate treatment where a failure to treat could result in death, injury, or lasting harm to the enrollee or serious danger to others.

“Encounter data” shall mean information reflecting a face-to-face meeting or other billable service furnished by a provider to a person served through the Iowa Plan. Medicaid encounter data must be submitted by the contractor to the department in an electronic format specified by the department.

“Enrollee” shall mean any Medicaid member who is enrolled in the Iowa Plan in accordance with the provisions of the contract.

“Enrollment” shall mean the inclusion of a Medicaid member on a contractor’s Medicaid enrollment file.

“Enrollment area” shall mean the geographical area in which the enrollees that are assigned by the department to the contractor reside.

“Fee-for-service” shall mean the method of making payment for Medicaid services reimbursable under the Medicaid state plan in which reimbursement is based on fees set by the department for defined

services. Payment of the fee is based upon delivery of the defined services and is done through the Iowa Medicaid enterprise.

"Grievance" shall mean a nonclinical incident, nonclinical complaint, or nonclinical concern which is received verbally and which cannot be resolved in a manner satisfactory to enrollees or participating or nonparticipating providers by the immediate response of the contractor's staff member or a nonclinical incident, nonclinical complaint, or nonclinical concern which is received in writing.

"Insolvency" shall mean a financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets.

"Integrated mental health services and supports" shall mean individualized mental health services and supports planned jointly by the contractor, the enrollee, and others significant to the enrollee as appropriate, which are not regularly defined services otherwise offered by the contractor.

"Iowa Plan" shall mean the Iowa Plan for Behavioral Health, established by this division as the managed care plan to provide mental health and substance abuse treatment.

"Licensed" shall mean a facility, equipment, individual or entity that has formally met state requirements for licensure and has been granted a license.

"Member" shall mean a person determined eligible for Medicaid.

"Mental health services" shall mean those clinical, rehabilitative, or supportive services provided by an individual, agency, or other entity that is licensed, accredited, certified, or otherwise approved as required by law to treat any mental disorder listed in the current version of the International Classification of Diseases (ICD) published by the World Health Organization. At a minimum, covered disorders include the following ranges of the ICD: F01, F03 to F06 (mental disorders due to known physiological conditions: vascular dementia, amnestic disorder due to physiological condition, delirium due to physiological condition, other mental disorders due to physiological conditions); F20 to F25, F28, F29 (schizophrenia, schizotypal, delusional and other non-mood psychotic disorders); F30 to F34, F39 (mood (affective) disorders); F40 to F45, F48 (anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders); F50 to F53, F59 (behavioral syndromes associated with physiological disturbances and physical factors: eating disorders, sleep disorders not due to substance/known physiological condition, sexual dysfunction not due to substance/known physiological condition, puerperal psychosis); F60, F63 to F66, F68, F69 (disorders of adult personality and behavior); F84 (except F84.2) (pervasive developmental disorders); and F90 to F95, F98, F99 (behavioral and emotional disorders with onset usually occurring in childhood and adolescence). Additional code ranges may be included in the contract. Mental health services shall include, but not be limited to, those services listed at subrule 88.65(3).

"MHI" shall mean a state mental health institute operated by the department.

"Open panel" shall mean that the contractor shall subcontract with all providers who are appropriately licensed, certified, or accredited to provide covered, required, or optional services, and who meet the credentialing criteria, agree to the standard contract terms, and wish to participate.

"Participating providers" shall mean the providers of mental health and substance abuse services who subcontract with the contractor.

"Prepaid health plan (PHP)" shall mean an entity defined at Section 1903(m)(2)(B)(iii) of the Social Security Act and determined to be a PHP by the department based upon criteria set forth in the Code of Federal Regulations at Title 42, Part 434.20(a)(3), as amended to March 13, 1991.

"Prior authorization" shall mean the process by which an enrollee or a provider obtains approval prior to the initiation or continuation of a service as to the appropriateness of a service. The contractor may require prior authorization as a condition of payment. Prior authorization of a mental health service shall be based on psychosocial necessity. Prior authorization of a substance abuse service shall be based on service necessity.

"Psychosocial necessity" shall mean that clinical, rehabilitative, or supportive mental health services meet all of the following conditions. The services shall be:

1. Appropriate and necessary to the symptoms, diagnoses or treatment of a covered mental health diagnosis.
2. Provided for the diagnosis or direct care and treatment of a mental disorder.

3. Within standards of good practice for mental health treatment.
4. Required to meet the mental health needs of the enrollee and not primarily for the convenience of the enrollee, the provider, or the contractor.
5. The most appropriate type of service which would reasonably meet the needs of the enrollee in the least costly manner.

The determination of psychosocial necessity shall be made after consideration of the enrollee's clinical history, including the impact of previous treatment and service interventions; services being provided concurrently by other delivery systems; the potential for services and supports to avert the need for more intensive treatment; the potential for services and supports to allow the enrollee to maintain functioning improvement attained through previous treatment; unique circumstances which may impact the accessibility or appropriateness of particular services for an individual enrollee (e.g., availability of transportation, lack of natural supports including a place to live); and the enrollee's choice of provider or treatment location.

"Required services" shall mean mental health and substance abuse treatment services and supports which are not reimbursable though the Iowa Medicaid fee-for-service program but which are the contractual responsibility of the contractor.

"Retroactive eligibility" shall mean the period of time consisting of the three months preceding the month in which an application for Medicaid is filed, during which the person may be eligible for Medicaid coverage as determined by the department.

"Routine care" shall mean those clinical, rehabilitative, or supportive mental health or substance abuse services which are typically arranged through regular, scheduled appointments with a provider. Conditions requiring routine care are not likely to substantially worsen or cause damage or disruption to the recipient's life without immediate intervention.

"Service necessity" shall mean that substance abuse services for the treatment of conditions related to substance abuse meet the following requirements according to the current version of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Addictive, Substance-Related, and Co-Occurring Conditions (ASAM-PPC) published by the American Society of Addiction Medicine. The services shall be:

1. Appropriate and necessary to the symptoms, diagnoses or treatment of a covered substance abuse diagnosis.
2. Provided for the diagnosis or direct care and treatment of a substance abuse disorder.
3. Within standards of good practice for substance abuse treatment.
4. Required to meet the substance abuse treatment needs of the enrollee and not primarily for the convenience of the enrollee, the provider, or the contractor.
5. The most appropriate type of service which would reasonably meet the needs of the enrollee in the least costly manner.

"Substance abuse licensed PMIC" shall mean a psychiatric medical institution for children (PMIC) which also is licensed in accordance with Iowa Code chapter 125 to provide substance abuse treatment services.

"Substance abuse services" shall mean those clinical, rehabilitative, supportive and other services provided in response to and to alleviate the symptoms of any substance abuse disorder listed in the current version of the International Classification of Diseases (ICD) published by the World Health Organization, disorders F10 to F19, F55 (mental and behavioral disorders due to known psychoactive substance use), provided by an individual, agency, or other entity that is licensed, accredited, certified, or otherwise approved as required by law to treat any of these substance abuse disorders. Services include, but are not limited to, services listed at subrule 88.65(4).

"Targeted case management services" shall mean MR/CMI/DD case management services targeted to adults with a primary diagnosis of chronic mental illness as defined at rule 441—90.1(249A), with standards set forth in 441—Chapter 24 and Medicaid requirements set forth in 441—Chapter 90.

"Third party" shall mean an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of mental health and substance abuse services related to any medical assistance covered by Medicaid.

“Urgent, nonemergency care” shall mean those clinical, rehabilitative, or supportive services provided for conditions which, although they do not present immediate risk of death, injury, or lasting harm, may risk significant damage or disruption to the recipient’s life or require expeditious treatment to alleviate the prospect that the condition will substantially worsen without immediate intervention.

[ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—88.62(249A) Participation.

88.62(1) Contract. The department may enter into a contract for the provision of mental health and substance abuse services specified in 441—Chapter 78, and Chapter 85, Division II, or any portion thereof, with a prepaid health plan.

a. The department shall also determine that the contractor meet the following additional requirements:

(1) The contractor shall make the services it provides to enrollees at least as accessible as those services were to members prior to the implementation of the Iowa Plan.

(2) The contractor shall comply with insolvency requirements established by the department in the contract and shall ensure that neither Medicaid enrollees nor the state shall be responsible for its debts if the contractor should become insolvent.

(3) The contractor shall be licensed by the department of commerce, division of insurance, as a limited service organization.

b. The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Specify the duration of the contract period.

(3) List the services which must and may be covered.

(4) Describe information access and disclosure.

(5) List conditions for nonrenewal, termination, suspension, and modification.

(6) Specify the method and rate of reimbursement.

(7) Provide for disclosure of ownership and subcontractor relationships.

(8) Specify that all subcontracts shall be in writing, shall comply with the provisions of the contract between the department and the contractor, and shall include any general requirements of the contract that are appropriate to the service or activity covered by the subcontract.

88.62(2) Assessment of penalties. Penalties shall be assessed according to terms of the contract for failure to perform in either of the following areas:

a. Substantial failure to provide necessary covered and required services included in this contract when the failure has seriously and adversely affected an enrollee.

b. Failure to comply with any provision of the contract.

[ARC 2026C, IAB 6/10/15, effective 8/1/15]

441—88.63(249A) Enrollment.

88.63(1) Enrollment area. The enrollment area shall be set forth in the contract between the department and the contractor. The department has determined that all counties of the state will be covered by the Iowa Plan, whether by a single statewide contractor or by multiple regional contractors.

88.63(2) Members subject to enrollment. All Medicaid members shall be subject to mandatory enrollment in the Iowa Plan.

a. Members who are enrolled in the Iowa Plan are notified of enrollment and the effective date of the enrollment.

b. When a coverage group is included in or excluded from Iowa Plan enrollment, the department and the contractor shall jointly notify members and participating and nonparticipating Medicaid providers before implementation of the change. The department shall implement a transition plan to ensure continuity of services to members.

88.63(3) Others to be served. The department may include other recipients of mental health and substance abuse services in the Iowa Plan. The department shall specify in the contract the services, persons to be served, and reimbursement methodology when other recipients are included.

88.63(4) Voluntary enrollment. There will be no voluntary enrollment in the Iowa Plan.

88.63(5) Effective date. For new members, the effective date of enrollment with the contractor shall be the first day of the month the Medicaid application was filed in the county office. Members under the age of 21 served at an MHI and members served at a substance abuse licensed PMIC will be enrolled for months of retroactive eligibility for Medicaid when the member resided in a substance abuse licensed PMIC or MHI during those months.

For current members who are no longer in an eligibility group excluded from the Iowa Plan, the effective date of enrollment shall be the first day of the month following the month they leave the excluded group.

88.63(6) Medical card. The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to each member. Before delivering mental health or substance abuse services, the provider shall access the department's eligibility verification system (ELVS) to verify the member's enrollment in the Iowa Plan.

441—88.64(249A) Disenrollment.

88.64(1) Disenrollments by the department. Disenrollments shall occur when:

- a. The enrollee becomes ineligible for Medicaid. If the enrollee becomes ineligible and is later reinstated to Medicaid, enrollment in the Iowa Plan shall also be reinstated.
- b. The enrollee is transferred to a coverage group excluded from the Iowa Plan.
- c. The enrollee dies.

88.64(2) Effective date. Disenrollment shall be effective the first day of the month following the month of disenrollment.

88.64(3) No disenrollment for health reasons. No enrollee shall be disenrolled from the Iowa Plan because of an adverse change in health status, including mental health and substance abuse status.

441—88.65(249A) Covered services.

88.65(1) Amount, duration, and scope of services. The contractor may not impose limitations on the amount, duration, or scope of services provided which are not allowable under the Medicaid state plan. The contractor may, however, require the use of participating providers, require prior authorization for services other than emergency services as set forth in rule 441—88.66(249A), and direct enrollees to the appropriate level of care for receipt of those services which are the responsibility of the contractor.

88.65(2) Enrollee use of Iowa Plan services. Enrollees shall receive all Medicaid-funded covered, required, and optional mental health and substance abuse services only through the Iowa Plan. An enrollee shall use only participating providers of service unless the contractor has authorized a referral to a nonparticipating provider for provision of a service or treatment plan. Payment shall be denied under Medicaid fee-for-service on claims for covered, required, and optional mental health and substance abuse services provided to enrollees. The contractor shall implement policies to ensure that no participating or nonparticipating provider bills an enrollee for all or any part of the cost of a covered, required, or optional service.

88.65(3) Covered, required and optional mental health services.

a. The contractor shall ensure, arrange, monitor and reimburse, at a minimum, the following covered mental health services:

- (1) Ambulance services for psychiatric conditions.
- (2) Emergency room services for psychiatric conditions available 24 hours per day, 365 days per year.
- (3) Inpatient hospital care for psychiatric conditions.
- (4) Outpatient hospital care for psychiatric conditions including intensive outpatient services.
- (5) Partial hospitalization.
- (6) Day treatment.
- (7) Psychiatric physician services including consultations requested for enrollees receiving treatment for other medical conditions.
- (8) Services of a licensed psychologist for testing, evaluation and treatment of mental illness.

(9) Services in state MHIs for enrollees under the age of 21 or through the age of 22 if the enrollee is hospitalized on the enrollee's twenty-first birthday.

(10) Services provided through a community mental health center.

(11) Targeted case management services to persons with chronic mental illness.

(12) Medication management.

(13) Psychiatric nursing services by a home health agency.

(14) Psychiatric or psychological screenings required subsequent to evaluations for persons applying for admission to nursing homes.

(15) Mental health services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.

(16) Behavioral health intervention as set forth in rule 441—78.12(249A).

(17) Inpatient psychiatric services in psychiatric medical institutions for children as set forth in 441—Chapter 85, Division II.

(18) Home- and community-based habilitation services as described at rule 441—78.27(249A).

b. The contractor shall ensure, arrange, monitor and reimburse the following required mental health services which are not reimbursable by Medicaid fee-for-service:

(1) Concurrent substance abuse and mental health services for those diagnosed with both chronic substance abuse and chronic mental illness.

(2) Services of a licensed social worker for treatment of mental illness.

(3) Mobile crisis services.

(4) Mobile counseling services.

(5) Integrated mental health services and supports.

(6) Psychiatric rehabilitation services.

(7) Peer support services for persons with chronic mental illness.

(8) Community support services.

(9) Periodic assessment of the level of functioning for each enrollee who meets the criteria of either a child with a serious emotional disability or a person with serious and persistent mental illness. The assessment is to be conducted by appropriately credentialed participating providers.

(10) Programs of assertive community treatment.

c. The contractor may develop optional services and supports to address the mental health needs of enrollees. These optional services and supports shall be implemented only after approval by the department. Optional services and supports shall be provided by or under the supervision of qualified mental health professionals or appropriately accredited agencies.

d. The department may require the coverage of other mental health services and supports under the terms of the contract.

88.65(4) Covered and required substance abuse services. The contractor shall ensure, arrange, monitor and reimburse the following services for the treatment of substance abuse:

a. Outpatient services (all Level 1 services according to the current version of the ASAM-PPC).

b. Intensive outpatient and partial hospitalization services (all Level 2 services according to the current version of the ASAM-PPC).

c. Residential or inpatient services (all Level 3 services according to the current version of the ASAM-PPC).

d. Medically managed intensive inpatient services (all Level 4 services according to the current version of the ASAM-PPC).

e. Detoxification.

f. PMIC substance abuse treatment services.

g. Emergency room services for substance abuse conditions available 24 hours a day, 365 days a year.

h. Ambulance services for substance abuse conditions.

i. Substance abuse treatment services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.

j. Intake, assessment, evaluation and diagnostic services, including testing for alcohol and drugs, to determine a substance abuse diagnosis.

88.65(5) Covered diagnoses. Services for a covered diagnosis cannot be denied solely on the basis of an individual's also having a noncovered diagnosis. Mental health services, including inpatient care, cannot be denied solely on the basis of an individual's having no diagnosis pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. The contractor will be responsible for ensuring, arranging, monitoring, and reimbursing services necessary for the behavioral care and treatment of the covered diagnoses for Iowa Plan enrollees who are diagnosed with a covered diagnosis and a noncovered diagnosis.

The services defined at subrules 88.65(3) and 88.65(4) shall be provided to all Iowa Plan enrollees who meet the diagnostic criteria for the following disorders listed in the current version of the International Classification of Diseases (ICD) published by the World Health Organization:

a. Mental health.

(1) Mental disorders due to known physiological conditions (vascular dementia, amnestic disorder due to physiological condition, delirium due to physiological condition, other mental disorders due to physiological conditions): ICD codes F01 and F03 to F06.

(2) Schizophrenia, schizotypal, delusional and other non-mood psychotic disorders: ICD codes F20 to F25, F28 and F29.

(3) Mood (affective) disorders: ICD codes F30 to F34 and F39.

(4) Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders: ICD codes F40 to F45 and F48.

(5) Behavioral syndromes associated with physiological disturbances and physical factors (eating disorders, sleep disorders not due to substance/known physiological condition, sexual dysfunction not due to substance/known physiological condition, puerperal psychosis): ICD codes F50 to F53 and F59.

(6) Disorders of adult personality and behavior: ICD codes F60, F63 to F66, F68 and F69.

(7) Pervasive developmental disorders: ICD codes F84 (except F84.2).

(8) Behavioral and emotional disorders with onset usually occurring in childhood and adolescence: ICD codes F90 to F95, F98 and F99.

b. Substance abuse. Mental and behavioral disorders due to known psychoactive substance use: ICD codes F10 to F19 and F55.

88.65(6) Excluded services. Unless the service is specifically included in the contract, the contractor shall not be required to provide long-term care (e.g., residential care facilities, nursing facilities, state resource centers, or intermediate care facilities for persons with mental retardation) services.

88.65(7) Iowa wellness plan service benefits. Services described in 441—Chapter 74 that otherwise constitute covered services pursuant to this rule shall be included in Iowa Plan services for members enrolled in the Iowa Plan who are also Iowa wellness plan members.

[ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—88.66(249A) Emergency services.

88.66(1) Availability of services. The contractor shall ensure that emergency services for covered diagnoses are available 24 hours a day, seven days a week, either through participating providers or through arrangements with other providers.

88.66(2) Payment for emergency room services. Emergency room services for covered diagnoses shall be reimbursed for enrollees regardless of whether authorized in advance or whether the provider of service is a participating provider.

a. For emergency room services provided to an Iowa Plan enrollee by a participating or a nonparticipating provider when covered diagnoses are the primary condition, the contractor may:

(1) Establish policies requiring notification of the provision of emergency room service within a stated time frame which shall be no less than 48 hours.

(2) Require authorization of any services beyond those provided in the emergency room.

b. For emergency room services provided to an Iowa Plan enrollee by a participating or a nonparticipating provider when covered diagnoses are the primary condition, the contractor shall:

(1) Provide a minimum triage fee to the emergency room, regardless of whether the facility notifies the contractor. The triage fee shall be no less than is paid under payment mechanisms established for the Medicaid fee-for-service program.

(2) Reimburse the emergency room for emergency room services provided, contingent upon the facility's compliance with notification policies. Reimbursement to nonparticipating providers shall be no less than the average payment which would be made to a participating provider.

88.66(3) Contractor payment liability. The contractor's payment liability for the provision of emergency mental health and substance abuse services by nonparticipating providers is limited to emergency mental health and substance abuse services provided before the enrollee can, without danger or harmful consequences to the enrollee or others, return to the care of a participating provider. If transportation is necessary to transport the enrollee from a nonparticipating provider to a participating provider, the contractor shall be financially liable for the transportation. In reimbursing nonparticipating providers, the contractor's liability is limited to the average reimbursement which the contractor would pay to a participating provider for the same services.

88.66(4) Notification and claim filing time spans. The contractor may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers and shall notify enrollees of these provisions. However, failure to give notice or to file claims within those time limitations shall not invalidate any claim if it can be shown that it was not reasonably possible to give the notice and that notice was, in fact, given as soon as was reasonably possible. In addition, the contractor shall provide payment for emergency services to nonparticipating providers within 60 days of receipt of a bill which complies with all billing requirements established by the contractor's policies.

441—88.67(249A) Access to service.

88.67(1) Choice of provider. Enrollees shall have the opportunity to choose their mental health care and substance abuse treatment professionals and service providers from any of the participating providers to the extent clinically appropriate.

88.67(2) Open panel requirement. The contractor shall establish and implement policies to ensure an open panel approach to the recruitment of participating providers.

88.67(3) Requirements for participating provider panel. The contractor shall develop and maintain a panel of participating providers which meets the following requirements. The panel shall:

a. Have sufficient staff resources to adequately provide mental health and substance abuse services to meet the needs of enrollees or have arrangements for services to be provided by other providers where capability of participating providers to serve specific mental health and substance abuse needs does not exist.

b. Maintain treatment sites in compliance with all applicable local, state, and federal standards related to the services provided as well as those for fire and safety.

88.67(4) Adequate appointment system. The contractor shall require that participating providers have procedures for the scheduling of enrollee appointments, which are appropriate to the reason for the service, as follows:

a. Enrollees with emergency needs shall be seen within 15 minutes of presentation at a service delivery site.

b. Persons with urgent nonemergency needs shall be seen within 1 hour of presentation at a service delivery site or within 24 hours of telephone contact with provider or contractor.

c. Persons with persistent symptoms shall be seen within 48 hours of reporting symptoms.

d. Persons with need for routine services shall be seen within three weeks of the request for appointment.

88.67(5) Adequate after-hours call-in coverage. The contractor shall ensure crisis counseling and referral are available 24 hours a day, 365 days per year via a toll-free telephone line, the number for which is regularly made available to all enrollees.

88.67(6) Adequate referral system. The contractor shall have in effect arrangements which provide for an adequate referral system for any specialty mental health and substance abuse treatment services not available through participating providers.

88.67(7) Discharge planning. The contractor shall implement policies to ensure that no enrollee who has been receiving services in a 24-hour setting funded by the contractor is discharged from that setting until a discharge plan has been developed which provides appropriate follow-up care and treatment which is accessible to that enrollee.

88.67(8) Lack of discharge plan. When a discharge plan as described in subrule 88.67(7) has not been developed or cannot be implemented, the following shall apply:

a. If the contractor is not required to pay for services at the 24-hour level of care as set forth in subrule 88.73(2) because the services do not meet the criteria of psychosocial necessity or service necessity, the contractor is required (keep kids safe policy) to authorize up to 14 calendar days of additional funding on an administrative basis for enrollees under the age of 18 if a safe and appropriate living arrangement is not available because:

- (1) A court order is in effect that must be modified to allow the placement of the child into that living arrangement;
- (2) A court order is required to allow placement of the child into the appropriate living arrangement;
- (3) A bed is not available in the level of care which has been determined as clinically appropriate for the child; or
- (4) Services and support must be arranged to assist the natural family, foster family, or other living arrangement to become ready to assist the enrollee after the enrollee's return to that environment.

b. If 24-hour services provided through the Iowa Plan are being decertified, payment is limited in accordance with subrule 88.73(2) except as provided in paragraph 88.67(8) "a."

441—88.68(249A) Review of contractor decisions and actions.

88.68(1) Clinical decision review. The contractor shall have written procedures by which enrollees and participating and nonparticipating providers may request a clinical decision review. The clinical decision review, when requested, shall be conducted by staff other than the person or persons who made the original clinical care decision. All policies related to clinical decision review shall be approved by the department prior to implementation. The contractor's clinical decision review policies shall further:

- a. Require acknowledgment of the receipt of a request for a clinical decision review to the enrollee and to the provider if applicable within three working days.
- b. Allow for participation by the enrollee and the provider.
- c. Set time frames for resolution including emergency procedures which are appropriate to the nature of the clinical decision under review.
- d. Require that 95 percent of all clinical decision reviews be resolved within 14 days of receipt of all required documentation and that 100 percent of all clinical decision reviews be resolved within 90 days of the receipt of all required documentation.
- e. Ensure the participation of contractor staff with authority to require corrective action.
- f. Include at least one level of internal review.
- g. Ensure the confidentiality of the enrollee.

88.68(2) Appeal to department. Enrollees may appeal clinical care decisions in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 7 if the enrollee is not satisfied with the final decision rendered by the contractor through the contractor's clinical decision review process.

88.68(3) Review of nonclinical decisions. The contractor shall have available to all enrollees and other persons who do business with the contractor a process for the review of any complaints or grievances concerning nonclinical matters. All policies related to the review of nonclinical decisions shall be approved by the department prior to implementation. Policies regarding the process for the review of nonclinical decisions shall incorporate the following:

- a. Allow initiation both verbally and in writing.
- b. Require a review conducted by someone other than the person who made the original decision.

- c. Require written notice acknowledging the receipt of a complaint or grievance.
- d. Require resolution of 95 percent of all complaints or grievances within 14 days of the receipt of all required documentation and resolution of 100 percent within 90 days of the receipt of all required documentation.

88.68(4) Written record. All requests for review of contractor decisions and actions, including all informal or verbal complaints which must be referred or researched for resolution, shall be recorded in writing. A log shall be retained and made available at the request of the department. The log shall include progress notes and method of resolution to allow determination of compliance with subrules 88.68(1) and 88.68(3).

88.68(5) Information concerning procedures relating to the review of contractor decisions and actions. The contractor's written procedures for the review of contractor decisions and actions shall be provided to each new enrollee, to participating providers in a provider manual, and to nonparticipating providers upon request.

88.68(6) Periodic reports to the department. The contractor shall make reports to the department summarizing the review of contractor decisions and actions and resolutions to the reviews at a frequency specified in the contract.

88.68(7) Consent for state fair hearing. Network providers which are contracted and in good standing with the Iowa plan contractor may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member. The network provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the network provider submits a document providing such member's approval of the request for a state fair hearing. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

[ARC 0583C, IAB 2/6/13, effective 4/1/13]

441—88.69(249A) Records and reports.

88.69(1) Records system. The contractor shall document and maintain clinical and fiscal records throughout the course of the contract. The record system shall:

- a. Identify transactions with or on behalf of each enrollee by the state identification number assigned to the enrollee by the department.
- b. Provide a rationale for and documentation of clinical care decisions made by the contractor based upon psychosocial necessity for mental health services and service necessity for substance abuse services.
- c. Permit effective professional review for medical audit processes.
- d. Facilitate an adequate system for monitoring treatment reimbursed by the contractor including follow-up of the implementation of discharge plans and referral to other providers.
- e. Meet contract reporting requirements and federal reporting requirements applicable to prepaid health plans.

88.69(2) Content of individual treatment record. The contractor shall have contractual requirements with participating providers which ensure an adequate record-keeping system, including documentation of all Iowa Plan services provided to each enrollee, in compliance with the provisions of rule 441—79.3(249A).

88.69(3) Confidentiality of mental health information. The contractor shall protect and maintain the confidentiality of mental health information by implementing policies for staff and through contract terms with participating providers which allow release of mental health information only as allowed by Iowa Code chapter 228.

88.69(4) Confidentiality of substance abuse information. The contractor shall protect and maintain the confidentiality of substance abuse information by implementing policies for staff and through contract terms with participating providers which allow release of substance abuse information only in compliance with policies set forth in the Code of Federal Regulations at Title 42, Part 2, as amended to May 5, 1995, and other applicable state and federal law and regulations.

88.69(5) Reports to the department. The contractor shall submit reports to the department as follows:

- a. Encounter data on a monthly basis.
- b. Annual audited financial statements no later than 180 days after the close of each contract year.
- c. Periodic financial, utilization, and statistical reports as required by the department in the contract.
- d. Other reporting requirements as specified in the contract.

88.69(6) Audits. The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the contractor, participating providers, nonparticipating providers, and subcontractors pertaining to services performed and reimbursed under the contract. The department or its designee or HHS may audit and inspect any records of the contractor, participating providers, nonparticipating providers and subcontractors of the contractor, pertaining to services performed and the determination of amounts paid under the contract. These records shall be made available at times, places, and in a manner as authorized representatives of the department, its designee, or HHS may request.

441—88.70(249A) Marketing. The marketing of Iowa Plan services is prohibited.

441—88.71(249A) Enrollee education.

88.71(1) Use of services. The contractor shall provide written information to all enrollees on the use of services the contractor is responsible to ensure, arrange, monitor, and reimburse. Information must include services covered; how to access services; providers participating; explanation of the process for the review of contractor decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 7 and how to access that fair hearing process; provision of after-hours and emergency care; procedures for notifying enrollees of a change in benefits or office sites; how to request a change in providers; statement of consumer rights and responsibilities; out-of-area use of service; availability of toll-free telephone information and crisis assistance; appropriate use of the referral system; and the method of accessing Medicaid-funded services not covered by the Iowa Plan, especially pharmacy services.

88.71(2) Outreach to members with special needs. The contractor shall provide enhanced outreach to members with special needs including, but not limited to, persons with psychiatric disabilities, mental retardation or other cognitive impairments, homeless persons, illiterate persons, non-English-speaking persons and persons with visual or hearing impairments.

88.71(3) Patient rights and responsibilities. The contractor shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrollees. This statement shall be part of enrollment information provided to all new enrollees.

441—88.72(249A) Payment to the contractor.

88.72(1) Capitation rate. In consideration for all services rendered by the contractor under a Medicaid contract with the department, the contractor shall receive a payment each month for each enrollee. This Medicaid capitation rate represents the total obligation of the department with respect to the costs of Medicaid mental health and substance abuse services provided to enrollees under the contract. The contractor accepts the rate as payment in full for the Medicaid-contracted services.

88.72(2) Determination of rate. The Medicaid capitation rates shall be established in the contract and shall not exceed the cost to the department of providing the same covered services on a fee-for-service basis to the same group of Medicaid members eligible for the plan.

88.72(3) Payment for services to other recipients. When the department chooses to include mental or substance abuse services for recipients other than enrollees, the department shall establish rates and reimbursement procedures in the contract.

88.72(4) Third-party liability. If an enrollee has health coverage or a responsible party other than the Medicaid program available for purposes of payment for mental health and substance abuse expenses, it is the right and responsibility of the contractor to investigate these third-party resources and attempt to obtain payment. The contractor may retain all funds collected through third-party sources. A complete record of third-party liability shall be maintained and made available to the department at the end of each contract year.

441—88.73(249A) Claims payment.

88.73(1) Claims payment by contractor. The contractor shall meet the following time lines for the payment of all claims for covered, required and optional mental health and substance abuse services submitted which meet the contractor's requirements for claim submission:

- a. For at least 85 percent of claims submitted, payment shall be mailed or claims shall be denied within 14 days of the date the claim is received by the contractor.
- b. For at least 90 percent of claims submitted, payment shall be mailed or claims shall be denied within 30 days of the date the claim is received by the contractor.
- c. For 100 percent of claims submitted, payment shall be mailed or claims shall be denied within 90 days of the date the claim is received by the contractor.

88.73(2) Limits on payment responsibility for services.

- a. The contractor is not required to reimburse providers for the provision of mental health services that do not meet the criteria of psychosocial necessity.
- b. The contractor is not required to reimburse providers for the provision of substance abuse services that do not meet the criteria of service necessity.
- c. The contractor is not required to reimburse providers for the provision of MR/CMI/DD case management services that do not meet the criteria and requirements set forth in 441—Chapter 90.
- d. The contractor has the right to require prior authorization of covered, required and optional services and to deny reimbursement to providers who do not comply with such requirements.
- e. Payment responsibilities for emergency room services are as provided at subrule 88.66(2).
- f. Payment responsibility for services provided under the “keep kids safe” policy is set forth at subrule 88.67(8).

88.73(3) Payment to nonparticipating providers. In reimbursing nonparticipating providers, the contractor is obligated to pay no more than the average rate of reimbursement which the contractor pays to participating providers for the same service.

88.73(4) Payment of crossover and copayments. Rescinded IAB 1/9/02, effective 3/1/02.

441—88.74(249A) Quality assurance. The contractor shall have in effect an internal quality assurance system which meets the requirements of 42 CFR, Part 434.34 as amended to March 12, 1984, and complies with all other requirements specified in the contract.

441—88.75(249A) Iowa Plan advisory committee. The department shall appoint an advisory committee to advise the department in the implementation and operation of the Plan and to provide for ongoing public input in its operation.

441—88.76 to 88.80 Reserved.

DIVISION V
PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

441—88.81(249A) Scope and definitions.

88.81(1) Purpose. A program of all-inclusive care for the elderly (PACE) organization provides prepaid, capitated, comprehensive health care services designed to meet the following objectives:

- a. Enhance the quality of life and autonomy of frail older adults.
- b. Maximize the dignity of and respect for frail older adults.
- c. Enable frail older adults to live in the community as long as medically and socially feasible.
- d. Preserve and support frail older adults' family units.

88.81(2) Scope. PACE programs may serve Medicaid members, Medicare beneficiaries, persons eligible for both Medicare and Medicaid benefits, and private-pay individuals. Enrollment to receive services from a PACE organization is voluntary.

- a. Enrollment is limited to persons who are 55 years of age or older and who need care at the nursing facility level but are able to live in a community setting without jeopardizing their health and safety.
- b. If a Medicaid member chooses to enroll in a PACE program, the member must receive Medicaid benefits solely through the PACE organization while enrolled in the program.

88.81(3) Authorization. A PACE organization must enter into a three-way agreement with the department and the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

88.81(4) Definitions. For purposes of this division:

"Alternate PACE service site" means a location outside a primary or alternate PACE center in which one or more PACE services are offered to PACE enrollees.

"Capitation rate" means the monthly fee the department pays to a PACE organization for each Medicaid enrollee for the provision of covered medical and health services, whether or not the enrollee received services during the month for which the fee is intended.

"CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

"Contract year" means the term of a PACE program agreement. The term is a calendar year, with the exception that a PACE organization's initial contract year is determined by CMS and may be from 12 to 23 months.

"Department" means the Iowa department of human services.

"Enrollee" means a person who is enrolled in a PACE program.

"Federal PACE regulations" means the standards published in 42 CFR Part 460, Programs of All-Inclusive Care for the Elderly. These rules shall be interpreted so as to comply with the federal PACE regulations.

"Interdisciplinary team" means the team designated by the PACE organization to assess the needs of and develop a comprehensive plan of care for each enrollee.

"Medicaid enrollee" means a Medicaid member who is enrolled in a PACE program.

"Medicare beneficiary" means a person who is entitled to Medicare Part A benefits, is enrolled under Medicare Part B, or both.

"Medicare enrollee" means a Medicare beneficiary who is enrolled in a PACE program.

"PACE" means programs of all-inclusive care for the elderly.

"PACE center" means a facility operated by a PACE organization where primary care is furnished to PACE enrollees. A primary PACE center is the principal facility operated by a PACE organization. An alternate PACE center is another facility operated by a PACE organization outside its primary center. "Primary care" shall include all program components in accordance with 42 CFR Section 460.92 as amended to December 8, 2006.

"PACE enrollment agreement" means the contract between the PACE organization and the enrollee that includes, at a minimum, all information identified in 42 CFR Section 460.154 as amended to December 8, 2006.

"PACE organization" means an entity that has in effect a PACE program agreement with the department and CMS to operate a PACE program in Iowa.

"PACE program" means a program of all-inclusive care for the elderly operated by an approved PACE organization that provides comprehensive health care services to enrollees in Iowa in accordance with a PACE program agreement.

"PACE program agreement" means a three-way agreement between CMS, the department, and an entity approved to be a PACE organization for the operation of a PACE program.

"Service area" means the specific counties in which a PACE provider may provide services, as identified in the PACE program agreement.

"Services" means both items and services provided to an enrollee by the PACE organization.

"Trial period" means the first three contract years in which a PACE organization operates under a PACE program agreement.

441—88.82(249A) PACE organization application and waiver process. This rule sets forth the application requirements for an entity that seeks approval from the department as a PACE organization and the process by which a prospective PACE organization may request department review and approval of requests to CMS for waiver of federal requirements.

88.82(1) Application requirements. A person authorized to act on behalf of an entity seeking approval as a PACE organization shall prepare an application in the format suggested by CMS at: http://www.cms.hhs.gov/PACE/06_ProviderApplicationandRelatedResources.asp.

a. The application shall:

(1) Describe how the entity meets the requirements of this division and of the federal PACE regulations; and

(2) Identify the counties in which the entity proposes to provide PACE services.

b. Upon completion of the application sections designated for PACE providers, the prospective PACE organization shall submit the application to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

88.82(2) Waiver of federal requirements. A prospective PACE organization must also receive CMS approval as a PACE organization. A prospective PACE organization must submit any request for waiver of federal PACE regulations to the department for initial review before submitting the request to CMS.

a. The waiver request shall be submitted as a document separate from the application. The request may be submitted:

(1) In conjunction with and at the same time as the application; or
(2) At any time during the approval process.

b. The prospective PACE organization shall submit the waiver request and documentation to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

88.82(3) Review of applications and requests for waiver of federal requirements. The department may conduct on-site visits and may request additional information from an entity in connection with an application for approval as a PACE organization or a request for waiver of federal requirements.

88.82(4) Department action on applications. Upon review of an application for approval as a PACE organization and action by CMS on any request for waiver of federal requirements, the department shall determine whether it considers the entity qualified to be a PACE organization and whether it is willing to enter into a PACE program agreement with the entity. If so, the department shall complete the application sections designated for the state administering agency and submit the completed application in its entirety to CMS.

441—88.83(249A) PACE program agreement. An entity that has been approved by the department and CMS to be a PACE organization must enter into an agreement with CMS and the department for the operation of a PACE program under Medicare and Medicaid. The agreement must be signed by an authorized official of CMS, the PACE organization, and the department.

88.83(1) Content and terms of agreement.

a. *Required content.* A PACE program agreement must include the following information:

(1) A designation of the service area of the PACE organization's program, identified by county. The department and CMS must approve any change in the designated service area.

(2) The PACE organization's commitment to meet all applicable requirements under federal, state, and local laws and regulations, including provisions of the Civil Rights Act, the Age Discrimination Act, and the Americans with Disabilities Act.

(3) The effective date and term of the agreement.

(4) A description of the organizational structure of the PACE organization and information on the organization's administrative contacts.

(5) An enrollee bill of rights approved by CMS and an assurance that the listed rights and protections will be provided.

(6) A description of the process for handling enrollee grievances and appeals.

(7) A statement of the PACE organization's policies on eligibility, enrollment, voluntary disenrollment, and involuntary disenrollment.

(8) A description of the services available to enrollees.

(9) A description of the PACE organization's quality assessment and performance improvement program.

(10) A statement of the levels of performance required in CMS standard quality measures.

(11) A statement of the data and information required by the department and CMS to be collected on enrollee care.

(12) The Medicaid capitation rate and the methodology used to calculate the Medicare capitation rate.

(13) A description of procedures that the PACE organization will follow if the PACE program agreement is terminated, including how the organization will:

1. Inform enrollees, the community, CMS, and the department, in writing, about the organization's termination and transition procedures.

2. Initiate contact with income maintenance staff in the local department office and assist enrollees in obtaining reinstatement of conventional Medicare and Medicaid benefits.

3. Transition enrollees' care to other providers.

4. Terminate marketing and enrollment activities.

b. *Optional content.* An agreement may:

(1) Provide additional requirements for individuals to qualify as PACE enrollees in accordance with subparagraph 88.84(1) "a"(5).

(2) Contain any additional terms and conditions agreed to by the parties.

88.83(2) Duration of agreement. A PACE program agreement shall be effective for a contract year but may be extended for additional contract years in the absence of a notice by a party to terminate.

88.83(3) Enforcement of agreement. If the department determines that the PACE organization is not in substantial compliance with requirements of the federal PACE regulations or of this division, the department may take one or more of the following actions:

a. Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

b. Withhold some or all payments under the PACE program agreement until the PACE organization corrects the deficiency.

c. Terminate the PACE program agreement.

88.83(4) Termination of agreement by the department.

a. *Grounds for termination.* The department may terminate a PACE program agreement at any time for cause, including but not limited to the following circumstances:

(1) Termination due to uncorrected deficiencies. The department may terminate a PACE program agreement if both of the following circumstances exist:

1. The department has determined through a review pursuant to subrule 88.87(4) that the PACE organization has significant deficiencies in the quality of care furnished to enrollees or has failed to comply substantially with the conditions for a PACE organization or PACE program under this division, the federal PACE regulations, or the terms of its PACE program agreement.

2. The PACE organization has failed to develop and successfully initiate a plan to correct the deficiencies within 30 days of the date of receipt of a written notice of deficiencies, as confirmed by certified mail, or has failed to continue implementation of the corrective action plan.

(2) Termination due to health and safety risk. The department may terminate a PACE program agreement if the department determines that the PACE organization cannot ensure the health and safety of its enrollees. This determination may result from the identification of deficiencies that the department determines cannot be corrected.

b. *Notice and opportunity for hearing.* Except as provided in paragraph "c" of this subrule, before terminating an agreement, the department shall furnish the PACE organization with the following:

(1) A reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that are the basis of the department's determination that cause exists for termination.

(2) Reasonable notice and opportunity for hearing (including the right to appeal an initial determination) before terminating the agreement.

c. *Immediate termination.* The department may terminate an agreement without invoking the procedures described in paragraph "b" of this subrule if the department determines that a delay in termination resulting from compliance with those procedures before termination would pose an imminent and serious risk to the health of the enrollees.

88.83(5) Termination of agreement by PACE organization. A PACE organization may terminate an agreement after timely notice issued as follows:

- a. To CMS and the department, 90 days before termination.
- b. To enrollees, 60 days before termination.

88.83(6) Transitional care during termination. A PACE organization whose PACE program agreement is being terminated must provide assistance to each enrollee in obtaining necessary transitional care by making appropriate referrals and making the enrollee's medical records available to new providers.

441—88.84(249A) Enrollment and disenrollment. A PACE organization must comply with the federal enrollment requirements stated in 42 CFR Sections 460.152 through 460.156 as amended to December 8, 2006.

88.84(1) Eligibility for Medicaid enrollees. To enroll in a PACE program as an Iowa Medicaid enrollee, a person must meet the eligibility requirements specified in this subrule.

a. *Basic eligibility requirements.*

- (1) The person must be 55 years of age or older.
- (2) The person must reside in the service area of the PACE organization.
- (3) The person must be eligible for Medicaid pursuant to the provisions in 441—Chapter 75 for persons in a medical institution.
- (4) The department must determine that the person is eligible for Iowa Medicaid pursuant to 441—Chapter 76.
- (5) The department must determine that the person needs the nursing facility level of care.
- (6) The person must meet any additional program-specific eligibility conditions imposed under the PACE program agreement. These additional conditions shall not modify the requirements stated in this subrule.

b. *Other eligibility requirements.*

- (1) At the time of enrollment, the person must be able to live in a community setting without jeopardizing the person's health or safety, pursuant to the criteria specified in the PACE program agreement.
- (2) To continue to be eligible for PACE as an Iowa Medicaid enrollee, a person must meet the annual recertification requirements specified in subrule 88.84(4).

88.84(2) Effective date of enrollment. A person's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.

88.84(3) Duration of enrollment. Enrollment continues until the enrollee's death unless either of the following actions occurs:

a. The enrollee voluntarily disenrolls. An enrollee may voluntarily disenroll from the program without cause at any time.

b. The enrollee is involuntarily disenrolled, as described in subrule 88.84(5).

88.84(4) Annual recertification.

a. At least annually, the department shall:

(1) Reevaluate whether each enrollee continues to need the nursing facility level of care; and

(2) Review all financial and nonfinancial eligibility requirements for Medicaid enrollees. The enrollee shall complete Form 470-3118 or 470-3118(S), Medicaid Review.

b. Deemed continued eligibility. If the department determines that an enrollee no longer needs the nursing facility level of care, the department, in consultation with the PACE organization, shall determine whether, in the absence of continued PACE coverage, the enrollee reasonably would be expected to meet the nursing facility level-of-care requirement within the next six months. This determination shall be based on a review of the enrollee's medical record and plan of care, applying criteria specified in the PACE program agreement. If the enrollee reasonably would be expected to meet the level-of-care requirement within six months, the enrollee's eligibility for the PACE program may continue until the next annual reevaluation.

88.84(5) Involuntary disenrollment. An involuntary disenrollment shall not become effective until the Department has determined that the PACE organization has adequately documented acceptable grounds for disenrollment.

a. *Reasons for involuntary disenrollment.* An enrollee may be involuntarily disenrolled for any of the following reasons:

(1) After a 30-day grace period, the enrollee fails to pay any amount due to the PACE organization pursuant to subrule 88.88(2) or refuses to make satisfactory arrangements to pay.

(2) The enrollee engages in disruptive or threatening behavior as described in paragraph 88.84(5) "b."

(3) The enrollee moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

(4) The department determines that the enrollee no longer needs the nursing facility level of care and the enrollee is not deemed eligible pursuant to paragraph 88.84(4) "b."

(5) The PACE program agreement with CMS and the department is not renewed or is terminated.

(6) The PACE organization is unable to offer health care services due to the loss of state licenses or contracts with outside providers.

b. *Disruptive or threatening behavior.* "Disruptive or threatening behavior" refers to either of the following:

(1) Behavior that jeopardizes the enrollee's health or safety or the safety of others; or

(2) Consistent refusal by the enrollee to comply with the enrollee's individual plan of care or the terms of the PACE enrollment agreement when the enrollee has decision-making capacity.

c. *Documentation of disruptive or threatening behavior.* If a PACE organization proposes to disenroll an enrollee who is disruptive or threatening, the organization must document the following information in the enrollee's medical record:

(1) The reasons for proposing to disenroll the enrollee.

(2) All efforts to remedy the situation.

d. *Noncompliant behavior.* A PACE organization may not disenroll an enrollee on the grounds that the enrollee has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the enrollee, unless the enrollee's behavior jeopardizes the enrollee's health or safety or the safety of others. "Noncompliant behavior" includes repeated noncompliance with medical advice and repeated failure to keep appointments.

88.84(6) Effective date of disenrollment.

a. In disenrolling a Medicaid enrollee, the PACE organization must:

- (1) Use the most expedient process allowed under the PACE program agreement;
- (2) Coordinate the disenrollment date between Medicare and Medicaid for an enrollee who is eligible for both Medicare and Medicaid; and

- (3) Give reasonable advance notice to the enrollee.
 - b. Until the date when enrollment is terminated, the following requirements must be met:
 - (1) The PACE organization must continue to furnish all needed services.
 - (2) The enrollee must continue to use PACE organization services.

88.84(7) Documentation of disenrollment. A PACE organization must meet the following requirements:

- a. Have a procedure in place to document the reasons for all voluntary and involuntary disenrollments.
- b. Make documentation available for review by CMS and the department.
- c. Use the information on voluntary disenrollments in the PACE organization's internal quality assessment and performance improvement program.

88.84(8) Reinstatement in other Medicare and medicaid programs. After a disenrollment, the PACE organization shall work with CMS and the department to facilitate the former enrollee's reinstatement in other Medicare and Medicaid programs by:

- a. Making appropriate referrals to other Medicare and Medicaid programs for which the enrollee may be eligible; and
- b. Ensuring that medical records are made available to new providers in a timely manner.

88.84(9) Reinstatement in PACE. A previously disenrolled enrollee may be reinstated in a PACE program.

[ARC 0758C, IAB 5/29/13, effective 8/1/13]

441—88.85(249A) Program services. A PACE organization shall furnish comprehensive medical, health, and social services that integrate acute and long-term care.

88.85(1) Required services. The PACE benefit package for all enrollees, regardless of the source of payment, must include the following:

- a. All Medicare-covered items and services.
- b. All Medicaid-covered items and services as specified in 441—Chapters 78, 81, 82, 85, and 90. Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost sharing do not apply to PACE services.
- c. Other services determined necessary by the enrollee's interdisciplinary team to improve or maintain the enrollee's overall health status.

88.85(2) Excluded services. The following services are excluded from coverage under PACE:

- a. Any service that is not authorized by the enrollee's interdisciplinary team, even if it is a required service, unless it is an emergency service.
- b. In an inpatient facility:
 - (1) A private room and private-duty nursing services unless medically necessary; and
 - (2) Nonmedical items for personal convenience, such as telephone charges and radio or television rental, unless specifically authorized by the interdisciplinary team as part of the enrollee's plan of care.
- c. Cosmetic surgery. "Cosmetic surgery" does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.

d. Experimental medical, surgical, or other health procedures.

e. Services furnished outside the United States, except in accordance with 42 CFR Sections 424.122 and 424.124 as amended to September 29, 1995, or as otherwise permitted under the Iowa Medicaid program.

88.85(3) Service delivery. The PACE organization must establish and implement a written plan to furnish care that meets the needs of each enrollee in all care settings 24 hours a day, every day of the year.

a. *Provision of services.* PACE services must be furnished in at least:

- (1) The PACE center,
- (2) The enrollee's home, and
- (3) Inpatient facilities.

b. *PACE center operation.* A PACE organization must ensure accessible and adequate services to meet the needs of its enrollees. The interdisciplinary team shall determine the frequency of each enrollee's attendance at a PACE center, based on the needs and preferences of the enrollee.

(1) A PACE organization must operate at least one PACE center either in or contiguous to its defined service area. A PACE center must be certified as an adult day services program pursuant to Iowa Code chapter 231D and the department of elder affairs' rules at 321—Chapter 24.

(2) If necessary to maintain sufficient capacity to allow routine attendance by enrollees, a PACE organization must add staff or develop alternate PACE centers or service sites. If a PACE organization operates more than one center, each alternate PACE center must offer the full range of services and have sufficient staff to meet the needs of enrollees.

88.85(4) Minimum services furnished at a PACE center. At a minimum, the following services must be furnished at each primary or alternate PACE center:

- a. Primary care, including physician and nursing services.
- b. Social services.
- c. Restorative therapies, including physical therapy and occupational therapy.
- d. Personal care and supportive services.
- e. Nutritional counseling.
- f. Recreational therapy.
- g. Meals.

88.85(5) Primary care. Primary medical care must be furnished to an enrollee by a PACE primary care physician. Each primary care physician is responsible for:

- a. Managing an enrollee's medical situations; and
- b. Overseeing an enrollee's use of medical specialists and inpatient care.

88.85(6) Out-of-network emergency care. A PACE organization must pay for out-of-network emergency care when the care is needed immediately because of an injury or sudden illness and the time required to reach the PACE organization or one of its contract providers would cause risk of permanent damage to the enrollee's health.

- a. *Definitions.* As used in this subrule, the following definitions apply:

“Emergency medical condition” means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Serious jeopardy to the health of the enrollee.
2. Serious impairment to bodily functions of the enrollee.
3. Serious dysfunction of any bodily organ or part of the enrollee.

“Emergency services” means inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and are furnished by a qualified emergency services provider other than the PACE organization or one of its contract providers, either inside or outside the PACE organization's service area.

“Poststabilization care” means services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized but that do not meet the definition of emergency services.

“Urgent care” means care that is provided to an enrollee outside the service area because the enrollee believes that an illness or injury is too severe to postpone treatment until the enrollee returns to the service area but that does not meet the definition of emergency services because the enrollee's life or functioning is not in severe jeopardy.

b. *Plan.* A PACE organization must establish and maintain a written plan to handle out-of-network emergency care. The plan must ensure that CMS, the department, and the enrollee are held harmless if

the PACE organization does not pay for out-of-network emergency services. The plan must provide for the following:

(1) An on-call provider available 24 hours per day to address enrollee questions about out-of-network emergency services and to respond to requests for authorization of out-of-network urgent care and poststabilization care following emergency services.

(2) Coverage of out-of-network urgent care and poststabilization care when either of the following conditions is met:

1. The PACE organization has approved the services.

2. The PACE organization has not approved the services because the PACE organization did not respond to a request for approval within one hour after being contacted or because the PACE organization cannot be contacted for approval.

c. *Explanation to enrollee.* The organization must ensure that the enrollee or caregiver, or both, understand:

(1) When and how to access out-of-network emergency services, and

(2) That no prior authorization is needed.

441—88.86(249A) Access to PACE services. An enrollee's access to PACE services is governed by a comprehensive plan of care developed for each enrollee by an interdisciplinary team based on a comprehensive assessment of the enrollee's health and social status.

88.86(1) Interdisciplinary team. A PACE organization shall establish an interdisciplinary team at each PACE center to comprehensively assess and meet the individual needs of each enrollee.

a. *Team composition.* The members of the interdisciplinary team must primarily serve PACE enrollees. At a minimum, the interdisciplinary team shall be composed of the following members:

(1) Primary care physician.

(2) Registered nurse.

(3) Master's-level social worker.

(4) Physical therapist.

(5) Occupational therapist.

(6) Recreational therapist or activity coordinator.

(7) Dietitian.

(8) PACE center manager.

(9) Home care coordinator.

(10) Personal care attendant or attendant's representative.

(11) Driver or driver's representative.

b. *Team responsibilities.* Each enrollee shall be assigned to an interdisciplinary team functioning at the PACE center that the enrollee attends. The interdisciplinary team is responsible for the initial assessment, periodic reassessments, plan of care, and coordination of 24-hour care delivery for each assigned enrollee. Each interdisciplinary team member is responsible for the following:

(1) Regularly informing the team of the medical, functional, and psychosocial condition of each enrollee.

(2) Remaining alert to pertinent input from other team members, enrollees, and caregivers.

(3) Documenting changes in an enrollee's condition in the enrollee's medical record, consistent with documentation policies established by the medical director.

c. *Exchange of information.* The PACE organization must establish, implement, and maintain documented internal procedures governing the exchange of information between team members, contractors, and enrollees and their caregivers consistent with the federal requirements for confidentiality in 42 CFR Section 460.200(e) as amended to November 24, 1999.

88.86(2) Initial assessment. The interdisciplinary team must conduct an initial comprehensive assessment of each enrollee promptly following enrollment.

a. Each of the following members of the interdisciplinary team must evaluate the enrollee, at appropriate intervals, and develop a discipline-specific assessment of the enrollee's health and social status:

- (1) Primary care physician.
- (2) Registered nurse.
- (3) Master's-level social worker.
- (4) Physical therapist.
- (5) Occupational therapist.
- (6) Recreational therapist or activity coordinator.
- (7) Dietitian.
- (8) Home care coordinator.

b. At the recommendation of interdisciplinary team members, other professional disciplines (such as speech-language pathology, dentistry, or audiology) may be included in the comprehensive assessment process.

- c. The assessment of each enrollee must include, but not be limited to, assessment of the following:
 - (1) Physical and cognitive function and ability.
 - (2) Medication use.
 - (3) Enrollee and caregiver preferences for care.
 - (4) Socialization and availability of family support.
 - (5) Current health status and treatment needs.
 - (6) Nutritional status.
 - (7) Home environment, including home access and egress.
 - (8) Enrollee behavior.
 - (9) Psychosocial status.
 - (10) Medical and dental status.
 - (11) Enrollee language.

88.86(3) Plan of care. The interdisciplinary team must promptly consolidate discipline-specific assessments into a single plan of care for each enrollee through discussion in team meetings and consensus of the entire team.

a. *Development.* The interdisciplinary team must develop, review, and reevaluate the plan of care in collaboration with the enrollee or caregiver, or both, to ensure that there is agreement with the plan of care and that the enrollee's concerns are addressed. In developing the plan of care, female enrollees must be informed that they are entitled to choose a qualified specialist for women's health services from the PACE organization's network to furnish routine or preventive women's health services.

b. *Content.* The plan of care must:

(1) Specify the care needed to meet the enrollee's medical, physical, emotional, and social needs, as identified in the initial comprehensive assessment.

(2) Identify measurable outcomes to be achieved.

c. *Documentation.* The interdisciplinary team shall document in the enrollee's medical record the plan of care and any changes made to the plan of care.

d. *Implementation.* The interdisciplinary team shall:

(1) Implement, coordinate, and monitor the plan of care, whether the services are furnished by PACE employees or contractors; and

(2) Continuously monitor the enrollee's health and psychosocial status, as well as the effectiveness of the plan of care, through the provision of services, informal observation, input from enrollees and caregivers, and communications among team members and other providers.

e. *Evaluation.* On at least a semiannual basis, the interdisciplinary team shall reevaluate the plan of care, including defined outcomes, and make changes as necessary.

88.86(4) Reassessment.

a. *Semiannual reassessment.* On at least a semiannual basis, or more often if an enrollee's condition dictates, the following interdisciplinary team members must conduct an in-person reassessment:

- (1) Primary care physician.
- (2) Registered nurse.
- (3) Master's-level social worker.

(4) Recreational therapist or activity coordinator.

(5) Other interdisciplinary team members actively involved in the development or implementation of the enrollee's plan of care, such as the home care coordinator, physical therapist, occupational therapist, or dietitian.

b. *Annual reassessment.* On at least an annual basis, the following interdisciplinary team members must conduct an in-person reassessment:

(1) Physical therapist.

(2) Occupational therapist.

(3) Dietitian.

(4) Home care coordinator.

c. *Unscheduled reassessments.* In addition to annual and semiannual reassessments, unscheduled reassessments may be required based on the following:

(1) A change in enrollee status. If the health or psychosocial status of an enrollee changes, the interdisciplinary team members listed in paragraph 88.86(2) "a" must conduct an in-person reassessment.

(2) A request by the enrollee or designated representative. If an enrollee (or the enrollee's designated representative) believes that the enrollee needs to initiate, eliminate, or continue a particular service, the appropriate interdisciplinary team members, as identified by the interdisciplinary team, must conduct an in-person reassessment.

d. *Changes to plan of care.* Interdisciplinary team members who conduct a reassessment must:

(1) Reevaluate the enrollee's plan of care.

(2) Discuss any changes in the plan of care with the interdisciplinary team.

(3) Obtain approval of the revised plan of care from the interdisciplinary team and the enrollee or the enrollee's designated representative.

(4) Document all assessment and reassessment information in the enrollee's medical record.

(5) Furnish to the enrollee any services included in the revised plan of care as a result of a reassessment as expeditiously as the enrollee's health condition requires.

88.86(5) Procedures for resolving enrollee request to change the plan of care. The PACE organization must have explicit procedures for timely resolution of a request by an enrollee or an enrollee's designated representative to initiate, eliminate, or continue a particular service.

a. Except as provided in paragraph "b" of this subrule, the interdisciplinary team must notify the enrollee or the enrollee's designated representative of its decision to approve or deny the request from the enrollee or the designated representative as expeditiously as the enrollee's condition requires, but no later than 72 hours after the date the interdisciplinary team receives the request.

b. The interdisciplinary team may extend the 72-hour period for notifying the enrollee or the designated representative of its decision to approve or deny the request by no more than five additional days if:

(1) The enrollee or designated representative requests the extension; or

(2) The interdisciplinary team documents its need for additional information and how the delay is in the interest of the enrollee.

c. The PACE organization must:

(1) Explain to the enrollee or the enrollee's designated representative orally and in writing any denial of a request to change the plan of care; and

(2) Provide the specific reasons for the denial in understandable language.

d. The PACE organization is responsible for:

(1) Informing the enrollee or the enrollee's designated representative of the enrollee's right to appeal the decision as specified in 42 CFR Section 460.122 as amended to December 8, 2006.

(2) Describing both the standard and expedited appeals processes of the PACE organization, including the right to obtain and conditions for obtaining expedited consideration of an appeal of a denial of services as specified in 42 CFR Section 460.122 as amended to December 8, 2006.

(3) Describing the right to and conditions for continuation of appealed services through the period of an appeal as specified in 42 CFR Section 460.122(e) as amended to December 8, 2006.

e. If the interdisciplinary team fails to provide the enrollee with timely notice of the resolution of the request or fails to furnish the services required by the revised plan of care, this failure constitutes an adverse decision. The enrollee's request must be automatically processed by the PACE organization as an appeal in accordance with 42 CFR Section 460.122 as amended to December 8, 2006.

f. The PACE organization must submit all documentation related to an appeal to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

441—88.87(249A) Program administrative requirements. A PACE organization shall comply with the federal administrative requirements stated in 42 CFR Sections 460.60 through 460.82 as amended to December 8, 2006, including requirements relating to organizational structure, governing body, qualifications for staff who have direct contact with enrollees, training, program integrity, contracted services, oversight of direct care services, physical environment, infection control, transportation services, dietary services, fiscal soundness, and marketing.

88.87(1) Enrollee rights. A PACE organization shall comply with the federal participant rights requirements stated in 42 CFR Sections 460.110 through 460.124 as amended to December 8, 2006. Upon exhaustion of the PACE organization's appeal process, a Medicaid enrollee has the right to appeal to the department any adverse coverage or payment decision regarding any service, including any denial, reduction, or termination of any service, pursuant to 441—Chapter 7.

88.87(2) Data collection, record maintenance, and reporting. A PACE organization shall comply with federal data collection, records maintenance, and reporting requirements stated in 42 CFR Sections 460.200 through 460.210 as amended to December 8, 2006.

88.87(3) Quality assessment and performance improvement. A PACE organization shall comply with the federal quality assessment and performance improvement requirements stated in 42 CFR Sections 460.130 through 460.140 as amended to November 24, 1999.

88.87(4) Federal and state monitoring.

a. The PACE program shall cooperate with federal and state monitoring pursuant to 42 CFR Sections 460.190 through 460.196 as amended to Nov. 24, 1999, including:

- (1) Corrective action required pursuant to 42 CFR Section 460.194; and
- (2) Disclosure of review results pursuant to 42 CFR Section 460.196(c) and (d).

b. The PACE program is subject to sanctions or termination pursuant to subrules 88.83(3) and 88.83(4).

c. During the trial period, CMS, in cooperation with the department, shall conduct comprehensive annual reviews of the operations of a PACE organization to ensure compliance with PACE federal regulations and 441—Chapter 88, Division V.

d. After the trial period, the department, in cooperation with CMS, shall conduct on-site reviews of a PACE organization at least every two years.

e. After a review, CMS and the department shall report the results of the review to the PACE organization, along with any recommendations for changes to the organization's program.

f. Within 30 days of issuance of the report, the PACE organization shall develop and implement a corrective action plan to address any deficiencies identified through the review.

g. CMS or the department shall monitor the effectiveness of the corrective actions implemented.

441—88.88(249A) Payment.

88.88(1) Medicaid payment to PACE organization. Under a PACE program agreement, the department shall make a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid enrollee. The monthly capitation payment amount shall be negotiated between the PACE organization and the department and shall be specified in the PACE program agreement.

a. The amount of the capitation payment:

(1) Shall be less than the amount that would otherwise have been paid under the Medicaid program if the enrollees were not enrolled under the PACE program.

(2) Shall be a fixed amount regardless of changes in the enrollee's health status.

(3) May be renegotiated on an annual basis.

b. The PACE organization must accept the capitation payment amount as payment in full for Medicaid enrollees. The organization shall not collect or receive any other form of payment from the department or from, or on behalf of, the enrollee except for any amounts due from the enrollee pursuant to subrule 88.88(2).

88.88(2) Liability of Medicaid enrollee. A Medicaid enrollee shall contribute toward the cost of the enrollee's care according to the terms of this subrule. A PACE organization may not charge a premium to a Medicaid enrollee except for any amounts due pursuant to this subrule.

a. *Institutionalized enrollees.* Medicaid enrollees who reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the exceptions allowed by 441—subrule 75.16(1) and the deductions allowed by 441—subrule 75.16(2).

b. *Noninstitutionalized enrollees.* Medicaid enrollees who do not reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the deductions required by 42 CFR Section 435.726(c) as amended to July 25, 1994, with maintenance needs amounts set at the following levels:

(1) The amount for the maintenance needs of the enrollee is set at 300 percent of the maximum SSI grant for an individual.

(2) The additional amount for the maintenance needs of a spouse at home is set at the Iowa Medicaid program's medically needy income standard for one person.

(3) The additional amount for the maintenance needs of a family at home is set at the Iowa Medicaid program's medically needy income standard for a family of the same size, to the extent that amount exceeds any amount allowed for the maintenance needs of a spouse at home.

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

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[◊] Two or more ARCs

¹ Effective date of 8/1/88 delayed 30 days by the Administrative Rules Review Committee at its July 1988 meeting.

² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

CHAPTER 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 an intellectual disability, a 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.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 2164C, IAB 9/30/15, effective 10/1/15]

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.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which:

1. Is made only when the onset of the person's condition was during the developmental period;
2. Is based on an assessment of the person's intellectual functioning and level of adaptive skills;
3. Is made by a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills; and
4. Is made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"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.

"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 intellectual disability, chronic mental illness or developmental disability; or
2. A child who is eligible to receive HCBS intellectual disability 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).

[ARC 7957B, IAB 7/15/09, effective 7/1/09]

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. The interdisciplinary team shall determine which of the following options will be included in the crisis intervention plan:

- After-hours contact information for all persons or resources identified for the member and an alternate contact to be used in the event that an individual provider not employed by an agency is not present to provide services as scheduled; or

- After-hours contact information for an on-call system for the provider of case management to ensure that in the event of an emergency, members have access to a case manager 24 hours per day, including weekends and holidays.

(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. E-mail contacts are allowed only when other means of communication are not feasible for the member, representative or family and the necessity for E-mail communication is documented in the member's comprehensive service plan. A copy of any written communication must be maintained in the case file. When E-mail communication is used, there must be clear two-way communication in the member's record showing an exchange of information as well as follow-up activity related to the information.
- (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, including but not limited to assertive community treatment (ACT).
- 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 management 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. Rescinded IAB 6/29/11, effective 9/1/11.

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; ARC 9588B, IAB 6/29/11, effective 9/1/11]

These rules are intended to implement Iowa Code sections 249A.4, 249A.26, and 249A.27.¹

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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.

CHAPTER 109
CHILD CARE CENTERS
[Filed as Chapter 108, 2/14/75 and renumbered 7/1/75]
[Prior to 7/1/83, Social Services[770] Ch 109]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The intent of this chapter is to specify minimum requirements for licensed child care centers and preschools and to define those child-caring environments that are governed by the licensing standards. The licensing standards govern licensing procedures, administration, parental participation, personnel, records, health and safety policies, physical facilities, activity programs, and food services.

441—109.1(237A) Definitions.

“*Adult*” means a person 18 years of age or older.

“*Child*” means either of the following:

1. A person 12 years of age or younger.

2. A person 13 years of age or older but younger than 19 years of age who has a developmental disability, as defined under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, Public Law No. 106-402, codified in 42 U.S.C. 15002(8).

“*Child care*” means the care, supervision, or guidance of a child by a person other than the parent, guardian, or custodian for periods of less than 24 hours per day per child on a regular basis in a place other than the child’s home, but does not include care, supervision, or guidance of a child by any of the following:

1. An instructional program administered by a public or nonpublic school system accredited by the department of education or the state board of regents.

2. Any of the following church-related programs:

• An instructional program.

• A youth program other than a preschool, before or after school child care program, or other child care program.

• A program providing care to children on church premises while the children’s parents are attending church-related or church-sponsored activities on the church premises.

3. Short-term classes of less than two weeks’ duration held between school terms or during a break within a school term.

4. A child care center for sick children operated as part of a pediatrics unit in a hospital licensed by the department of inspections and appeals pursuant to Iowa Code chapter 135B.

5. A program operated not more than one day per week by volunteers that meets all the following conditions:

• Not more than 11 children are served per volunteer.

• The program operates for less than 4 hours during any 24-hour period.

• The program is provided at no cost to the children’s parent, guardian, or custodian.

6. A nationally accredited camp.

7. A program administered by a political subdivision of the state which is primarily for recreational or social purposes and is limited to children who are five years of age or older and attending school.

8. An instructional program for children at least four years of age who are attending prekindergarten, as defined by the state board of education, or a higher grade level, administered by a nonpublic school system which is not accredited by the department of education or the state board of regents.

9. An after-school program continuously offered throughout the school year to children who are at least five years of age and enrolled in school and attend the program intermittently, or a summer-only program for such children. The program must be provided through a nominal membership fee or at no cost.

10. A special activity program which meets less than four hours per day for the sole purpose of the special activity. Special activity programs include but are not limited to music or dance classes,

organized athletic or sports programs, recreational classes, scouting programs, and hobby or craft clubs or classes.

11. A structured program for the purpose of providing therapeutic, rehabilitative, or supervisory services to children under any of the following:

- A purchase of service or managed care contract with the department.
- A contract approved by a local decategorization governance board.
- An arrangement approved by a juvenile court order.

12. Care provided on site to children of parents residing in an emergency, homeless, or domestic violence shelter.

13. A child care facility providing respite care to a licensed foster family home for a period of 24 hours or more to a child who is placed with that licensed foster family home.

14. A program offered to a child whose parent, guardian, or custodian is engaged solely in a recreational or social activity, remains immediately available and accessible on the physical premises on which the child's care is provided, and does not engage in employment while the care is provided. However, if the recreational or social activity is provided in a fitness center or on the premises of a nonprofit organization, the parent, guardian, or custodian of the child may be employed to teach or lead the activity.

"Child care center" or *"center"* means a facility providing child day care for seven or more children, except when the facility is registered as a child development home. For the purposes of this chapter, the word "center" shall apply to a child care center or preschool, unless otherwise specified.

"Child care facility" or *"facility"* means a child care center, a preschool, or a registered child development home.

"Department" means the department of human services.

"Direct responsibility for child care" means being charged with the care, supervision, or guidance of a child.

"Extended evening care" means child care provided by a child care center between the hours of 9 p.m. and 5 a.m.

"Facility" means a building or physical plant established for the purpose of providing child day care.

"Get-well center" means a facility that cares for a child with an acute illness of short duration for short enrollment periods.

"Involvement with child care" means licensed or registered as a child care facility, employed in a child care facility, residing in a child care facility, receiving public funding for providing child care, providing child care as a child care home provider, or residing in a child care home.

"National Health and Safety Performance Standards" means the National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs produced by the American Public Health Association and the American Academy of Pediatrics with the support of the Maternal and Child Health Bureau, Department of Health and Human Services.

"Parent" means parent or legal guardian.

"Person subject to an evaluation" means a person who has committed a transgression and who is described by any of the following:

1. The person is being considered for licensure or is licensed.
2. The person is being considered by a child care facility for employment involving direct responsibility for a child or with access to a child when the child is alone, or the person is employed with such responsibilities.
3. The person will reside or resides in a child care facility.
4. The person has applied for or receives public funding for providing child care.

"Preschool" means a child day care facility which provides care to children aged three through five, for periods of time not exceeding three hours per day. The preschool's program is designed to help the children develop intellectual, social and motor skills, and to extend their interest in and understanding of the world about them.

"Regulatory fee" means the amount payable to the department for licensure of a child care center based on the capacity of the center.

“Requesting entity” means an entity covered by these rules that is requesting an evaluation to determine if the person being evaluated can have involvement with child care. The requesting entity must be a child care facility as defined in Iowa Code chapter 237A.

“Transgression” means the existence of any of the following in a person’s record:

1. Conviction of a crime.
2. A record of having committed founded child or dependent adult abuse.
3. Listing in the sex offender registry established under Iowa Code chapter 692A.
4. A record of having committed a public or civil offense.
5. Department revocation or denial of a child care facility registration or license due to the person’s continued or repeated failure to operate the child care facility in compliance with licensing and registration laws and rules.

“Unrestricted access” means that a person has contact with a child alone or is directly responsible for child care.

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 0030C, IAB 3/7/12, effective 5/1/12; ARC 1809C, IAB 1/7/15, effective 3/1/15; ARC 2169C, IAB 9/30/15, effective 1/1/16]

441—109.2(237A) Licensure procedures.

109.2(1) Application for license.

a. Any adult or agency has the right to apply for a license. The application for a license shall be made to the department on Form 470-0722, Application for a License to Operate a Child Care Center, provided by the department.

b. Requested reports including the fire marshal’s report and other information relevant to the licensing determination shall be furnished to the department upon application and renewal. A building owned or leased by a school district or accredited nonpublic school that complies with rules adopted by the state fire marshal for school buildings under 661—Chapter 5 is considered appropriate for use by a child care facility.

c. When a center makes a sufficient application for an initial license, it may operate for a period of up to 120 calendar days from the date of issuance of Form 470-4690, Permission to Open Without a License, pending a final licensing decision. A center has made a sufficient application when it has submitted the following to the department:

- (1) An application for a license.
- (2) An approved fire marshal’s report.
- (3) A floor plan indicating room descriptions and dimensions, including location of windows and doors.
- (4) Information sufficient to determine that the center director meets minimum personnel qualifications.

d. Applicants shall be notified of approval or denial of initial applications within 120 days from the date the application is submitted.

(1) If the applicant has been issued Form 470-4690, Permission to Open Without a License, the applicant shall be notified of approval or denial within 120 calendar days of the date of issuance of Form 470-4690.

(2) No full or provisional license shall be issued before payment of the applicable regulatory fee as determined pursuant to subrule 109.2(7).

e. The department shall not act on a licensing application for 12 months after an applicant’s child care center license has been denied or revoked.

f. When the department has denied or revoked a license, the applicant or person shall be prohibited from involvement with child care unless the department specifically permits involvement through a record check decision.

109.2(2) License.

a. An applicant showing full compliance with center licensing laws and these rules, including department approval of center plans and procedures and submission of the regulatory fee as specified in subrule 109.2(7) to the department by the date due, shall be issued a license for 24 months. In determining

whether or not a center is in compliance with the intent of a licensing standard outlined in this chapter, the department shall make the final decision.

b. A new license shall be applied for when the center moves, expands, or the facility is remodeled to change licensed capacity.

c. A new license shall be applied for when another adult or agency assumes ownership or legal responsibility for the center.

109.2(3) *Provisional license.*

a. A provisional license may be issued or a previously issued license may be reduced to a provisional license for a period up to one year when the center does not meet all standards imposed by law and these rules.

b. A provisional license shall be renewable when written plans giving specific dates for completion to bring the center up to standards are submitted to and approved by the department. A provisional license shall not be reissued for more than two consecutive years when the lack of compliance with the same standards has not been corrected within two years.

c. When the center submits documentation or it can otherwise be verified that the center fully complies with all standards imposed by law or these rules, the license shall be upgraded to a full license.

109.2(4) *Denial.* Initial applications or renewals shall be denied when:

a. The center does not comply with center licensing laws and these rules in order to qualify for a full or provisional license.

b. The center is operating in a manner which the department determines impairs the safety, health, or well-being of children in care.

c. A person subject to an evaluation has transgressions that merit prohibition of involvement with child care and of licensure, as determined by the department.

d. Information provided either orally or in writing to the department or contained in the center's files is shown to have been falsified by the provider or with the provider's knowledge.

e. The center is not able to obtain an approved fire marshal's certificate as prescribed by the state fire marshal in 661—Chapter 5 or Iowa Code chapter 100 or fails to comply in correcting or repairing any deficiencies in the time determined by the fire marshal or the fire marshal determines the facility is not safe for occupancy.

f. The regulatory fee as specified in subrule 109.2(7) is not received by the department's division of fiscal management by the due date indicated on Form 470-4834, Child Care Center Licensing Fee Invoice.

109.2(5) *Revocation and suspension.* A license shall be revoked or suspended if corrective action has not been taken when:

a. The center does not comply with center licensing laws or these rules.

b. The center is operating in a manner which the department determines impairs the safety, health, or well-being of the children in care.

c. A person subject to an evaluation has transgressions that merit prohibition of involvement with child care and of licensure, as determined by the department.

d. Information provided to the department or contained in the center's files is shown to have been falsified by the provider or with the provider's knowledge.

e. The facility is not able to obtain an approved fire marshal's certificate as prescribed by the state fire marshal in 661—Chapter 5 or Iowa Code chapter 100 or fails to comply in correcting or repairing any deficiencies in the time determined by the fire marshal or the fire marshal determines the facility is not safe for occupancy.

f. The regulatory fee as specified in subrule 109.2(7) is not paid in full due to insufficient funds to cover a check submitted to the department for the fee.

109.2(6) *Adverse actions.*

a. Notice of adverse actions for a denial, revocation, or suspension and the right to appeal the licensing decision shall be given to applicants and licensees in accordance with 441—Chapter 7.

b. An applicant or licensee affected by an adverse action may request a hearing by means of a written request directed to the Department of Human Services, Appeals Section, 1305 E. Walnut Street,

Fifth Floor, Des Moines, Iowa 50319-0114. The request shall be submitted within 30 days after the date the department mailed the official notice containing the nature of the denial, revocation, or suspension.

c. A letter received by an owner or director of a licensed center initiating action to deny, suspend, or revoke the facility's license shall be conspicuously posted at the main entrance to the facility where it can be read by parents or any member of the public. The letter shall remain posted until resolution of the action to deny, suspend or revoke the license. If the action to deny, suspend, or revoke is upheld, the center shall return the license to the department.

d. If the center's license is denied, suspended or revoked, the administrator of the department shall notify the parent, guardian, or legal custodian of each child for whom the facility provides child care. The center shall cooperate with the department in providing the names and address of the parent, guardian, or legal custodian of each child for whom the facility provides child care.

109.2(7) Regulatory fees. For relicensures with an effective date on or after August 1, 2010, as indicated on the license certificate, and for initial applications for licensure submitted on or after June 1, 2010, a fee based upon center capacity is due to the department before the issuance of the license in accordance with this subrule.

a. *Fee structure.* The amount of the fee is based on the capacity of the center as indicated below:

<u>Center Capacity</u>	<u>Fee Amount</u>
0 to 20 children	\$50
21 to 50 children	\$75
51 to 100 children	\$100
101 to 150 children	\$125
151 or more children	\$150

b. *Determination of capacity.* The licensing consultant shall determine center capacity by dividing the amount of usable space by the amount of space required per child, as specified in subrule 109.11(1) and subparagraphs 109.11(3)"a"(2) and (3). Upon approval by the department, the final determination of center capacity may include evaluation of other factors that influence capacity, as long as physical space requirements per child as defined in subrule 109.11(1) and subparagraphs 109.11(3)"a"(2) and (3) are maintained.

c. *Notification.* Upon final determination of center capacity by the licensing consultant, the licensing consultant or designee shall sign and provide Form 470-4834, Child Care Center Licensing Fee Invoice, to the center.

d. *Payment.* The center shall return Form 470-4834 to the department with the licensing fee payment within 30 calendar days from the date of the licensing consultant's or designee's signature on Form 470-4834. Payment may be in the form of cash, check, money order, or cashier's check.

(1) Payment must be received before the department will issue a full or provisional license.

(2) Regulatory fees are nonrefundable and nontransferrable.

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 1209C, IAB 12/11/13, effective 2/1/14]

441—109.3(237A) Inspection and evaluation. The department shall conduct an on-site visit in order to make a licensing recommendation for all initial and renewal applications for licensure and shall determine compliance with licensing standards imposed by licensing laws and these rules when a complaint is received.

109.3(1) At least one unannounced on-site visit shall be conducted each calendar year.

109.3(2) After each visit and complaint, the department shall document whether a center was in compliance with center licensing standards imposed by licensing laws and these rules.

109.3(3) The written documentation of the department's conclusion as to whether a center was in compliance with licensing standards for all licensing visits and complaints shall be available to the public. However, the identity of the complainant shall be withheld unless expressly waived by the complainant.

441—109.4(237A) Administration.

109.4(1) Purpose and objectives. Incorporated and unincorporated centers shall submit a written statement of purpose and objectives. The plan and practices of operation shall be consistent with this statement.

109.4(2) Required written policies. The child care center owner, board or director shall:

- a. Develop fee policies and financial agreements for the children served.
- b. Develop and implement policies for enrollment and discharge of children, field trips and non-center activities, transportation, discipline, nutrition, and health and safety policies.
- c. Develop a curriculum or program structure that uses developmentally appropriate practices and an activity program appropriate to the developmental level and needs of the children.
- d. Develop and implement a written plan for staff orientation to the center's policies and to the provisions of 441—Chapter 109 where applicable to staff.
- e. Develop and implement a written plan for ongoing training and staff development in compliance with professional growth and development requirements established by the department in rule 441—109.7(237A).
- f. Make available for review a copy of the center policies and program to all staff at the time of employment and each parent at the time a child is admitted to the center. A copy of the fee policies and financial agreements shall be provided to each parent at the time a child is admitted to the center.
- g. Develop and implement a policy for responding to incidents of biting that includes the following elements.
 - (1) An explanation of the center's perspective on biting.
 - (2) A description of how the center will respond to individual biting incidents and episodes of ongoing biting.
 - (3) A description of how the center will assess the adequacy of caregiver supervision and the context and the environment in which the biting occurred.
 - (4) A description of how the center will respond to the individual child or caregiver who was bitten.
 - (5) A description of the process for notification of parents of children involved in the incident.
 - (6) A description of how the incident will be documented.
 - (7) A description of how confidentiality will be protected.
 - (8) A description of first-aid procedures that the center will use in response to biting incidents.

h. Develop a policy to ensure that people do not have unauthorized access to children at the center.

The policy shall be subject to review for minimum safety standards by the licensing consultant. The policy shall include but is not limited to the following:

- (1) The center's criteria for allowing people to be on the property of the facility when children are present.
- (2) A description of how center staff will supervise and monitor people who are permitted on the property of the center when children are present, but who have not been cleared for involvement with child care through the formal record check process as outlined in subrule 109.6(6). The description shall include definitions of "supervision" and "monitoring."
- (3) A description of how responsibility for supervision and monitoring of people in the center will be delegated to center staff, which includes provisions that address conflicts of interest.
- (4) A description of how the policy will be shared with parents, guardians, and custodians of all children who are enrolled at the center.

109.4(3) Required postings.

- a. Postings are required for the certificate of license, notice of exposure of children to a communicable disease, and notice of action to deny, suspend, or revoke the center's license or reduce the center's license to a provisional status. The center's license, reflecting current regulatory status, and all other required postings shall be conspicuously placed at the main entrance to the center. If the center is located in a building used for additional purposes and shares the main entrance to the building, the required postings shall be conspicuously placed in the center in an area that is frequented daily by parents or the public.

b. Postings are required for mandatory reporter requirements, the notice of availability of the handbook required in subrule 109.4(5), and the program activities and shall be placed in an area that is frequented daily by parents or the public.

109.4(4) Mandatory reporters. Requirements and procedures for mandatory reporting of suspected child abuse as defined in Iowa Code section 232.69 shall be posted where they can be read by staff and parents. Methods of identifying and reporting suspected child abuse and neglect shall be discussed with all staff within 30 days of employment.

109.4(5) Handbook. A copy of Form SS-0711, Child Care Centers and Preschools Licensing Standards and Procedures, shall be available in the center, and a notice stating that a copy is available for review upon request from the center director shall be conspicuously posted. The name, office mailing address and telephone number of the child care consultant shall be included in the notice.

109.4(6) Certificate of license. The child care license shall be posted in a conspicuous place and shall state the particular premises in which child care may be offered and the number of children who may be cared for at any one time. Notwithstanding the requirements in rule 441—109.8(237A), no greater number of children than is authorized by the license shall be cared for at any one time.
[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 1209C, IAB 12/11/13, effective 2/1/14]

441—109.5(237A) Parental participation.

109.5(1) Unlimited access. Parents shall be afforded unlimited access to their children and to the provider caring for their children during the center's hours of operation or whenever their children are in the care of a provider, unless parental contact is prohibited by court order. The provider shall inform all parents of this policy in writing at the time the child is admitted to the center.

109.5(2) Parental evaluation. If requested by the department, centers shall assist the department in conducting an annual survey of parents being served by their center by providing to parents Form 470-3409, Parent Survey: Child Care Centers. The department shall notify centers of the time frames for distribution and completion of the survey and the procedures for returning the survey to the department. The purpose of the survey shall be to increase parents' understanding of developmentally appropriate and safe practice, solicit statewide information regarding parental satisfaction with the quality of care being provided to children and obtain the parents' perspective regarding the center's compliance with licensing requirements.

441—109.6(237A) Personnel. The board or director of the center shall develop policies for hiring and maintaining staff that demonstrate competence in working with children and that meet the following minimum requirements:

109.6(1) Center director requirements. Centers that have multiple sites shall have a center director or on-site supervisor in each center. The center director is responsible for the overall functions of the center, including supervising staff, designing curriculum and administering programs. The director shall ensure services are provided for the children within the framework of the licensing requirements and the center's statement of purpose and objectives. The center director shall have overall responsibility for carrying out the program and ensuring the safety and protection of the children. Information shall be submitted in writing to the child care consultant prior to the start of employment. Final determination shall be made by the department. Information shall be submitted sufficient to determine that the director meets the following minimum qualifications:

- a. Is at least 21 years of age.
- b. Has obtained a high school diploma or passed a general education development test.
- c. Has completed at least one course in business administration or 12 contact hours in administrative-related training related to personnel, supervision, record keeping, or budgeting or has one year of administrative-related experience.
- d. Has certification in infant, child, and adult cardiopulmonary resuscitation (CPR), first aid, and Iowa's training for the mandatory reporting of child abuse.
- e. Has achieved a total of 100 points obtained through a combination of education, experience, and child development-related training as outlined in the following chart:

EDUCATION		EXPERIENCE (Points multiplied by years of experience)		CHILD DEVELOPMENT-RELATED TRAINING
Bachelor's or higher degree in early childhood, child development, or elementary education	75	Full-time (20 hours or more per week) in a child care center or preschool setting	20	One point per contact hour of training
Associate's degree in child development or bachelor's degree in a child-related field	50	Part-time (less than 20 hours per week) in a child care center or preschool setting	10	
Child development associate (CDA) or one-year diploma in child development from a community college or technical school	40	Full-time (20 hours or more per week) child development-related experience	10	
Bachelor's degree in a non-child-related field	40	Part-time (less than 20 hours per week) child development-related experience	5	
Associate's degree in a non-child-related field or completion of at least two years of a four-year degree	20	Registered child development home provider	10	
		Nonregistered family home provider	5	

(1) In obtaining the total of 100 points, a minimum of two categories must be used, no more than 75 points may be achieved in any one category, and at least 20 points shall be obtained from the experience category.

(2) Points obtained in the child development-related training category shall have been taken within the past five years.

(3) For directors in centers predominantly serving children with special needs, the directors may substitute a disabilities-related or nursing degree for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, experience in working with children with special needs in an administrative or direct care capacity shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

(4) For directors in centers serving predominantly school-age children, the directors may substitute a degree in secondary education, physical education, recreation or related fields for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, child-related experience working with school-age children shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

109.6(2) On-site supervisor. The on-site supervisor is responsible for the daily supervision of the center and must be on site daily either during the hours of operation that children are present or a minimum of eight hours of the center's hours of operation. Information shall be submitted in writing to the child care consultant prior to the start of employment. Final determination shall be made by the department. Information shall be submitted sufficient to determine that the on-site supervisor meets the following minimum qualifications:

- a. Is an adult.
- b. Has obtained a high school diploma or passed a general education development test.
- c. Has certification in infant, child, and adult cardiopulmonary resuscitation (CPR), first aid, and Iowa's mandatory reporting of child abuse.
- d. Has achieved a total of 75 points obtained through a combination of education, experience, and child development-related training as outlined in the following chart:

EDUCATION		EXPERIENCE (Points multiplied by years of experience)		CHILD DEVELOPMENT-RELATED TRAINING
Bachelor's or higher degree in early childhood, child development, or elementary education	75	Full-time (20 hours or more per week) in a child care center or preschool setting	20	One point per contact hour of training
Associate's degree in child development or bachelor's degree in a child-related field	50	Part-time (less than 20 hours per week) in a child care center or preschool setting	10	
Child development associate (CDA) or one-year diploma in child development from a community college or technical school	40	Full-time (20 hours or more per week) child development-related experience	10	
Bachelor's degree in a non-child-related field	40	Part-time (less than 20 hours per week) child development-related experience	5	
Associate's degree in a non-child-related field or completion of at least two years of a four-year degree	20	Registered child development home provider	10	
		Nonregistered family home provider	5	

(1) In obtaining the total of 75 points, a minimum of two categories must be used, no more than 50 points may be achieved in any one category, and at least 10 points shall be obtained from the experience category.

(2) Points obtained in the child development-related training category shall have been taken within the past five years.

(3) For on-site supervisors in centers predominantly serving children with special needs, the on-site supervisor may substitute a disabilities-related or nursing degree for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, experience in working with children with special needs in an administrative or direct care capacity shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

(4) For on-site supervisors in centers serving predominantly school-age children, the on-site supervisor may substitute a degree in secondary education, physical education, recreation or related fields for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, child-related experience working with school-age children shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

109.6(3) Director and on-site supervisor functions combined. In a center where the functions of the center director and the on-site supervisor are accomplished by the same person, the educational and experience requirements for a center director shall apply. If the center director is serving in the role of the on-site supervisor, the director shall be on site daily either during the hours of operation or a minimum of at least eight hours of the center's hours of operation. If the staff person designated as the on-site supervisor is temporarily absent from the center, another responsible adult staff shall be designated as the interim on-site supervisor.

109.6(4) Transition period for staff. In achieving the qualifications outlined in rule 441—109.6(237A), staff hired prior to April 1, 1998, shall obtain the education, experience or child-developmental training sufficient to meet the required point totals by April 1, 1999.

109.6(5) Volunteers and substitutes. A volunteer shall be at least 16 years of age. All volunteers and substitutes shall:

a. Sign a statement indicating whether or not they have one of the following:

(1) A conviction of any law in any state or any record of founded child abuse or dependent adult abuse in any state.

(2) A communicable disease or other health concern that could pose a threat to the health, safety, or well-being of the children.

b. Sign a statement indicating the volunteer or substitute has been informed of the volunteer's or substitute's responsibilities as a mandatory reporter.

c. Undergo the record check process when any of the following criteria are met:

(1) The volunteer or substitute is included in meeting the required child-to-staff ratio;

(2) The volunteer or substitute has direct responsibility for a child or children; or

(3) The volunteer or substitute has access to a child or children with no other staff present.

d. Have on file at the facility a record containing the statements required in paragraphs 109.6(5)"a" and "b" and documentation of any record check process. The record shall be maintained as required in paragraph 109.9(1)"b."

109.6(6) Record checks.

a. *Applicability.*

(1) Criminal and child abuse record checks shall be conducted for:

1. Each owner, director, staff member, substitute, volunteer, or subcontracted staff person with direct responsibility for child care or with access to a child when the child is alone;

2. Anyone living in the child care facility who is 14 years of age or older.

(2) Parents, guardians, and custodians are exempt from the record check process in relation to access to their own children or wards.

(3) Professional staff who hold a current, valid license issued by the educational examiners board are exempt from the record check process in relation to children in the center to whom they provide professional services consistent with Iowa Code chapter 272 and rules adopted by the educational examiners board.

b. *Authorization.* A requesting entity shall request a record check evaluation prior to the employment of a person subject to record checks. The person subject to record checks shall complete the DHS criminal history record check form and any other forms required by the department of public safety to authorize the release of records.

c. *Iowa records checks.* Checks and evaluations of Iowa child abuse and criminal records, including the sex offender registry, shall be completed before the person's involvement with child care at the center. Iowa records checks shall be repeated at a minimum of every two years and when the department or the center becomes aware of any possible transgressions. The department is not responsible for the cost of conducting the Iowa records check.

(1) The child care center may access the single-contact repository (SING) as necessary to conduct a criminal and child abuse record check of the person in Iowa. If the results of the check indicate a potential transgression, the center shall send a copy of the results to the department for determination of whether or not the person may be involved with child care, regardless of the person's status with the center.

(2) Unless a record check has already been conducted in accordance with subparagraph (1), the department shall conduct a criminal and child abuse record check in Iowa for a person who is subject to a record check. When the department conducts the records check, the fee shall be \$25 for each record check through June 30, 2010, and \$35 effective July 1, 2010. The center shall submit the fee before the department initiates the record check process. Payment must be in the form of cash, check, money order, or cashier's check. The department may access SING to conduct the records check. The department may also conduct dependent adult abuse, sex offender, and other public or civil offense record checks in Iowa for a person who is subject to a record check.

(3) Centers that participate in student intern programs may seek a waiver for substitution of the state record check process with a check performed by the student's educational institution. Requests for a waiver shall be submitted on Form 470-4893, Record Check Waiver, to the address listed on the form.

d. *National criminal history checks.* National criminal history checks based on fingerprints are required for all persons subject to record checks under this subrule effective with a center's initial licensure or relicensure on or after June 1, 2010. The national criminal history check shall be repeated for each person every four years and when the department or center becomes aware of any new

transgressions committed by that person in another state. The department is not responsible for the cost of conducting the national criminal history check.

(1) The child care center is responsible for obtaining the fingerprints of all persons subject to record checks. Fingerprints may be taken by law enforcement agencies, by agencies or companies that specialize in taking fingerprints, or by center staff or subcontractors who have received appropriate training in the taking of fingerprints.

(2) If the results of the Iowa records checks do not warrant prohibition of the person's involvement with child care or otherwise present protective concerns, the person may be involved with child care on a provisional basis until the national criminal history check and evaluation have been completed.

(3) The child care center shall provide fingerprints to the department of public safety no later than 30 days after the subject's approval for employment at the center. The center shall submit the fingerprints on forms or in a manner allowed by the department of public safety.

(4) Centers that are required to submit fingerprint-based checks of the FBI national criminal database to comply with federal regulations may seek a waiver to substitute that record check for the procedure required in this subrule. Requests for a waiver shall be submitted on Form 470-4893, Record Check Waiver, to the address listed on the form.

(5) Centers that participate in student intern programs may seek a waiver to substitute the fingerprint-based check of the FBI national criminal database performed by the student's educational institution for the procedure required in this subrule. Requests for a waiver shall be submitted on Form 470-4893, Record Check Waiver, to the address listed on the form.

(6) A center considering involvement of a person who has had a national criminal history check at another center may request information from that center. That center may provide the following information in writing upon a center's request, using Form 470-4896, National Criminal History Check Confirmation:

1. Date of most recent national criminal history check conducted by the center on the person in question, and

2. Whether or not the national check process resulted in clearance of the person for involvement with child care.

(7) If the results of the national criminal history check indicate that the person has committed a transgression, the center, if interested in continuing the person's involvement in child care, shall send a copy of the results to the department for evaluation. The department shall determine whether or not the person may be involved with child care.

(8) A center shall submit all required fingerprints to the department of public safety before the issuance or renewal of the center's license on or after June 1, 2010. EXCEPTION: Centers that have an initial or renewal licensure date of June 1, 2010, shall have until July 1, 2010, to submit the fingerprints to the department of public safety.

e. *Mandatory prohibition.* A person with the following convictions or founded abuse reports is prohibited from involvement with child care:

(1) Founded child or dependent adult abuse that was determined to be sexual abuse.

(2) Placement on the sex offender registry.

(3) Felony child endangerment or neglect or abandonment of a dependent person.

(4) Felony domestic abuse.

(5) Felony crime against a child including, but not limited to, sexual exploitation of a minor.

(6) Forcible felony.

f. *Mandatory time-limited prohibition.*

(1) A person with the following convictions or founded abuse reports is prohibited from involvement with child care for five years from the date of the conviction or founded abuse report:

1. Conviction of a controlled substance offense under Iowa Code chapter 124.

2. Founded child abuse that was determined to be physical abuse.

(2) After the five-year prohibition period imposed pursuant to 109.6(6)"f"(1), the person may request the department to perform an evaluation under paragraph 109.6(6)"g" to determine whether prohibition of the person's involvement with child care continues to be warranted.

g. *Evaluation required.* For all other transgressions, and as requested under subparagraph 109.6(6)“f”(2), the department shall notify the requesting entity that an evaluation shall be conducted to determine whether prohibition of the person’s involvement with child care is warranted.

(1) The person with the transgression shall complete the record check evaluation form. The requesting entity shall provide the form and any other documents to the department within ten calendar days of the date on the form. The department shall use the information the person with the transgression provides on this form to assist in the evaluation. Failure of the person with the transgression to complete and the requesting entity to return this form by the specified date shall result in denial or revocation of the license or denial of employment. The department shall not process evaluations that are not signed by the person subject to an evaluation.

(2) The department may use information from the department’s case records in performing the evaluation.

(3) The requesting entity may provide, or the department may request from the person subject to an evaluation or from the requesting entity, information to assist in performance of the evaluation that includes, but is not limited to, the following:

1. Documentation of criminal justice proceedings.
2. Documentation of rehabilitation.
3. Written employment references or applications.
4. Documentation of substance abuse education or treatment.
5. Criminal history records, child abuse information, and dependent adult abuse information from other states.
6. Documentation of the person’s prior residences.

(4) Any person or agency that might have pertinent information regarding criminal or abuse history and rehabilitation of the prospective employee may be contacted.

(5) In an evaluation, the department shall consider all of the following factors:

1. The nature and seriousness of the transgression in relation to the position sought or held.
2. The time elapsed since the commission of the transgression.
3. The circumstances under which the transgression was committed.
4. The degree of rehabilitation.
5. The likelihood that the person will commit the transgression again.
6. The number of transgressions committed by the person.

(6) When a person subject to a record check has a transgression that has been determined in a previous evaluation not to warrant prohibition of the person’s involvement with child care and has no subsequent transgressions, an exemption from reevaluation of the latest record check is authorized. The person may commence employment with another child care facility in accordance with the department’s previous evaluation. The exemption is subject to all of the following conditions:

1. The person’s position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

2. Any restrictions placed on the person’s employment by the department in the previous evaluation shall remain applicable in the person’s subsequent employment.

3. The person subject to the record check has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer, or the previous employer provides to the subsequent employer the previous evaluation from the person’s personnel file pursuant to the person’s authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, the record check shall be reevaluated.

4. The subsequent employer may request a reevaluation of the record check and may employ the person while the reevaluation is being performed.

h. *Evaluation decision.* Within 30 days of receipt of a completed record check evaluation, the department shall make a decision on the person’s involvement with child care. The department has final authority in determining whether prohibition of the person’s involvement with child care is warranted and in developing any conditional requirements and corrective action plan under this paragraph.

(1) The department shall mail to the requesting entity and the person on whom the evaluation was completed the record check decision that explains the decision reached regarding the evaluation of the transgression.

(2) If the department determines through an evaluation of a person's transgressions that the person's prohibition of involvement with child care is warranted, the person shall be prohibited from involvement with child care. The department may identify a period of time after which the person may request that another record check and evaluation be performed.

(3) The department may permit a person who is evaluated to maintain involvement with child care if the person complies with the department's conditions and corrective action plan relating to the person's involvement with child care.

(4) The department shall send a letter to the employer that informs the employer whether the person subject to an evaluation has been approved or denied involvement with child care. If the person has been approved, the letter shall inform the employer of any conditions and corrective action plan relating to the person's involvement with child care.

i. *Notice to parents.* The administrator of the department shall notify the parents, guardians, and legal custodians of each child for whom the person provides child care if there has been founded child abuse committed by an owner, director, or staff member of the child care center. The center shall cooperate with the department in providing the names and addresses of the parents, guardians, and legal custodians of each child for whom the facility provides child care.

109.6(7) Use of controlled substances and medications. All owners, personnel, and volunteers shall be free of the use of illegal drugs and shall not be under the influence of alcohol or of any prescription or nonprescription drug that could impair their ability to function.

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 9441B, IAB 4/6/11, effective 6/1/11; ARC 0418C, IAB 10/31/12, effective 1/1/13; ARC 1209C, IAB 12/11/13, effective 2/1/14; ARC 1809C, IAB 1/7/15, effective 3/1/15]

441—109.7(237A) Professional growth and development. The center director, on-site supervisor, and staff counted as part of the staff ratio shall meet the following minimum staff training requirements:

109.7(1) Required training within the first six months of employment. During their first six months of employment, all staff shall receive the following training:

- a. Two hours of Iowa's training for mandatory reporting of child abuse.
- b. At least one hour of training regarding universal precautions and infectious disease control.

109.7(2) Center directors and staff employed 20 hours or more per week. The requirements of this subrule apply to all center directors, regardless of whether the director works on a full-time or part-time basis.

a. During their first year of employment, all center directors and all staff employed 20 hours or more per week shall receive the following training:

(1) Certification in American Red Cross or American Heart Association infant, child, and adult cardiopulmonary resuscitation (CPR) or equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

(2) Certification in infant, child, and adult first aid that uses a nationally recognized curriculum or is received from a nationally recognized training organization including the American Red Cross, American Heart Association, the National Safety Council, and Emergency Medical Planning (Medic First Aid) or an equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

- (3) Ten contact hours of training from one or more of the following content areas:
1. Planning a safe, healthy learning environment (includes nutrition).
 2. Steps to advance children's physical and intellectual development.
 3. Positive ways to support children's social and emotional development (includes guidance and discipline).
 4. Strategies to establish productive relationships with families (includes communication skills and cross-cultural competence).
 5. Strategies to manage an effective program operation (includes business practices).

6. Maintaining a commitment to professionalism.
7. Observing and recording children's behavior.
8. Principles of child growth and development.

(4) At least four hours of the ten contact hours of training shall be received in a group setting as defined in subrule 109.7(7). Six hours may be received in self-study using a training package approved by the department as defined in subrule 109.7(8). Training received for cardiopulmonary resuscitation (CPR), first aid, mandatory reporting of child abuse, and universal precautions shall not count toward the ten contact hours. A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

(5) Center directors and on-site supervisors shall receive all ten hours of training in a group setting as defined in subrule 109.7(7).

(6) Staff who have completed a comprehensive training package of at least ten contact hours offered through a child care resource and referral agency or community college within six months prior to initial employment shall have the first year's ten contact hours of training waived.

b. Following their first year of employment, all center directors and all staff who are employed 20 hours or more a week shall:

(1) Maintain current certification for Iowa's training for the mandatory reporting of child abuse; infant, child and adult CPR; and infant, child and adult first aid.

(2) Receive six contact hours of training annually from one or more of the content areas listed in subparagraph 109.7(2) "a"(3). A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

(3) Center directors and on-site supervisors shall receive eight contact hours of training annually from one or more of the content areas listed in subparagraph 109.7(2) "a"(3). At least four of the eight contact hours shall be in a group setting as defined in subrule 109.7(7).

109.7(3) Staff employed less than 20 hours per week.

a. During their first year of employment, all staff who are employed less than 20 hours a week shall receive the following training:

(1) Five contact hours of training from one or more of the following topical areas: child development, guidance and discipline, developmentally appropriate practices, nutrition, health and safety, communication skills, professionalism, business practices, and cross-cultural competence.

(2) At least two of the five contact hours shall be in a sponsored group setting.

(3) Staff who have completed a comprehensive training package of at least ten contact hours offered through a child care resource and referral agency or community college within six months prior to initial employment shall have the five contact hours required in the first year waived.

b. Following their first year of employment, all staff who are employed less than 20 hours a week shall:

(1) Maintain current certification for Iowa's training for mandatory reporting of child abuse.

(2) Receive four contact hours of training annually from one or more of the following topical areas: child development, guidance and discipline, developmentally appropriate practices, nutrition, health and safety, communication skills, professionalism, business practices, and cross-cultural competence. At least two of the four contact hours shall be in a sponsored group setting.

109.7(4) Staff employed in centers that operate summer-only programs. Staff who are employed in centers that operate only in the summer months when school is not in session shall receive the following training:

a. Two hours of Iowa's training for mandatory reporting of child abuse.

b. At least one hour of training regarding universal precautions and infectious disease control.

c. At least one staff person on duty in the center and outdoor play area when children are present and on field trips shall have certification in American Red Cross or American Heart Association infant, child, and adult cardiopulmonary resuscitation (CPR) or equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

d. At least one staff person on duty in the center and outdoor play area when children are present and on field trips shall receive certification in infant, child and adult first aid that uses a nationally

recognized curriculum or is received from a nationally recognized training organization including the American Red Cross, American Heart Association, the National Safety Council, and Emergency Medical Planning (Medic First Aid) or an equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

109.7(5) Training plans. Training shall supplement educational and experience requirements in rule 441—109.6(237A) and shall enhance the staff's skill in working with the developmental and cultural characteristics of the children served.

109.7(6) Substitution. A provider who submits documentation from a child care resource and referral agency that the provider has completed the Iowa Program for Infant/Toddler Care (IA PITC), ChildNet, or Beyond Business Basics training series may use those hours to fulfill a maximum of two years' training requirements, not including first-aid and mandatory reporter training.

109.7(7) Group training. Training received in a group setting is not self-study, but is training received with other adults, either in or out of the child care center.

a. The training must be conducted by a trainer who is employed by or under contract with one of the following entities or who uses curriculum or training materials developed or obtained with the written permission of one of the following entities:

- (1) An accredited university or college.
- (2) A community college.
- (3) Iowa State University Extension.
- (4) A child care resource and referral agency.
- (5) An area education agency.
- (6) The regents' center for early developmental education at the University of Northern Iowa.
- (7) A hospital (for health and safety, first-aid, and CPR training).
- (8) The American Red Cross, the American Heart Association, the National Safety Council, or Medic First Aid (for first-aid and CPR training).
- (9) An Iowa professional association, including the Iowa Association for the Education of Young Children (Iowa AEYC), the Iowa Family Child Care Association (IFCCA), the Iowa After School Alliance, and the Iowa Head Start Association.
- (10) A national professional association, including the National Association for the Education of Young Children (NAEYC), the National Child Care Association (NCCA), the National Association for Family Child Care (NAFCC), the National After School Association, and the American Academy of Pediatrics.
- (11) The Child and Adult Care Food Program and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).
- (12) The Iowa department of public health, department of education, or department of human services.

b. Training received in a group setting must follow a presentation format that incorporates a variety of adult learning methods. The material or content of the training must be obtained from one of the entities listed in paragraph "a" or an entity approved under paragraph "g." Approved training shall be made available to Iowa child care providers through the child care provider training registry beginning July 1, 2009.

c. Training received in a group setting may include distance learning opportunities such as training conducted over the Iowa communications network, on-line courses, or Web conferencing (webinars) if:

- (1) The training meets the requirements in subrule 109.7(9);
 - (2) The training is taught by an instructor and requires interaction between the instructor and the participants, such as required chats or message boards; and
 - (3) The training organization meets the requirements listed in this subrule or is approved by the department.
- d. The department will not approve more than eight hours of training delivered in a single day.
- e. The department may randomly monitor any state-approved training for quality control purposes.

f. Training conducted with staff either during the hours of operation of the facility, staff lunch hours, or while children are resting must not diminish the required staff ratio coverage. Staff shall not be actively engaged in care and supervision and simultaneously participate in training.

g. A training organization not approved by the department may submit training for approval to the department on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

109.7(8) *Self-study training.*

a. Self-study training packages approved by the department include curriculum developed and materials distributed by:

- (1) Department child care licensing consultants,
- (2) Iowa State University Extension, or
- (3) A child care resource and referral agency.

b. Self-study training materials not distributed by these entities may be submitted by the training organization to the department for approval on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

109.7(9) *Approved training.* Training provided to Iowa child care providers shall offer:

a. Instruction that is consistent with:

- (1) Iowa child care regulatory standards;
- (2) The Iowa early learning standards; and

(3) The philosophy of developmentally appropriate practice as defined by the National Association for the Education of Young Children, the Program for Infant/Toddler Care, and the National Health and Safety Performance Standards.

b. Content equal to at least one contact hour of training.

c. An opportunity for ongoing interaction and timely feedback, including questions and answers within the contact hours if training is delivered in a group setting.

d. A certificate of training for each participant that includes:

- (1) The name of the participant.
- (2) The title of the training.
- (3) The dates of training.
- (4) The content area addressed.
- (5) The name of the training organization.
- (6) The name of the instructor.
- (7) The number of contact hours.

(8) An indication of whether the training was delivered through self-study or in a group setting.

[ARC 8650B, IAB 4/7/10, effective 6/1/10]

441—109.8(237A) Staff ratio requirements.

109.8(1) *Staff requirements.* Persons counted as part of the staff ratio shall meet the following requirements:

a. Be at least 16 years of age. If less than 18 years of age, the staff shall be under the direct supervision of an adult.

b. Be involved with children in programming activities.

c. At least one staff person on duty in the center and outdoor play area when children are present and present on field trips shall be over the age of 18 and hold current certification in first aid and cardiopulmonary resuscitation (CPR) as required in rule 441—109.7(237A).

109.8(2) *Staff ratio.* The staff-to-child ratio shall be as follows:

<u>Age of children</u>	<u>Minimum ratio of staff to children</u>
Two weeks to two years	One to every four children
Two years	One to every six children
Three years	One to every eight children
Four years	One to every twelve children
Five years to ten years	One to every fifteen children
Ten years and over	One to every twenty children

a. Combinations of age groupings for children four years of age and older may be allowed and may have staff ratio determined on the age of the majority of the children in the group. If children three years of age and under are included in the combined age group, the staff ratio for children aged three and under shall be maintained for these children. Preschools shall have staff ratios determined on the age of the majority of the children, including children who are three years of age.

b. If a child between the ages of 18 and 24 months is placed outside the infant area, as defined at subrule 109.11(2), the staff ratio of 1 to 4 shall be maintained as would otherwise be required for the group until the child reaches the age of two.

c. Every child-occupied program room shall have adult supervision present in the room.

d. During nap time, at least one staff shall be present in every room where children are resting. Staff ratio requirements may be reduced to one staff per room where children are resting for a period of time not to exceed one hour provided staff ratio coverage can be maintained in the center. The staff ratio shall always be maintained in the infant area.

e. The minimum staff ratio shall be maintained at mealtimes and for any outdoor activities at the center.

f. When seven or more children over the age of three are present on the licensed premises or are being transported in one vehicle, at least two adult staff shall be present. Only one adult is required when a center is transporting children in a center-owned vehicle with parent authorization for the sole purpose of transporting children to and from school. When a center contracts with another entity to provide transportation other than for the purpose of transporting school-age children to or from school, at least one adult staff in addition to the driver shall be present if at least seven children provided care by the center are transported.

g. Any child care center-sponsored program activity involving five or more children conducted away from the licensed facility shall provide a minimum of one additional staff over the required staff ratio for the protection of the children.

h. For a period of two hours or less at the beginning or end of the center's hours of operation, one staff may care for six children or less, provided no more than two of the children are under the age of two years.

i. For centers or preschools serving school-age children, the ratio for school-age children may be exceeded for a period of no more than four hours during a day when school classes start late or are dismissed early due to inclement weather or structural damage provided the children are already enrolled at the center and the center does not exceed the licensed capacity.

441—109.9(237A) Records.

109.9(1) Personnel records. The center shall maintain personnel information sufficient to ensure that persons employed in the center meet minimum staff and training requirements and do not pose any threat to the health, safety, or well-being of the children. Each employee's file shall contain, at a minimum, the following:

a. A statement signed by each individual indicating whether or not the individual has any conviction of violating any law in any state or has any record of founded child abuse or dependent adult abuse in any state.

b. Copies of all records checks kept in accordance with state and federal law regarding confidentiality of records checks. These records shall include:

(1) A copy of Form 595-1396, DHS Criminal History Record Check Form B, or any other permission form approved by the department of public safety for conducting an Iowa or national criminal history record check.

(2) A copy of Form 470-0643, Request for Child Abuse Information, when applicable.

(3) Copies of the results of Iowa records checks conducted through the SING for review by the department upon request.

(4) Copies of national criminal history check results.

(5) Any department-issued documents sent to the center related to a records check, regardless of findings.

c. Reserved.

d. A physical examination report. Personnel shall have good health as evidenced by a preemployment physical examination. Acceptable physical examinations shall be documented on Form 470-5152, Child Care Provider Physical Examination Report. The examination shall include any necessary testing for communicable diseases; shall include a discussion regarding current Advisory Committee on Immunization Practices (ACIP)-recommended vaccinations; shall be performed within six months prior to beginning employment by a licensed medical doctor, doctor of osteopathy, physician assistant or advanced registered nurse practitioner; and shall be repeated at least every three years.

e. Documentation showing the minimum staff training requirements as outlined at rule 441—109.7(237A) are met, including current certifications in first aid and cardiopulmonary resuscitation (CPR) and Iowa's training for the mandatory reporting of child abuse.

f. A photocopy of a valid driver's license if the staff will be involved in the transportation of children.

109.9(2) *Child's file.* Centers shall maintain sufficient information in a file for each child, which shall be updated at least annually or when the parent notifies the center of a change or the center becomes aware of a change, to ensure that:

a. A parent or an emergency contact authorized by the parent can be contacted at any time the child is in the care of the center.

b. Appropriate emergency medical and dental services can be secured for the child while in the center's care.

c. Information is available in the center regarding the specific health and medical needs of a child, including information regarding any professionally prescribed treatment. Information shall include a physical examination report as required at subrule 109.10(1). For a center serving school-age children that operates in the same school facility in which the child attends school, documentation shall include a statement signed by the parent that the immunization information is available in the school file.

d. A child is released only to authorized persons.

e. Documentation of injuries, accidents, or other incidents involving the child is maintained.

f. Parent authorization is obtained for a child to attend center-sponsored field trips and non-center activities. If parental authorization is obtained on an authorization form inclusive of all children participating in the activity, the authorization form shall be kept on file at the center.

109.9(3) *Immunization certificates.* Signed and dated Iowa immunization certificates, provided by the state department of public health, shall be on file for each child enrolled as prescribed by the department of public health at 641—Chapter 7.

109.9(4) *Daily activities.* For each child under two years of age, the center shall make a daily written record. At the end of the child's day at the center, the daily written record shall be provided verbally or in writing to the parent or the person who removes the child from the center. The record shall contain information on each of these areas:

a. The time periods in which the child has slept.

b. The amount of food consumed and the times at which the child has eaten.

c. The time of and any irregularities in the child's elimination patterns.

d. The general disposition of the child.

e. A general summary of the activities in which the child participated.

441—109.10(237A) Health and safety policies. The child care center shall establish definite health policies, including the criteria for excluding a sick child from the center. The policies shall be consistent with the recommendations of the National Health and Safety Performance Standards and shall include, but are not limited to:

109.10(1) Physical examination report.

a. *Preschool-age children.* For each child five years of age and younger not enrolled in kindergarten, the child care center shall require an admission physical examination report, submitted within 30 days from the date of admission, signed by a licensed medical doctor, doctor of osteopathy, physician's assistant or advanced registered nurse practitioner. The date of the physical examination shall be no more than 12 months prior to the first day of attendance at the center. The written report shall include past health history, status of present health including allergies, medications, and acute or chronic conditions, and recommendations for continued care when necessary. Annually thereafter, a statement of health condition, signed by a licensed medical doctor, doctor of osteopathy, physician's assistant or advanced registered nurse practitioner, shall be submitted that includes any change in functioning, allergies, medications, or acute or chronic conditions.

b. *School-age children.* For each child five years of age and older and enrolled in school, the child care center shall require, prior to admission, a statement of health status signed by the parent or legal guardian that certifies that the child is free of communicable disease and that specifies any allergies, medications, or acute or chronic conditions. The statement from the parent shall be submitted annually thereafter.

c. *Religious exemption.* Nothing in this rule shall be construed to require medical treatment or immunization for staff or the child of any person who is a member of a church or religious organization which has guidelines governing medical treatment for disease that are contrary to these rules. In these instances, an official statement from the organization shall be incorporated in the personnel or child's file.

109.10(2) Medical and dental emergencies. The center shall have sufficient information and authorization to meet the medical and dental emergencies of children. The center shall have written procedures for medical and dental emergencies and shall ensure, through orientation and training, that all staff are knowledgeable of and able to implement the procedures.

109.10(3) Medications. The center shall have written procedures for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications, including the following:

a. All medications shall be stored in their original containers, with accompanying physician or pharmacist's directions and label intact and stored so they are inaccessible to children and the public. Nonprescription medications shall be labeled with the child's name.

b. For every day an authorization for medication is in effect and the child is in attendance, there shall be a notation of administration including the name of the medicine, date, time, dosage given or applied, and the initials of the person administering the medication or the reason the medication was not given.

c. In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

109.10(4) Daily contact. Each child shall have direct contact with a staff person upon arrival for early detection of apparent illness, communicable disease, or unusual condition or behavior which may adversely affect the child or the group. The center shall post notice at the main entrance to the center where it is visible to parents and the public of exposure of a child receiving care by the center to a communicable disease, the symptoms, and the period of communicability. If the center is located in a building used for other purposes and shares the main entrance to the building, the notice shall be conspicuously posted in the center in an area that is frequented daily by parents or the public.

109.10(5) Infectious disease control. Centers shall establish policies and procedures related to infectious disease control and the use of universal precautions with the handling of any bodily excrement or discharge, including blood and breast milk. Soiled diapers shall be stored in containers separate from other waste.

109.10(6) Quiet area for ill or injured. The center shall provide a quiet area under supervision for a child who appears to be ill or injured. The parents or a designated person shall be notified of the child's status in the event of a serious illness or emergency.

109.10(7) Staff hand washing. The center shall ensure that staff demonstrate clean personal hygiene sufficient to prevent or minimize the transmission of illness or disease. All staff shall wash their hands at the following times:

- a. Upon arrival at the center.
- b. Immediately before eating or participating in any food service activity.
- c. After diapering a child.
- d. Before leaving the rest room either with a child or by themselves.
- e. Before and after administering nonemergency first aid to a child if gloves are not worn.
- f. After handling animals and cleaning cages.

109.10(8) Children's hand washing. The center shall ensure that staff assist children in personal hygiene sufficient to prevent or minimize the transmission of illness or disease. For each infant or child with a disability, a separate cloth for washing and one for rinsing may be used in place of running water. Children's hands shall be washed at the following times:

- a. Immediately before eating or participating in any food service activity.
- b. After using the rest room or being diapered.
- c. After handling animals.

109.10(9) First-aid kit. The center shall ensure that a clearly labeled first-aid kit is available and easily accessible to staff at all times whenever children are in the center, in the outdoor play area, and on field trips. The kit shall be sufficient to address first aid related to minor injury or trauma and shall be stored in an area inaccessible to children.

109.10(10) Recording incidents. Incidents involving a child, including minor injuries, minor changes in health status, or other minor behavioral concerns, shall be reported to the parents, guardians, and legal custodians on the day of the incident. Incidents resulting in an injury to a child shall be reported to the parent on the day of the incident. Incidents resulting in a serious injury to a child or incidents resulting in a significant change in the health status of a child shall be verbally reported to the parents, guardians, and legal custodians immediately. The parents, guardians, and legal custodians of any child included in incidents involving inappropriate, sexually acting-out behavior shall be notified immediately after the incident. A written report, fully documenting every incident, shall be provided to the parent or person authorized to remove the child from the center. The written report shall be prepared by the staff member who observed the incident and a copy shall be retained in the child's file.

109.10(11) Smoking. Smoking and the use of tobacco products shall be prohibited at all times in the center and in every vehicle used to transport children. Smoking and the use of tobacco products shall be prohibited in the outdoor play area during hours of operation of the center. Nonsmoking signs shall be posted at every entrance of the child care center and in every vehicle used to transport children. All signs shall include:

- a. The telephone number for reporting complaints, and
- b. The Internet address of the department of public health (www.iowasmokefreeair.gov).

109.10(12) Transportation. As outlined in Iowa Code section 321.446, all children transported in a motor vehicle subject to registration, except a bus, shall be individually secured by a safety belt, safety seat, or harness in accordance with federal motor vehicle safety standards and the manufacturer's instructions.

a. Children under the age of 6 shall be secured during transit in a federally approved child restraint system. Children under 1 year of age and weighing less than 20 pounds shall be secured during transit in a rear-facing child restraint system.

b. Children under the age of 12 shall not be located in the front seating section of the vehicle.

c. Drivers of vehicles shall possess a valid driver's license and shall not operate a vehicle while under the influence of alcohol, illegal drugs, prescription or nonprescription drugs that could impair the drivers' ability to operate a motor vehicle.

d. Vehicles that are owned or leased by the center shall receive regular maintenance and inspection according to manufacturer-recommended guidelines for vehicle and tire maintenance and inspection.

109.10(13) Field trip emergency numbers. Emergency telephone numbers for each child shall be taken by staff when transporting children to and from school and on field trips and non-center-sponsored activities away from the premises.

109.10(14) Pets. Animals kept on site shall be in good health with no evidence of disease, be of such disposition as to not pose a safety threat to children, and be maintained in a clean and sanitary manner. Documentation of current vaccinations shall be available for all cats and dogs. No ferrets, reptiles, including turtles, or birds of the parrot family shall be kept on site. Pets shall not be allowed in kitchen or food preparation areas.

109.10(15) Emergency plans.

a. The center shall have written emergency plans for responding to fire, tornado, flood (if area is susceptible to flood), intruders within the center, intoxicated parents and lost or abducted children. In addition, the center shall have guidelines for responding or evacuating in case of blizzards, power failures, bomb threats, chemical spills, earthquakes, or other disasters that could create structural damage to the center or pose health hazards. If the center is located within a ten-mile radius of a nuclear power plant or research facility, the center shall also have plans for nuclear evacuations. Emergency plans shall include written procedures including plans for transporting children and notifying parents, emergency telephone numbers, diagrams, and specific considerations for immobile children.

b. Emergency instructions, telephone numbers, and diagrams for fire, tornado, and flood (if area is susceptible to floods) shall be visibly posted by all program and outdoor exits. Emergency plan procedures shall be practiced and documented at least once a month for fire and for tornado. Records on the practice of fire and tornado drills shall be maintained for the current and previous year.

c. The center shall develop procedures for annual staff training on these emergency plans and shall include information on responding to fire, tornadoes, intruders, intoxicated parents and lost or abducted children in the orientation provided to new employees.

d. The center shall conduct a daily check to ensure that all exits are unobstructed.

109.10(16) Supervision and access.

a. The center director and on-site supervisor shall ensure that each staff member, substitute, or volunteer knows the number and names of children assigned to that staff member, substitute, or volunteer for care. Assigned staff, substitutes, and volunteers shall provide careful supervision.

b. Any person in the center who is not an owner, staff member, substitute, or volunteer who has a record check and department approval to be involved with child care shall not have unrestricted access to children for whom that person is not the parent, guardian, or custodian.

c. Persons who are exempt from the record check process are granted access in accordance with 109.6(6) "a" (2) unless the provisions of paragraph 109.10(16) "d" apply.

d. A sex offender who has been convicted of a sex offense against a minor and who is required to register with the Iowa sex offender registry under the provisions contained in Iowa Code chapter 692A shall not operate, manage, be employed by, or act as a contractor or volunteer at a child care center. The sex offender also shall not be present upon the property of a child care center without the written permission of the center director, except for the time reasonably necessary to transport the offender's own minor child or ward to and from the center.

(1) Written permission shall include the conditions under which the sex offender may be present, including:

1. The precise location in the center where the sex offender may be present;
2. The reason for the sex offender's presence at the facility;
3. The duration of the sex offender's presence;
4. Description of the supervision that the center staff will provide the sex offender to ensure that no child is alone with the sex offender.

(2) Before giving written permission, the center director shall consult with the center licensing consultant. The written permission shall be signed and dated by the center director and the sex offender and kept on file for review by the center licensing consultant.

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 1209C, IAB 12/11/13, effective 2/1/14]

441—109.11(237A) Physical facilities.

109.11(1) Room size. The program room size shall be a minimum of 80 square feet of useable floor space or sufficient floor space to provide 35 square feet of useable floor space per child. In rooms where floor space occupied by cribs is counted as useable floor space, there shall be 40 square feet of floor space per child. Kitchens, bathrooms, halls, lobby areas, storage areas and other areas of the center not designed as activity space for children shall not be used as regular program space or counted as useable floor space.

109.11(2) Infants' area. An area shall be provided properly and safely equipped for the use of infants and free from the intrusion of children two years of age and older. Children over 18 months of age may be grouped outside this area if appropriate to the developmental needs of the child. Upon the recommendation of a child's physician or the area education agency serving the child, a child who is two years of age or older with a disability that results in significant developmental delays in physical and cognitive functioning who does not pose a threat to the safety of the infants may, if appropriate and for a limited time approved by the department, remain in the infant area.

109.11(3) Facility requirements.

a. The center shall ensure that:

(1) The facility and premises are sanitary, safe and hazard-free.

(2) Adequate indoor and outdoor program space that is adjacent to the center is provided. Centers shall have a safe outdoor program area with at least sufficient square footage to accommodate 30 percent of the enrollment capacity at any one time at 75 square feet per child. The outdoor area shall include safe play equipment and an area of shade.

(3) Sufficient program space is provided for dining to allow ease of movement and participation by children and to allow staff sufficient space to attend to the needs of the children during routine care and emergency procedures.

(4) Sufficient lighting shall be provided to allow children to adequately perform developmental tasks without eye strain.

(5) Sufficient ventilation is provided to maintain adequate indoor air quality.

(6) Sufficient heating is provided to allow children to perform tasks comfortably without excessive clothing.

(7) Sufficient cooling is provided to allow children to perform tasks without being excessively warm or subject to heat exposure.

(8) Sufficient bathroom and diapering facilities are provided to attend immediately to children's toileting needs and maintained to reduce the transmission of disease.

(9) Equipment, including kitchen appliances, placed in a program area is maintained so as not to result in burns, shock or injury to children.

(10) Sanitation and safety procedures for the center are developed and implemented to reduce the risk of injury or harm to children and reduce the transmission of disease.

b. Approval may be given by the department to waive the outdoor space requirement for programs of three hours or less, provided there is suitable substitute space and equipment available.

c. Approval may be given by the department for centers operating in a densely developed area to use alternative outdoor play areas in lieu of adjacent outdoor play areas.

d. The director or designated person shall complete and keep a record of at least monthly inspections of the outdoor recreation area and equipment for the purpose of assessing and rectifying potential safety hazards. If the outdoor play area is not used for a period of time due to inclement weather conditions, the center shall document the reasons why the monthly inspection did not occur and shall complete and document an inspection prior to resuming use of the area.

e. Centers that operate in a public school building, including before and after school programs and summer programs serving school-age children, may receive limited exemption from a facility requirement at subrule 109.11(3), particularly relating to ventilation and bathroom facilities, if complying with the requirement would require a structural or mechanical change to the school building. Centers shall ensure that the space occupied by the center is sanitary, safe, and hazard-free and shall conduct monthly playground inspections or provide documentation that one has been completed by the public school personnel.

109.11(4) Bathroom facilities. At least one functioning toilet and one sink for each 15 children shall be provided in a room with natural or artificial ventilation. Training seats or chairs may be used for children under two years of age. New construction after November 1, 1995, shall provide for at least one sink in the same area as the toilet and, for centers serving children two weeks to two years of age, shall provide for at least one sink in the central diapering area. At least one sink shall be provided in program rooms for infants and toddlers or in an adjacent area other than the kitchen. New construction after April 1, 1998, shall have at least one sink provided in the program rooms for infants and toddlers.

109.11(5) Telephone. A working nonpay telephone shall be available in the center with emergency telephone numbers for police or 911, fire, ambulance, and poison information center posted adjacent to the telephone. The street address and telephone number of the center shall be included in the posting. A separate file or listing of emergency telephone numbers for each child shall be maintained near the telephone.

109.11(6) Kitchen appliances and microwaves. Gas or electric ranges or ovens shall not be placed in the program area. If kitchen appliances are maintained in the program area for food preparation activities, the area shall be sectioned off and shall not be counted as useable floor space for room size. Centers using microwave ovens for warming infant bottles or infant food shall ensure that the formula or food item is not served immediately to the child after being removed from the microwave. The infant bottle shall be shaken or food stirred and the formula or food item tested by the caregiver before being fed to the infant. Breast milk shall not be warmed in a microwave.

109.11(7) Environmental hazards.

a. Within one year of being issued an initial or renewal license, centers operating in facilities built prior to 1960 shall conduct a visual assessment for lead hazards that exist in the form of peeling or chipping paint. If the presence of peeling or chipping paint is found, the paint shall be presumed to be lead-based paint unless a certified inspector as defined in department of public health rules at 641—Chapter 70 determines that it is not lead-based paint. If the presence of peeling or chipping paint is found, interim controls using safe work methods as defined by the state department of public health shall be accomplished prior to a full license being issued.

b. Within one year of being issued an initial or renewal license, centers operating in facilities that are at ground level, use a basement area as program space, or have a basement beneath the program area shall have radon testing performed as prescribed by the state department of public health at 641—Chapter 43. Testing shall be required if test kits are available from the local health department or the Iowa Radon Coalition. Retesting shall be accomplished at least every two years from the date of the initial measurement if test kits are available from the local health department or the Iowa Radon Coalition. If testing determines confirmed radon gas levels in excess of 4.0 picocurie per liter, a plan using radon mitigation procedures established by the state department of public health shall be developed with and approved by the state department of public health prior to a full license being issued.

c. To reduce the risk of carbon monoxide poisoning, all centers shall, on an annual basis prior to the heating season, have a professional inspect all fuel-burning appliances, including oil and gas furnaces, gas water heaters, gas ranges and ovens, and gas dryers, to ensure the appliances are in good working order with proper ventilation. All centers shall install one carbon monoxide detector on each floor of the center that is listed with Underwriters Laboratory (UL) as conforming to UL Standard 2034.

d. Centers that operate before and after school programs and summer-only programs that serve only school-age children and that operate in a public school building are exempted from testing for lead, radon, and carbon monoxide.

441—109.12(237A) Activity program requirements.

109.12(1) Activities. The center shall have a written curriculum or program structure that uses developmentally appropriate practices and a written program of activities planned according to the developmental level of the children. The center shall post a schedule of the program in a visible place. The child care program shall complement but not duplicate the school curriculum. The program shall be designed to provide children with:

- a. A curriculum or program of activities that promotes self-esteem and positive self-image; social interaction; self-expression and communication skills; creative expression; and problem-solving skills.
- b. A balance of active and quiet activities; individual and group activities; indoor and outdoor activities; and staff-initiated and child-initiated activities.
- c. Activities which promote both gross and fine motor development.
- d. Experiences in harmony with the ethnic and cultural backgrounds of the children.
- e. A supervised nap or quiet time for all children under the age of six not enrolled in school who are present at the center for five or more hours.

109.12(2) Discipline. The center shall have a written policy on the discipline of children which provides for positive guidance, with direction for resolving conflict and the setting of well-defined limits. The written policy shall be provided to staff at the start of employment and to parents at time of admission. The center shall not use as a form of discipline:

- a. Corporal punishment including spanking, shaking, and slapping.
- b. Punishment which is humiliating or frightening or which causes pain or discomfort to the child. Children shall never be locked in a room, closet, box or other device. Mechanical restraints shall never be used as a form of discipline. When restraints are part of a treatment plan for a child with a disability authorized by the parent and a psychologist or psychiatrist, staff shall receive training on the safe and appropriate use of the restraint.
- c. Punishment or threat of punishment associated with a child's illness, lack of progress in toilet training, or in connection with food or rest.
- d. No child shall be subjected to verbal abuse, threats, or derogatory remarks about the child or the child's family.

109.12(3) Policies for children requiring special accommodations. Reasonable accommodations, based on the special needs of the child, shall be made in providing care to a child with a disability. Accommodation can be a specific treatment prescribed by a professional or a parent, or a modification of equipment, or removal of physical barriers. The accommodation shall be recorded in the child's file.

109.12(4) Play equipment, materials and furniture. The center shall provide sufficient and safe indoor play equipment, materials, and furniture that conform with the standards or recommendations of the Consumer Product Safety Commission or the American Society for Testing and Materials for juvenile products. Play equipment, materials, and furniture shall meet the developmental, activity, and special needs of the children.

Rooms shall be arranged so as not to obstruct the direct observation of children by staff. Individual covered mats, beds, or cots and appropriate bedding shall be provided for all children who nap. The center shall develop procedures to ensure that all equipment and materials are maintained in a sanitary manner. Sufficient spacing shall be maintained between equipment to reduce the transmission of disease, to allow ease of movement and participation by children and to allow staff sufficient space to attend to the needs of the children during routine care and emergency procedures. The center shall provide sufficient toilet articles for each child for hand washing. Parents may provide items for oral hygiene (if appropriate to the developmental age and needs of the child). The center shall ensure that sanitary procedures are followed for use and storage of the articles.

109.12(5) Infant environment. A child care center serving children two weeks to two years old must provide an environment which protects the children from physical harm, but is not so restrictive as to inhibit physical, intellectual, emotional, and social development.

- a. Stimulation shall be provided to each child through being held, rocked, played with and talked with throughout the time care is provided. Insofar as possible, the same adult should provide complete care for the same child.

b. Each infant and toddler shall be diapered in a sanitary manner as frequently as needed at a central diapering area. Diapering, sanitation, and hand-washing procedures shall be posted and implemented in every diapering area. There shall be at least one changing table for every 15 infants.

c. Highchairs or hook-on seats shall be equipped with a safety strap which shall be engaged when the chair is in use and shall be constructed so the chair will not topple.

d. Safe, washable toys, large enough so they cannot be swallowed and with no removable parts, shall be provided. All hard-surface toys used by children shall be sanitized daily.

e. Children under the age of one year shall be placed on their backs when sleeping unless otherwise authorized by a parent or physician. A crib or criblike furniture which has a waterproof mattress covering and sufficient bedding to enable a child to rest comfortably and which meets the current standards or recommendations from the Consumer Product Safety Commission or the American Society for Testing and Materials for juvenile products shall be provided for each child under two years of age if developmentally appropriate. Crib railings shall be fully raised and secured when the child is in the crib. A crib or criblike furniture shall be provided for the number of children present at any one time. The center shall develop procedures for maintaining all cribs or criblike furniture and bedding in a clean and sanitary manner. There shall be no restraining devices of any type used in cribs.

f. When playpens are provided, no more than one child shall be placed in one at any time.

g. Infant walkers shall not be used.

h. For programs operating five hours or less on a daily basis, the center shall have a sufficient number of cribs or criblike furniture which has a waterproof mattress covering and sufficient bedding to enable a child to rest comfortably and which meets the current standards from the Consumer Product Safety Commission or the American Society for Testing and Materials for juvenile products for children who may nap during the time in attendance. Cribs or criblike furniture shall be used by only one child at a time and shall be maintained in a clean and sanitary manner.

441—109.13(237A) Extended evening care. A center providing extended evening care shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter, with the additional requirements set forth below.

109.13(1) Facility requirements.

a. The center shall ensure that sufficient cribs, beds, cots and bedding are provided appropriate to the child's age and that sufficient furniture, lighting, and activity materials are available for the children. Equipment and materials shall be maintained in a safe and sanitary manner.

b. The center shall ensure that a separate space is maintained for school-age boys and girls to provide privacy during bathroom and bedtime activities. Bathroom doors used by children shall be nonlockable.

c. The center shall ensure that parents have provided the personal effects needed to meet their child's personal hygiene and prepare for sleep. The center shall supplement those items needed for personal hygiene which the parent does not provide. The center shall obtain written information from the parent regarding the child's snacking, toileting, personal hygiene and bedtime routines.

109.13(2) Activities.

a. Evening activities shall be primarily self-selected by the child.

b. Every child-occupied room except those rooms used only by school-age children for sleeping shall have adult supervision present in the room. Staff counted for purposes of meeting child-to-staff ratios shall be present and awake at all times. In rooms where only school-age children are sleeping, visual monitoring equipment may be used. If a visual monitor is used, the monitoring must allow for all children to be visible at all times. Staff shall be present in the room with the monitor and shall enter the room used for sleeping to conduct a check of the children every 15 minutes.

441—109.14(237A) Get-well center. A get-well center shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter with the additional requirements and exceptions set forth below.

109.14(1) Staff requirements.

a. The center shall have a medical advisor for the center's health policy. The medical advisor shall be a medical doctor or a doctor of osteopathy currently in pediatrics or family practice.

b. A center shall have a licensed LPN or RN on duty at all times that children are present. If the nurse on duty is an LPN, the medical advisor or an RN shall be available in the proximate area as defined in state board of nursing rules at 655—6.1(152).

109.14(2) Health policies.

a. The center shall have a written health policy, consistent with the National Health and Safety Performance Standards, approved and signed by the owner or the chair of the board and by the medical advisor before the center can begin operations. Changes in the health policy shall be approved by the medical advisor and submitted in writing to the department. A written summary of the health policy shall be given to the parent when a child is enrolled in the center. The center's health policy at a minimum shall address procedures in the following areas:

(1) Medical consultation, medical emergencies, triage policies, storage and administration of medications, dietary considerations, sanitation and infection control, categorization of illness, length of enrollment periods, exclusion policy, and employee health policy.

(2) Reportable disease policies as required by the state department of public health.

b. The child shall be given a brief evaluation by an LPN or RN upon each arrival at the center.

c. The parent shall receive a brief written summary when the child is picked up at the end of the day. The summary must include:

(1) Admitting symptoms.

(2) Medications administered and time they were administered.

(3) Nutritional intake.

(4) Rest periods.

(5) Output.

(6) Temperature.

109.14(3) Exceptions. The following exceptions to 441—Chapter 109 shall be applied to get-well centers:

a. A center shall maintain a minimum staff ratio of one-to-four for infants and one-to-five for children over the age of two.

b. All staff that have contact with children shall have a minimum of 17 clock hours of special training in caring for mildly ill children. Current certification of the training shall be contained in the personnel files. Special training shall be department-approved and include the following:

(1) Four hours' training in infant and child cardiopulmonary resuscitation (CPR), four hours' training in pediatric first aid, and one hour of training in infection control within the first month of employment.

(2) Six hours' training in care of ill children, and two hours' training in child abuse identification and reporting within the first six months of employment and every five years thereafter.

c. There shall be 40 square feet of program space per child.

d. There shall be a sink with hot and cold running water in every child-occupied room.

e. Outdoor space may be waived with the approval of the department if the program is in an area adjacent to the pediatrics unit of a hospital.

f. Grouping of children shall be allowed by categorization of illness or by transmission route without regard to age, and shall be in separate rooms with full walls and doors.

441—109.15(237A) Food services. Centers participating in the USDA Child and Adult Care Food Program (CACFP) may have requirements that differ from those outlined in this rule in obtaining CACFP reimbursement and shall consult with a state CACFP consultant.

109.15(1) Nutritionally balanced meals or snacks. The center shall serve each child a full, nutritionally balanced meal or snack as defined by the USDA Child and Adult Care Food Program (CACFP) guidelines and shall ensure that staff provide supervision at the table during snacks and meals.

Children remaining at the center two hours or longer shall be offered food at intervals of not less than two hours or more than three hours apart unless the child is asleep.

109.15(2) Menu planning. The center shall follow the minimum CACFP menu patterns for meals and snacks and serving sizes for children aged infant to 13 years. Menus shall be planned at least one week in advance, made available to parents, and kept on file at the center. Substitutions in the menu, including substitutions made for infants, shall be noted and kept on file. Foods with a high incident rate of causing choking in young children shall be avoided or modified. Provisions of this subrule notwithstanding, exceptions shall be allowed for special diets because of medical reasons in accordance with the child's needs and written instructions of a licensed physician or health care provider.

109.15(3) Feeding of children under two years of age.

a. All children under 12 months of age shall be fed on demand, unless the parent provides other written instructions. Meals and snacks provided by the center shall follow the CACFP infant menu patterns. Foods shall be appropriate for the infant's nutritional requirements and eating abilities. Menu patterns may be modified according to written instructions from the parent, physician or health care provider. Special formulas prescribed by a physician or health care provider shall be given to a child who has a feeding problem.

b. All children under six months of age shall be held or placed in a sitting-up position sufficient to prevent aspiration during feeding. No bottles shall be propped for children of any age. A child shall not be placed in a crib with a bottle or left sleeping with a bottle. Spoon feeding shall be adapted to the developmental capabilities of the child.

c. Single-service, ready-to-feed formulas, concentrated or powdered formula following the manufacturer's instructions or breast milk shall be used for children 12 months of age and younger unless otherwise ordered by a parent or physician.

d. Whole milk for children under age two who are not on formula or breast milk unless otherwise directed by a physician.

e. Cleaned and sanitized bottles and nipples shall be used for bottles prepared on site. Prepared bottles shall be kept under refrigeration when not in use.

109.15(4) Food brought from home.

a. The center shall establish policies regarding food brought from home for children under five years of age who are not enrolled in school. A copy of the written policy shall be given to the parent at admission. Food brought from home for children under five years of age who are not enrolled in school shall be monitored and supplemented if necessary to ensure CACFP guidelines are maintained.

b. The center may not restrict a parent from providing meals brought from home for school-age children or apply nutritional standards to the meals.

c. Perishable foods brought from home shall be maintained to avoid contamination or spoilage.

d. Snacks that may not meet CACFP nutrition guidelines may be provided by parents for special occasions such as birthdays or holidays.

109.15(5) Food preparation, storage, and sanitation. Centers shall ensure that food preparation and storage procedures are consistent with the recommendations of the National Health and Safety Performance Standards and provide:

a. Sufficient refrigeration appropriate to the perishable food to prevent spoilage or the growth of bacteria.

b. Sanitary and safe methods in food preparation, serving, and storage sufficient to prevent the transmission of disease, infestation of insects and rodents, and the spoilage of food. Staff preparing food who have injuries on their hands shall wear protective gloves. Staff serving food shall have clean hands or wear protective gloves and use clean serving utensils.

c. Sanitary methods for dish-washing techniques sufficient to prevent the transmission of disease.

d. Sanitary methods for garbage disposal sufficient to prevent the transmission of disease and infestation of insects and rodents.

109.15(6) Water supply. The center shall ensure that suitable water and sanitary drinking facilities are available and accessible to children. Centers that serve infants and toddlers shall provide individual cups for drinking in addition to drinking fountains that may be available in the center.

a. Private water supplies shall be of satisfactory bacteriological quality as shown by an annual laboratory analysis. Water for the analysis shall be drawn between May 1 and June 30 of each year. When the center provides care for children under two years of age, a nitrate analysis shall also be obtained.

b. When public or private water supplies are determined unsuitable for drinking, commercially bottled water certified as chemically and bacteriologically potable or water treated through a process approved by the health department or designee shall be provided.

These rules are intended to implement Iowa Code section 232.69 and chapter 237A.

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**TITLE XV
INDIVIDUAL AND FAMILY SUPPORT
AND PROTECTIVE SERVICES**

**CHAPTER 170
CHILD CARE SERVICES**

[Prior to 7/1/83, Social Services[770] Ch 132]
[Previously appeared as Ch 132—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The intent of this chapter is to establish requirements for the payment of child care services. Child care services are for children of low-income parents who are in academic or vocational training; or employed or looking for employment; or for a limited period of time, unable to care for children due to physical or mental illness; or needing protective services to prevent or alleviate child abuse or neglect. Services may be provided in a licensed child care center, a registered child development home, the home of a relative, the child's own home, or a nonregistered family child care home.
[ARC 2169C, IAB 9/30/15, effective 1/1/16]

441—170.1(237A) Definitions.

“*Agency error*” means child care assistance incorrectly paid for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Loss or misfiling of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the department.
6. Failure to make timely changes in assistance following amendments of policies that require the changes by a specific date.

“*Child care*” means a service that provides child care in the absence of parents for a portion of the day, but less than 24 hours. Child care supplements parental care by providing care and protection for children who need care in or outside their homes for part of the day. Child care provides experiences for each child's social, emotional, intellectual, and physical development. Child care may involve comprehensive child development care or it may include special services for a child with special needs. Components of this service shall include supervision, food services, program and activities, and may include transportation.

“*Child with protective needs*” means a child who is not in foster care and has a case file that identifies child care as a safety or well-being need to prevent or alleviate the effects of child abuse or neglect. Child care is provided as part of a safety plan during a child abuse or child in need of assistance assessment or as part of the service plan established in the family's case plan. The child must have:

1. An open child abuse assessment;
2. An open child in need of assistance assessment;
3. An open child welfare case as a result of a child abuse assessment;
4. A petition on file for a child in need of assistance adjudication; or
5. Adjudication as a child in need of assistance.

“*Child with special needs*” means a child with one or more of the following conditions:

1. The child has been diagnosed by a physician or by a person endorsed for service as a school psychologist by the Iowa department of education to have a developmental disability which substantially limits one or more major life activities, and the child requires professional treatment, assistance in self-care, or the purchase of special adaptive equipment.

2. The child has been determined by a qualified mental retardation professional to have a condition which impairs the child's intellectual and social functioning.

3. The child has been diagnosed by a mental health professional to have a behavioral or emotional disorder characterized by situationally inappropriate behavior which deviates substantially from behavior appropriate to the child's age, or which significantly interferes with the child's intellectual, social, or personal adjustment.

"*Client*" means a current or former recipient of the child care assistance program.

"*Client error*" means and may result from:

1. False or misleading statements, oral or written, regarding the client's income, resources, or other circumstances which affect eligibility or the amount of assistance received;

2. Failure to timely report changes in income, resources, or other circumstances which affect eligibility or the amount of assistance received;

3. Failure to timely report the receipt of child care units in excess of the number approved by the department;

4. Failure to comply with the need for service requirements.

"*Department*" means the Iowa department of human services.

"*Food services*" means the preparation and serving of nutritionally balanced meals and snacks.

"*Fraudulent means*" means knowingly making or causing to be made a false statement or a misrepresentation of a material fact, knowingly failing to disclose a material fact, or committing a fraudulent practice.

"*In-home*" means care which is provided within the child's own home.

"*Migrant seasonal farm worker*" means a person to whom all of the following conditions apply:

1. The person performs seasonal agricultural work which requires travel so that the person is unable to return to the person's permanent residence within the same day.

2. Most of the person's income is derived from seasonal agricultural work performed during the months of July through October. Most shall mean the simple majority of the income.

3. The person generally performs seasonal agricultural work in Iowa during the months of July through October.

"*On-line or distance learning*" means training such as, but not limited to, training conducted over the Iowa communications network, on-line courses, or Web conferencing. The training includes:

1. Interaction between the instructor and the student, such as required chats or message boards;

2. Mechanisms for evaluation and measurement of student achievement.

"*Overpayment*" means any benefit or payment received in an amount greater than the amount the client or provider is entitled to receive.

"*Parent*" means the parent or the person who serves in the capacity of the parent of the child receiving child care assistance services.

"*Program and activities*" means the daily schedule of experiences in a child care setting.

"*PROMISE JOBS*" means the department's training program, promoting independence and self-sufficiency through employment job opportunities and basic skills, as described in 441—Chapter 93.

"*Provider*" means a licensed child care center, a registered child development home, a relative who provides care in the relative's own home solely for a related child, a caretaker who provides care for a child in the child's home, or a nonregistered child care home.

"*Provider error*" means and may result from:

1. Presentation for payment of any false or fraudulent claim for services or merchandise;

2. Submittal of false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled;

3. Failure to report the receipt of a child care assistance payment in excess of that approved by the department;

4. Charging the department an amount for services rendered over and above what is charged private pay clients for the same services;

5. Failure to maintain a copy of Form 470-4535, Child Care Assistance Billing/Attendance Provider Record, signed by the parent and the provider.

“Recoupment” means the repayment of an overpayment by a payment from the client or provider or both.

“Relative” means an adult aged 18 or older who is a grandparent, aunt or uncle to the child being provided child care.

“Supervision” means the care, protection, and guidance of a child.

“Transportation” means the movement of children in a four or more wheeled vehicle designed to carry passengers, such as a car, van, or bus, between home and facility.

“Unit of service” means a half day which shall be up to 5 hours of service per 24-hour period.

“Vocational training or education” means a training plan which includes a specific goal, that is, high school completion, improved English skills, or development of specific academic or vocational skills.

Training may be approved for high school completion activities, high school equivalency, adult basic education, English as a second language, or postsecondary education, up to and including an associate or a baccalaureate degree program.

[ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 1525C, IAB 7/9/14, effective 7/1/14; ARC 1606C, IAB 9/3/14, effective 10/8/14; ARC 2169C, IAB 9/30/15, effective 1/1/16]

441—170.2(237A,239B) Eligibility requirements. A person deemed eligible for benefits under this chapter is subject to all other state child care assistance requirements including, but not limited to, provider requirements under Iowa Code chapter 237A and provider reimbursement methodology. The department shall determine the number of units of service to be approved.

170.2(1) Financial eligibility. Financial eligibility for child care assistance shall be based on federal poverty levels as determined by the Office of Management and Budget and on Iowa’s median family income as determined by the U.S. Census Bureau. Poverty guidelines and median family income amounts are updated annually. Changes shall go into effect for the child care assistance program on July 1 of each year.

a. *Income limits.* For initial and ongoing eligibility, a family’s nonexempt gross monthly income as established in paragraph 170.2(1) “c” cannot exceed:

(1) 145 percent of the federal poverty level applicable to the family size for children needing basic care, or

(2) 200 percent of the federal poverty level applicable to the family size for children needing special-needs care, or

(3) 85 percent of Iowa’s median family income, if that figure is lower than the standard in subparagraph (1) or (2).

b. *Exceptions to income limits.*

(1) A person who is participating in activities approved under the PROMISE JOBS program is eligible for child care assistance without regard to income if there is a need for child care services.

(2) A person who is part of the family investment program or whose earned income was taken into account in determining the needs of a family investment program recipient is eligible for child care assistance without regard to income if there is a need for child care services.

(3) Protective child care services are provided without regard to income.

(4) In certain cases, the department will provide child care services directed in a court order.

c. *Determining gross income.* Eligibility shall be determined using a projection of income based on the best estimate of future income. In determining a family’s gross monthly income, the department shall consider all income received by a family member from sources identified by the U.S. Census Bureau in computing median income, unless excluded under paragraph 170.2(1) “d.”

(1) Income considered shall include wages or salary, net profit from farm or nonfarm self-employment, social security, dividends, interest, income from estates or trusts, net rental income and royalties, public assistance or welfare payments, pensions and annuities, unemployment compensation, workers’ compensation, alimony, child support, veterans pensions, cash payments, casino profits, railroad retirement, permanent disability insurance, strike pay and living allowance payments made to participants of the AmeriCorps program. “Net profit from self-employment” means gross income

less the costs of producing the income other than depreciation. A net loss in self-employment income cannot be offset from other earned or unearned income.

(2) For migrant seasonal farm workers, the monthly gross income shall be determined by calculating the total amount of income earned in a 12-month period preceding the date of application and dividing the total amount by 12.

(3) When income received weekly or once every two weeks is projected for future months, income shall be projected by adding all income received in the period being used for the projection and dividing the result by the number of instances of income received in that period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

d. *Income exclusions.* The following sources are excluded from the computation of monthly gross income:

(1) Per capita payments from or funds held in trust in satisfaction of a judgment of the Indian Claims Commission or the court of claims.

(2) Payments made pursuant to the Alaska Claims Settlement Act, to the extent the payments are exempt from taxation under Section 21(a) of the Act.

(3) Money received from the sale of property, unless the person was engaged in the business of selling property.

(4) Withdrawals of bank deposits.

(5) Money borrowed.

(6) Tax refunds.

(7) Gifts.

(8) Lump-sum inheritances or insurance payments or settlements.

(9) Capital gains.

(10) The value of the food assistance allotment under the Food and Nutrition Act of 2008.

(11) The value of USDA donated foods.

(12) The value of supplemental food assistance under the Child Nutrition Act of 1966 and the special food program for children under the National School Lunch Act.

(13) Earnings of a child 14 years of age or younger.

(14) Loans and grants obtained and used under conditions that preclude their use for current living expenses.

(15) Any grant or loan to any undergraduate student for educational purposes made or insured under the Higher Education Act.

(16) Home produce used for household consumption.

(17) Earnings received by any youth under the Workforce Investment Act (WIA).

(18) Stipends received for participating in the foster grandparent program.

(19) The first \$65 plus 50 percent of the remainder of income earned in a sheltered workshop or work activity setting.

(20) Payments from the Low-Income Home Energy Assistance Program.

(21) Agent Orange settlement payments.

(22) The income of the parents with whom a teen parent resides.

(23) For children with special needs, income spent on any regular ongoing cost that is specific to that child's disability.

(24) Moneys received under the federal Social Security Persons Achieving Self-Sufficiency (PASS) program or the Income-Related Work Expense (IRWE) program.

(25) Income received by a Supplemental Security Income recipient if the recipient's earned income was considered in determining the needs of a family investment program recipient.

(26) The income of a child who would be in the family investment program eligible group except for the receipt of Supplemental Security Income.

(27) Any adoption subsidy payments received from the department.

(28) Federal or state earned income tax credit.

(29) Payments from the Iowa individual assistance grant program (IIAGP).

(30) Payments from the transition to independence program (TIP).

(31) Payments to volunteers participating in the Volunteers in Service to America (VISTA) program.

EXCEPTION: This exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteer is serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938 or the minimum wage under the laws of the state where the volunteer is serving, whichever is greater.

(32) Reimbursement from the employer for job-related expenses.

(33) Stipends from the preparation for adult living (PAL) program.

(34) Payments from the subsidized guardianship waiver program.

(35) The earnings of a child aged 18 or under who is a full-time student.

(36) Census earnings received by temporary workers from the Bureau of the Census.

(37) Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

e. *Family size.* The following people shall be included in the family size for the determination of eligibility:

(1) Legal spouses (including common law) who reside in the same household.

(2) Natural mother or father, adoptive mother or father, or stepmother or stepfather, and children who reside in the same household.

(3) A child or children who live with a person or persons not legally responsible for the child's support.

f. *Effect of temporary absence.* The composition of the family does not change when a family member is temporarily absent from the household. "Temporary absence" means:

(1) An absence for the purpose of education or employment.

(2) An absence due to medical reasons that is anticipated to last less than three months.

(3) Any absence when the person intends to return home within three months.

170.2(2) General eligibility requirements. In addition to meeting financial requirements, the child needing services must meet age, citizenship, and residency requirements. Each parent in the household must have at least one need for service and shall cooperate with the department's quality control review and with investigations conducted by the department of inspections and appeals.

a. *Age.* Child care shall be provided only to children up to age 13, unless they are children with special needs, in which case child care shall be provided up to age 19.

b. *Need for service.* Except for assistance provided under subparagraph 170.2(2)"b"(3), assistance shall be provided to a two-parent family only during the parents' coinciding hours of participation in training, employment, or job search. Each parent in the household shall meet one or more of the following requirements:

(1) The parent is in academic or vocational training. Training shall be on a full-time basis. The training facility shall define what is considered as full-time. Part-time training may be approved only if the number of credit hours to complete training is less than that required for full-time status, the required prerequisite credits or remedial course work is less than that required for full-time status, or training is not offered on a full-time basis. Child care services may be provided for the parent's hours of participation in the academic or vocational training and for actual travel time between the child care location and the training facility.

1. Child care provided while the parent participates in postsecondary education leading up to and including a baccalaureate degree program or vocational training shall be limited to a 24-month lifetime limit. A month is defined as a fiscal month or part thereof and shall generally have starting and ending dates that fall within two adjacent calendar months but shall only count as one month. Time spent in high school completion, adult basic education, high school equivalency, or English as a second language does not count toward the 24-month limit. PROMISE JOBS child care allowances provided while the parent is a recipient of the family investment program and participating in PROMISE JOBS components in postsecondary education or training shall count toward the 24-month lifetime limit.

2. Payment shall not be approved for child-care during training in the following circumstances:

• Labor market statistics for a local area indicate low employment potential for workers with that training. Exceptions may be made when the parent has a job offer before entering the training or if a parent is willing to relocate after training to an area where there is employment potential. Parents willing to relocate must provide documentation from the department of workforce development, private employment agencies, or employers that jobs paying at least minimum wage for which training is being requested are available in the locale specified by the parent.

• The training is for jobs paying less than minimum wage.
• A parent who possesses a baccalaureate degree wants to take additional college coursework unless the coursework is to obtain a teaching certificate or complete continuing education units.

• The course or training is one that the parent has previously completed.
• The parent was previously unable to maintain the cumulative grade point average required by the training or academic facility in the same training for which application is now being made. This does not apply to parents under the age of 18 who are enrolled in high school completion activities.
• The education is in a field in which the parent will not be able to be employed due to known criminal convictions or founded child or dependent adult abuse.
• The parent wants to participate in on-line or distance learning from the parent's own home, and the training facility does not require specified hours of attendance.

(2) The parent is employed 28 or more hours per week or an average of 28 or more hours per week during the month. Child care services may be provided for the hours of employment and for actual travel time between the child care location and the place of employment. If the parent works a shift consisting of at least six hours of employment between the hours of 8 p.m. and 6 a.m. and needs to sleep during daytime hours, child care services may also be provided to allow the parent to sleep during daytime hours.

(3) The parent has a child with protective needs for child care.
(4) The parent is absent from the home due to inpatient hospitalization or outpatient treatment because of physical or mental illness, or is present but due to medical incapacity is unable to care for the child or participate in work or training, as verified by a physician.

1. Eligibility under this paragraph is limited to parents who become medically incapacitated while eligible for child care assistance based on the need criteria in subparagraph 170.2(2)"b"(1) or 170.2(2)"b"(2).

2. Child care assistance shall continue to be available for up to 30 consecutive days after the parent becomes medically incapacitated. Assistance beyond 30 days may be approved by the service area manager or designee if extenuating circumstances are verified by a physician.

3. The number of units of service authorized shall be determined as follows:
• For a single parent family or for a two-parent family where both parents are incapacitated, the number of units authorized for the period of incapacity shall not exceed the number of units authorized for the family before the onset of incapacity.

• For a two-parent family where only one parent is incapacitated, the units of service authorized shall be based on the need of the parent who is not incapacitated.

(5) The parent is looking for employment. Child care for job search hours shall be limited to only those hours the parent is actually looking for employment including travel time.

1. A job search plan shall be approved by the department and be limited to a maximum of 30 consecutive calendar days in a 12-month period. EXCEPTION: Additional job search hours may be paid for PROMISE JOBS participants if approved by the PROMISE JOBS worker.

2. Documentation of job search contacts shall be furnished to the department. The department may enter into a nonfinancial coordination agreement for information exchange concerning job search documentation.

(6) The parent needs child care services due to participation in activities approved under the PROMISE JOBS program.

(7) The family is part of the family investment program and there is a need for child care services due to employment or participation in vocational training or education. A family who meets this requirement due to employment is not required to work a minimum number of hours. If a parent in a

family investment program household remains in the home, child care assistance can be paid if that parent receives Supplemental Security Income.

(8) The parent is employed and participating in academic or vocational training for 28 or more hours per week or an average of 28 or more hours per week in the aggregate, during the month. Child care services may be provided for the hours of employment, the hours of participation in academic or vocational training and for actual travel time between the child care location and the place of employment or training. All of the requirements relating to academic or vocational training found at subparagraph 170.2(2)"b "(1), except for the requirement to be enrolled full-time, apply to the part-time training in this subparagraph.

c. *Residency.* To be eligible for child care services, the person must be living in the state of Iowa. "Living in the state" shall include those persons living in Iowa for a temporary period, other than for the purpose of vacation.

d. *Citizenship.* As a condition of eligibility, the applicant shall attest to the child's citizenship or alien status by signing Form 470-3624 or 470-3624(S), Child Care Assistance Application, or Form 470-0462 or 470-0462(S), Health and Financial Support Application. Child care assistance payments may be made only for a child who:

(1) Is a citizen or national of the United States; or

(2) Is a qualified alien as defined at 8 U.S.C. Section 1641. The applicant shall furnish documentation of the alien status of any child declared to be a qualified alien. A child who is a qualified alien is not eligible for child care assistance for a period of five years beginning on the date of the child's entry into the United States with qualified alien status.

EXCEPTION: The five-year prohibition from receiving assistance does not apply to:

1. Qualified aliens described at 8 U.S.C. Section 1613; or
2. Qualified aliens as defined at 8 U.S.C. Section 1641 who entered the United States before August 22, 1996.

e. *Cooperation.* Parents shall cooperate with the department when the department selects the family's case for quality control review to verify eligibility. Parents shall also cooperate with investigations conducted by the department of inspections and appeals to determine whether information supplied by the parent regarding eligibility for child care assistance is complete and correct. (See 481—Chapter 72.)

(1) Failure to cooperate shall serve as a basis for cancellation or denial of the family's child care assistance.

(2) Once denied or canceled for failure to cooperate, the family may reapply but shall not be considered for approval until cooperation occurs.

170.2(3) Priority for assistance. Child care services shall be provided only when funds are available. Funds available for child care assistance shall first be used to continue assistance to families currently receiving child care assistance and to families with protective child care needs. When funds are insufficient, families applying for services must meet the specific requirements in this subrule.

a. *Priority groups.* As funds are determined available, families shall be served on a statewide basis from a service-area-wide waiting list as specified in subrule 170.3(4) based on the following schedule in descending order of prioritization.

(1) Families with an income at or below 100 percent of the federal poverty level whose members, for at least 28 hours per week in the aggregate, are employed or are participating at a satisfactory level in an approved training program or educational program, and parents with a family income at or below 100 percent of the federal poverty level who are under the age of 21 and are participating in an educational program leading to a high school diploma or equivalent.

(2) Parents under the age of 21 with a family income at or below 100 percent of the federal poverty guidelines who are participating, at a satisfactory level, in an approved training program or in an education program.

(3) Families with an income of more than 100 percent but not more than 145 percent of the federal poverty guidelines whose members, for at least 28 hours per week in the aggregate, are employed or are participating at a satisfactory level in an approved training program or educational program.

(4) Families with an income at or below 200 percent of the federal poverty guidelines whose members are employed at least 28 hours per week with a special-needs child as a member of the family.

b. *Exceptions to priority groups.* The following are eligible for child care assistance notwithstanding waiting lists for child care services:

(1) Families with protective child care needs.

(2) Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients.

(3) Families that receive a state adoption subsidy for a child.

c. *Effect on need for service.* Families approved under a priority group are not required to meet the requirements in paragraph 170.2(2) "b" except at review or redetermination.

170.2(4) Reporting changes. The parent must report any changes in circumstances affecting these eligibility requirements and changes in the choice of provider to the department worker or the PROMISE JOBS worker within ten calendar days of the change.

a. If the change is timely reported within ten calendar days, the effective date of the change shall be the date when the change occurred.

b. If the change is not timely reported, the effective date of the change shall be the date when the change is reported to the department office or PROMISE JOBS office.

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441—170.3(237A,239B) Application and determination of eligibility.

170.3(1) Application process.

a. Application for child care assistance may be made at any local office of the department on:

(1) Form 470-3624 or 470-3624(S), Child Care Assistance Application,

(2) Form 470-0462 or 470-0462(S), Health and Financial Support Application, or

(3) Form 470-4377 or 470-4377(S), Child Care Assistance Review, when returned after the end of the certification period.

b. The application may be filed by the applicant, by the applicant's authorized representative or, when the applicant is incompetent or incapacitated, by a responsible person acting on behalf of the applicant.

c. The date of application is the date a signed application form containing a legible name and address is received in the department office. An electronic or paper application delivered to a closed office is considered to be received on the first day following the day the office was last open that is not a weekend or state holiday.

d. Families who are determined eligible for child care assistance shall be approved for a certification period of no longer than six months. Families who fail to complete the review and redetermination process as described at subrule 170.3(5) will lose eligibility at the end of the certification period.

170.3(2) Exceptions to application requirement. An application is not required for:

a. A person who is participating in activities approved under the PROMISE JOBS program.

b. Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients. The date of application is the date the family requests child care assistance from the department.

c. Children with protective needs.

d. Child care services provided under a court order.

e. Families whose application has been denied for failure to provide requested information who have provided all necessary information to determine eligibility within 14 days of the denial of the application, or by the next working day if the fourteenth day falls on a weekend or state holiday.

170.3(3) Application processing. The department shall approve or deny an application as soon as possible, but no later than 30 days following the date the application was received. This time limit shall apply except in unusual circumstances, such as when the department and the applicant have made every reasonable effort to secure necessary information that has not been supplied by the date the time

limit expires, or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department.

a. The department worker or PROMISE JOBS worker shall determine the number of units of service authorized for each eligible family and shall:

(1) Inform the family through the notice of decision; and

(2) Inform the family's provider through the notice of decision or through Form 470-4444, Certificate of Enrollment.

b. The department shall issue a written notice of decision to the applicant by the next working day following a determination of eligibility.

c. The effective date of assistance shall be the date of application or the date the need for service began, whichever is later. When an application is not required as described under subrule 170.3(2), the effective date shall be as follows:

(1) For a person participating in activities under the PROMISE JOBS program, the effective date of child care assistance shall be the date the person becomes a PROMISE JOBS participant as defined in rule 441—93.1(239B) or the date the person has a need for child care assistance to participate in an approved PROMISE JOBS activity as described in 441—Chapter 93, whichever is later.

(2) For a family receiving family investment program benefits, the effective date of child care assistance shall be no earlier than the effective date of family investment program benefits, or 30 days before the date of application for child care assistance, or the date the need for service began, whichever is the latest.

(3) For a family with protective service needs, the effective date of assistance shall be the date the family signs Form 470-0615 or 470-0615(S), Application for All Social Services.

(4) When child care services are provided under a court order, the effective date of assistance shall be the date specified in the court order or the date of the court order if no date is specified.

(5) For a family whose application was denied for failure to provide requested information but who provides all information necessary to determine eligibility, including verification of all changes in circumstances, within 14 days of the denial, the effective date of assistance shall be the date that all information required to establish eligibility is provided. If the fourteenth calendar day falls on a weekend or state holiday, the family shall have until the next business day to provide the information.

170.3(4) Waiting lists for child care services. When the department has determined that there may be insufficient funding, applications for child care assistance shall be taken only for the priority groups for which funds have been determined available according to subrule 170.2(3).

a. The department shall maintain a log of families applying for child care services that meet the requirements within the priority groups for which funds may be available.

(1) Each family shall be entered on the logs according to their eligibility priority group and in sequence of their date of application.

(2) If more than one application is received on the same day for the same priority group, families shall be entered on the log based on the day of the month of the birthday of the oldest eligible child. The lowest numbered day shall be first on the log. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

b. When the department determines that there is adequate funding, the department shall notify the public regarding the availability of funds.

170.3(5) Review and redetermination. The department shall redetermine a family's financial and general eligibility for child care assistance at least every six months. EXCEPTION: The department shall redetermine only general eligibility for recipients of the family investment program (FIP), persons whose earned income was taken into account in determining the needs of FIP recipients, and parents who have children with protective needs, because these families are deemed financially eligible so long as the FIP eligibility or need for protective services continues.

a. If FIP or protective services eligibility ends, the department shall redetermine financial and general eligibility for child care assistance according to the requirements in rule 441—170.2(237A,239B). The redetermination of eligibility shall be completed within 30 days.

b. The department shall use information gathered on Form 470-4377 or 470-4377(S), Child Care Assistance Review, to redetermine eligibility, except when the family is not required to complete a review form as provided in paragraph 170.3(5) "c."

(1) The department shall issue a notice of expiration for the child care assistance certification period on Form 470-4377 or 470-4377(S).

(2) If the family does not return a complete review form to the department by the end of the certification period, the family must reapply for benefits, except as provided in paragraph 170.3(6) "b." A complete review form is Form 470-4377 or 470-4377(S) with all items answered that is signed and dated by the applicant and is accompanied by all verification needed to determine continued eligibility.

c. Families who have children with protective needs and families who are receiving child care assistance because the parent is participating in activities under the PROMISE JOBS program are not required to complete Form 470-4377 or 470-4377(S).

(1) The department shall issue a notice of expiration for the child care assistance certification period on the notice of decision when the department approves the family's certification period.

(2) The department shall gather information needed to redetermine general eligibility. If the department needs information from the family, the department will send a written request to the family. If the family does not return the requested information by the due date, the family must reapply for child care assistance, except as provided in paragraph 170.3(6) "b."

d. Families who are receiving child care assistance because the parent is seeking employment are not subject to review requirements because eligibility is limited to 30 consecutive calendar days. This waiver of the review requirement applies only when the parent who is seeking employment does not have another need for service.

170.3(6) *Reinstatement.*

a. Assistance shall be reinstated without a new application when all necessary information is provided before the effective date of cancellation and eligibility can be reestablished. If there is a change in circumstances, the change must be verified before the case will be reinstated.

b. Assistance shall be reinstated without a new application when the case was canceled for failure to provide requested information but all information necessary to determine eligibility, including verification of all changes in circumstances, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the family shall have until the next business day to provide the information. The effective date of child care assistance shall be the date that all information required to establish eligibility is provided.

[**ARC 8506B**, IAB 2/10/10, effective 3/1/10; **ARC 9651B**, IAB 8/10/11, effective 10/1/11]

441—170.4(237A) Elements of service provision.

170.4(1) *Case file.* The child welfare case file shall document the eligibility for service under 170.2(2) "b"(3).

170.4(2) *Fees.* Fees for services received shall be charged to clients according to the schedules in this subrule, except that fees shall not be charged to clients receiving services without regard to income. The fee is a per-unit charge that is applied to the child in the family who receives the largest number of units of service. The fee shall be charged for only one child in the family, regardless of how many children receive assistance.

a. Sliding fee schedule.

(1) The fee schedule shown in the following table is effective for eligibility determinations made on or after July 1, 2015:

Level	Monthly Income According to Family Size										Unit Fee Based on Number of Children in Care		
	1	2	3	4	5	6	7	8	9	10	1	2	3 or more
A	\$932	\$1,262	\$1,591	\$1,920	\$2,250	\$2,579	\$2,908	\$3,238	\$3,567	\$3,896	\$0.00	\$0.00	\$0.00
B	\$981	\$1,328	\$1,675	\$2,021	\$2,368	\$2,715	\$3,061	\$3,408	\$3,755	\$4,101	\$0.20	\$0.45	\$0.70
C	\$1,008	\$1,365	\$1,722	\$2,078	\$2,434	\$2,791	\$3,147	\$3,503	\$3,860	\$4,216	\$0.45	\$0.70	\$0.95
D	\$1,036	\$1,402	\$1,769	\$2,134	\$2,501	\$2,867	\$3,232	\$3,599	\$3,965	\$4,331	\$0.70	\$0.95	\$1.20
E	\$1,065	\$1,442	\$1,818	\$2,194	\$2,571	\$2,947	\$3,323	\$3,700	\$4,076	\$4,452	\$0.95	\$1.20	\$1.45
F	\$1,094	\$1,481	\$1,868	\$2,254	\$2,641	\$3,028	\$3,413	\$3,800	\$4,187	\$4,573	\$1.20	\$1.45	\$1.70
G	\$1,125	\$1,522	\$1,920	\$2,317	\$2,715	\$3,112	\$3,509	\$3,907	\$4,305	\$4,701	\$1.45	\$1.70	\$1.95
H	\$1,155	\$1,564	\$1,972	\$2,380	\$2,789	\$3,197	\$3,605	\$4,013	\$4,422	\$4,829	\$1.70	\$1.95	\$2.20
I	\$1,188	\$1,608	\$2,028	\$2,447	\$2,867	\$3,287	\$3,706	\$4,126	\$4,546	\$4,964	\$1.95	\$2.20	\$2.45
J	\$1,220	\$1,651	\$2,083	\$2,513	\$2,945	\$3,376	\$3,806	\$4,238	\$4,669	\$5,100	\$2.20	\$2.45	\$2.70
K	\$1,254	\$1,698	\$2,141	\$2,584	\$3,027	\$3,471	\$3,913	\$4,357	\$4,800	\$5,243	\$2.45	\$2.70	\$2.95
L	\$1,288	\$1,744	\$2,200	\$2,654	\$3,110	\$3,565	\$4,020	\$4,475	\$4,931	\$5,385	\$2.70	\$2.95	\$3.20
M	\$1,324	\$1,793	\$2,261	\$2,728	\$3,197	\$3,665	\$4,132	\$4,601	\$5,069	\$5,536	\$2.95	\$3.20	\$3.45
N	\$1,360	\$1,842	\$2,323	\$2,803	\$3,284	\$3,765	\$4,245	\$4,726	\$5,207	\$5,687	\$3.20	\$3.45	\$3.70
O	\$1,398	\$1,893	\$2,388	\$2,881	\$3,376	\$3,870	\$4,364	\$4,858	\$5,353	\$5,846	\$3.45	\$3.70	\$3.95
P	\$1,437	\$1,945	\$2,453	\$2,959	\$3,468	\$3,976	\$4,482	\$4,991	\$5,499	\$6,005	\$3.70	\$3.95	\$4.20
Q	\$1,477	\$1,999	\$2,521	\$3,042	\$3,565	\$4,087	\$4,608	\$5,130	\$5,653	\$6,173	\$3.95	\$4.20	\$4.45
R	\$1,517	\$2,054	\$2,590	\$3,125	\$3,662	\$4,198	\$4,733	\$5,270	\$5,807	\$6,342	\$4.20	\$4.45	\$4.70
S	\$1,559	\$2,111	\$2,663	\$3,213	\$3,764	\$4,316	\$4,866	\$5,418	\$5,969	\$6,519	\$4.45	\$4.70	\$4.95
T	\$1,602	\$2,169	\$2,735	\$3,300	\$3,867	\$4,433	\$4,998	\$5,565	\$6,132	\$6,697	\$4.70	\$4.95	\$5.20
U	\$1,647	\$2,229	\$2,812	\$3,393	\$3,975	\$4,558	\$5,138	\$5,721	\$6,303	\$6,884	\$4.95	\$5.20	\$5.45
V	\$1,692	\$2,290	\$2,888	\$3,485	\$4,083	\$4,682	\$5,278	\$5,877	\$6,475	\$7,072	\$5.20	\$5.45	\$5.70
W	\$1,739	\$2,354	\$2,969	\$3,583	\$4,198	\$4,813	\$5,426	\$6,041	\$6,656	\$7,270	\$5.45	\$5.70	\$5.95
X	\$1,786	\$2,418	\$3,050	\$3,680	\$4,312	\$4,944	\$5,574	\$6,206	\$6,838	\$7,468	\$5.70	\$5.95	\$6.20
Y	\$1,836	\$2,486	\$3,136	\$3,783	\$4,433	\$5,082	\$5,730	\$6,380	\$7,029	\$7,677	\$5.95	\$6.20	\$6.45
Z	\$1,886	\$2,554	\$3,221	\$3,886	\$4,554	\$5,221	\$5,886	\$6,553	\$7,221	\$7,886	\$6.20	\$6.45	\$6.70
AA	\$1,939	\$2,625	\$3,311	\$3,995	\$4,681	\$5,367	\$6,051	\$6,737	\$7,423	\$8,107	\$6.45	\$6.70	\$6.95
BB	\$1,992	\$2,697	\$3,401	\$4,104	\$4,809	\$5,513	\$6,216	\$6,920	\$7,625	\$8,328	\$6.70	\$6.95	\$7.20

- (2) To use the chart:
1. Find the family size used in determining income eligibility for service.
 2. Move across the monthly income table to the column headed by that number. (See paragraph "5" if the family has more than ten members.)
 3. Move down the column for the applicable family size to the highest figure that is equal to or less than the family's gross monthly income. Income at or above that amount (but less than the amount in the next row) corresponds to the fees in the last three columns of that row.
 4. Choose the fee that corresponds to the number of children in the family who receive child care assistance.
 5. When a family has more than ten members, determine the income level by multiplying the figures in the four-member column for the rows closest to the family's income level by 0.03. Round the numbers to the nearest dollar and multiply by the number of family members in excess of ten. Add the results to the amounts in the ten-member column to determine the threshold amounts.
- b. *Collection.* The provider shall collect fees from clients.
- (1) The provider shall maintain records of fees collected. These records shall be available for audit by the department or its representative.

(2) When a client does not pay the fee, the provider shall demonstrate that a reasonable effort has been made to collect the fee. "Reasonable effort to collect" means an original billing and two follow-up notices of nonpayment.

c. *Inability of client to pay fees.* Child care assistance may be continued without a fee, or with a reduced fee, when a client reports in writing the inability to pay the assessed fee due to the existence of one or more of the conditions set forth below. Before reducing the fee, the worker shall assess the case to verify that the condition exists and to determine whether a reduced fee can be charged. The reduced fee shall then be charged until the condition justifying the reduced fee no longer exists. Reduced fees may be justified by:

- (1) Extensive medical bills for which there is no payment through insurance coverage or other assistance.
- (2) Shelter costs that exceed 30 percent of the household income.
- (3) Utility costs not including the cost of a telephone that exceed 15 percent of the household income.
- (4) Additional expenses for food resulting from diets prescribed by a physician.

170.4(3) Method of provision. Parents shall be allowed to exercise their choice for in-home care, except when the parent meets the need for service under subparagraph 170.2(2)"b"(3), as long as the conditions in paragraph 170.4(7)"d" are met. When the child meets the need for service under 170.2(2)"b"(3), parents shall be allowed to exercise their choice of licensed, registered, or nonregistered child care provider except when the department service worker determines it is not in the best interest of the child.

The provider must meet one of the applicable requirements set forth below.

a. *Licensed child care center.* A child care center shall be licensed by the department to meet the requirements set forth in 441—Chapter 109 and shall have a current Certificate of License, Form 470-0618.

b. *Registered child development home.* A child development home shall meet the requirements for registration set forth in 441—Chapter 110 and shall have a current Certificate of Registration, Form 470-3498.

c. *Registered family child care home.* Rescinded IAB 1/7/04, effective 3/1/04.

d. *Relative care.* Rescinded IAB 2/6/02, effective 4/1/02.

e. *In-home care.* The adult caretaker selected by the parent to provide care in the child's own home shall be sent the pamphlet Comm. 95 or Comm. 95(S), Minimum Health and Safety Requirements for Nonregistered Child Care Home Providers, and Form 470-2890 or 470-2890(S), Payment Application for Nonregistered Providers. The provider shall complete and sign Form 470-2890 or 470-2890(S) and return the form to the department before payment may be made. An identifiable application is an application that contains a legible name and address and that has been signed. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered providers that include:

- (1) Minimum health and safety requirements;
- (2) Limits on the number of children for whom care may be provided;
- (3) Unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order; and
- (4) Conditions that warrant nonpayment.

f. *Nonregistered family child care home.* The adult caretaker selected by the parent to provide care in a nonregistered family child care home shall be sent the pamphlet Comm. 95 or Comm. 95(S), Minimum Health and Safety Requirements for Nonregistered Child Care Home Providers, and Form 470-2890 or 470-2890(S), Payment Application for Nonregistered Providers. The provider shall complete and sign Form 470-2890 or 470-2890(S) and return the form to the department before payment may be made. An identifiable application is an application that contains a legible name and address and that has been signed. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered providers that include:

- (1) Minimum health and safety requirements;

- (2) Limits on the number of children for whom care may be provided;
- (3) Unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order; and
- (4) Conditions that warrant nonpayment.

g. Iowa records checks for nonregistered child care homes and in-home care. If a nonregistered child care provider or a person who provides in-home care applies to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete and submit to the department Form 470-5143, Iowa Department of Human Services Record Check Authorization Form, for the provider, for anyone having access to a child when the child is alone, and for anyone 14 years of age or older living in the home. The department shall use this form to conduct Iowa criminal history record and child abuse record checks.

(1) The purpose of these checks is to determine whether the person has committed a transgression that prohibits or limits the person's involvement with child care.

(2) The department may also conduct criminal and child abuse record checks in other states and may conduct dependent adult abuse, sex offender registry, and other public or civil offense record checks in Iowa or in other states.

(3) Records checks shall be repeated for each person subject to the check every two years and when the department or provider becomes aware of any new transgressions committed by that person.

h. National criminal history record checks for nonregistered child care homes and in-home care. If a nonregistered child care provider or a person who provides in-home care applies to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete Form DCI-45, Waiver Agreement, and Form FD-258, Federal Fingerprint Card, for the provider, for anyone 18 years of age or older who is living in the home, or for anyone having access to a child when the child is alone.

(1) The provider or other person subject to this check shall submit any other forms required by the department of public safety to authorize the release of records.

(2) The provider or other person subject to this check is responsible for any costs associated with obtaining the fingerprints and for submitting the prints to the department.

(3) Fingerprints may be taken (rolled) by law enforcement agencies or by agencies or companies that specialize in taking fingerprints.

(4) The national criminal history record check shall be repeated for each person subject to the check every four years and when the department or provider becomes aware of any new transgressions committed by that person in another state.

(5) The department may rely on the results of previously conducted national criminal history record checks when a person subject to a record check in one child development home or child care home submits a request for involvement with child care in another child care home, so long as the person's national criminal history record check is within the allowable four-year time frame. All initial or new applications shall require a new national criminal history record check.

i. Transgressions. If any person subject to the record checks in paragraph 170.4(3)"g" or 170.4(3)"h" has a record of founded child abuse, dependent adult abuse, a criminal conviction, or placement on the sex offender registry, the department shall follow the process for prohibition or evaluation defined at 441—subrule 110.7(3).

(1) If any person would be prohibited from registration, employment, or residence, the person shall not provide child care and is not eligible to receive public funds to do so. The department's designee shall notify the applicant.

(2) A person who continues to provide child care in violation of this rule is subject to penalty and injunction under Iowa Code chapter 237A.

170.4(4) Components of service program. Every child eligible for child care services shall receive supervision, food services, and program and activities, and may receive transportation.

170.4(5) Levels of service according to age. Rescinded IAB 9/30/92, effective 10/1/92.

170.4(6) Provider's individual program plan. Rescinded IAB 2/10/10, effective 3/1/10.

170.4(7) Payment. The department shall make payment for child care provided to an eligible family when the family reports their choice of provider to the department and the provider has a completed Form 470-3871 or 470-3871(S), Child Care Assistance Provider Agreement, on file with the department. Both the child care provider and the department worker shall sign this form.

a. Rate of payment. The rate of payment for child care services, except for in-home care which shall be paid in accordance with 170.4(7) "d," shall be the actual rate charged by the provider for a private individual, not to exceed the maximum rates shown below. When a provider does not have a half-day rate in effect, a rate is established by dividing the provider's declared full-day rate by 2. When a provider has neither a half-day nor a full-day rate, a rate is established by multiplying the provider's declared hourly rate by 4.5. Payment shall not exceed the rate applicable to the provider and age group in Table I, except for special needs care which shall not exceed the rate applicable to the provider and age group in Table II. To be eligible for the special needs rate, the provider must submit documentation to the child's service worker that the child needing services has been assessed by a qualified professional and meets the definition for "child with special needs," and a description of the child's special needs, including, but not limited to, adaptive equipment, more careful supervision, or special staff training.

Table I Half-Day Rate Ceilings for Basic Care				
Age Group	Child Care Center	Child Development Home Category A or B	Child Development Home Category C	Nonregistered Family Home
Infant and Toddler	\$16.78	\$12.98	\$12.44	\$8.19
Preschool	\$13.53	\$12.18	\$12.18	\$7.19
School Age	\$12.18	\$10.82	\$10.82	\$7.36

Table II Half-Day Rate Ceilings for Special Needs Care				
Age Group	Child Care Center	Child Development Home Category A or B	Child Development Home Category C	Nonregistered Family Home
Infant and Toddler	\$51.94	\$17.05	\$13.40	\$10.24
Preschool	\$30.43	\$15.83	\$13.40	\$ 8.99
School Age	\$30.34	\$14.61	\$12.18	\$ 9.20

The following definitions apply in the use of the rate tables:

(1) "Child care center" shall mean those providers as defined in 170.4(3) "a" and "g." "Registered child development home" shall mean those providers as defined in 170.4(3) "b." "Nonregistered family child care home" shall mean those providers as defined in 170.4(3) "f."

(2) Under age group, "infant and toddler" shall mean age two weeks to two years; "preschool" shall mean two years to school age; "school age" shall mean a child in attendance in full-day or half-day classes.

b. Payment for days of absence. Payment may be made to a child care provider defined in subrule 170.4(3) for an individual child not in attendance at a child care facility not to exceed four days per calendar month providing that the child is regularly scheduled on those days and the provider also charges a private individual for days of absence.

c. Payment for multiple children in a family. When a provider reduces the charges for the second and any subsequent children in a family with multiple children whose care is unsubsidized, the rate of payment made by the department for a family with multiple children shall be similarly reduced.

d. Payment for in-home care. Payment may be made for in-home care when there are three or more children in a family who require child care services. The rate of payment for in-home care shall be the minimum wage amount.

e. *Limitations on payment.* Payment shall not be made for therapeutic services that are provided in the care setting and include, but are not limited to, services such as speech, hearing, physical and other therapies, individual or group counseling, therapeutic recreation, and crisis intervention.

f. *Review of the calculation of the rate of payment.* Maximum rate ceilings are not appealable. A provider who is in disagreement with the calculation of the half-day rate as set forth in 170.4(7) "a" may request a review. The procedure for review is as follows:

(1) Within 15 calendar days of notification of the rate in question, the provider shall send a written request for review to the service area manager. The request shall identify the specific rate in question and the methodology used to calculate the rate. The service manager shall provide a written response within 15 calendar days of receipt of the request for review.

(2) When dissatisfied with the response, the provider may, within 15 calendar days of the response, request a review by the chief of the bureau of financial support. The provider shall submit to the bureau chief the original request, the response received, and any additional information desired. The bureau chief shall render a decision in writing within 15 calendar days of receipt of the request.

(3) The provider may appeal the decision to the director of the department or the director's designee within 15 calendar days of the decision. The director or director's designee shall issue the final department decision within 15 calendar days of receipt of the request.

g. *Submission of claims.* The department shall issue payment when the provider submits correctly completed documentation of attendance and charges. The department shall pay for no more than the number of units of service authorized in the notice of decision issued pursuant to subrule 170.3(3). Providers shall submit a claim in one of the following ways:

(1) Using Form 470-4534, Child Care Assistance Billing/Attendance; or

(2) Using an electronic request for payment submitted through the KinderTrack system. Providers using this method shall print Form 470-4535, Child Care Assistance Billing/Attendance Provider Record, to be signed by the provider and the parent. The provider shall keep the signed Form 470-4535 for a period of five years after the billing date.

[ARC 7837B, IAB 6/3/09, effective 7/1/09; ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9490B, IAB 5/4/11, effective 7/1/11; ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 0152C, IAB 6/13/12, effective 7/18/12; ARC 0546C, IAB 1/9/13, effective 1/1/13; ARC 0715C, IAB 5/1/13, effective 7/1/13; ARC 0825C, IAB 7/10/13, effective 7/1/13; ARC 0854C, IAB 7/24/13, effective 7/1/13; ARC 1063C, IAB 10/2/13, effective 11/6/13; ARC 1446C, IAB 4/30/14, effective 7/1/14; ARC 1978C, IAB 4/29/15, effective 7/1/15; ARC 2169C, IAB 9/30/15, effective 1/1/16]

441—170.5(237A) Adverse actions.

170.5(1) Provider agreement. The department may refuse to enter into or may revoke the Child Care Assistance Provider Agreement, Form 470-3871 or 470-3871(S), if any of the following occur:

a. The department finds a hazard to the safety and well-being of a child, and the provider cannot or refuses to correct the hazard.

b. The provider has submitted claims for payment for which the provider is not entitled.

c. The provider fails to cooperate with an investigation conducted by the department of inspections and appeals to determine whether information the provider supplied to the department regarding payment for child care services is complete and correct. Once the agreement is revoked for failure to cooperate, the department shall not enter into a new agreement with the provider until cooperation occurs.

d. The provider does not meet one of the applicable requirements set forth in subrule 170.4(3).

e. The provider fails to comply with any of the terms and conditions of the Child Care Assistance Provider Agreement, Form 470-3871 or 470-3871(S).

f. The provider submits attendance documentation for payment and the provider knows or should have known that the documentation is false or inaccurate.

g. An overpayment of CCA funds with a balance of \$3,000 or more exists for a provider and that provider fails to enter into a repayment agreement with the department of inspections and appeals (DIA) or does not make payments according to the repayment agreement on file with DIA.

h. The provider is found to have more children in care at one time than allowed for the provider type as found at rule 441—110.4(237A) and 441—subrules 110.8(1), 110.9(1), 110.10(1) and 170.4(3).

170.5(2) Denial. Child care assistance shall be denied when the department determines that:

- a. The client is not in need of service; or
- b. The client is not financially eligible; or
- c. There is another resource available to provide the service or a similar service free of charge that allows parents to select from the full range of eligible providers; or
 - d. An application is required and the client or representative refuses or fails to sign the application form; or
 - e. Funding is not available; or
 - f. The client refuses or fails to supply information or verification requested or to request assistance and authorize the department to secure the required information or verification from other sources (signing a general authorization for release of information to the department does not meet this responsibility); or
 - g. The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections and appeals.

170.5(3) Termination. Child care assistance may be terminated when the department determines that:

- a. The client no longer meets the eligibility criteria in subrule 170.2(2); or
- b. The client's income exceeds the financial guidelines; or
- c. The client refuses or fails to supply information or verification requested or to request assistance and authorize the department to secure the required information or verification from other sources (signing a general authorization for release of information to the department does not meet this responsibility); or
- d. No payment or only partial payment of client fees has been received within 30 days following the issuance of the last billing; or
- e. Another resource is available to provide the service or a similar service free of charge that allows parents to select from the full range of eligible providers; or
- f. Funding is not available; or
- g. The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections and appeals.

170.5(4) Reduction. Authorized units of service may be reduced when the department determines that:

- a. Continued provision of service at the current level is not necessary to meet the client's service needs; or
- b. Another resource is available to provide the same or similar service free of charge that will meet the client's needs and allow parents to select from the full range of eligible providers; or
- c. Funding is not available to continue the service at the current level. When funding is not available, the department may limit on a statewide basis the number of units of child care services for which payment will be made.

170.5(5) Provider agreement sanction. If a Child Care Assistance Provider Agreement, Form 470-3871 or 470-3871(S), is terminated for any of the reasons in subrule 170.5(1), the agreement shall remain terminated for the time periods set forth below:

- a. The first time the agreement is terminated, the provider may reapply for another agreement at any time.
- b. The second time the agreement is terminated, the provider may not reapply for another agreement for 12 months from the effective date of termination.
- c. The third or subsequent time the agreement is terminated, the provider may not reapply for another agreement for 36 months from the effective date of termination.
- d. The department shall not act on an application for a child care assistance provider agreement submitted by a provider during the sanction period.

[ARC 7740B, IAB 5/6/09, effective 6/10/09; ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 1893C, IAB 3/4/15, effective 7/1/15]

441—170.6(237A) Appeals. Notice of adverse actions and the right of appeal shall be given in accordance with 441—Chapter 7.

441—170.7(237A) Provider fraud.

170.7(1) Fraud. The department shall consider a child care provider to have committed fraud when:

a. The department of inspections and appeals, in an administrative or judicial proceeding, has found the provider to have obtained by fraudulent means child care assistance payment in an amount in excess of \$1,000; or

b. The provider has agreed to entry of a civil judgment or judgment by confession that includes a conclusion of law that the provider has obtained by fraudulent means child care assistance payment in an amount in excess of \$1,000.

170.7(2) Potential sanctions. Providers found to have committed fraud shall be subject to one or more of the following sanctions, as determined by the department:

a. Special review of the provider's claims for child care assistance.

b. Suspension from receipt of child care assistance payment for six months.

c. Ineligibility to receive payment under child care assistance.

170.7(3) Factors considered in determining level of sanction. The department shall evaluate the following factors in determining the sanction to be imposed:

a. *History of prior violations.*

(1) If the provider has no prior violations, the sanction imposed shall be a special review of provider claims.

(2) If the provider has one prior violation, the sanction imposed shall be a suspension from receipt of child care assistance payment for six months as well as a special review of provider claims.

(3) If the provider has more than one prior violation, the sanction imposed shall be ineligibility to receive payment under child care assistance.

b. *Prior imposition of sanctions.*

(1) If the provider has not been sanctioned before, the sanction imposed shall be a special review of the provider's claims for child care assistance.

(2) If the provider has been sanctioned once before, the sanction imposed shall be a suspension from receipt of child care assistance payment for six months as well as a special review of provider claims.

(3) If the provider has been sanctioned more than once before, the sanction imposed shall be ineligibility to receive payment under child care assistance.

c. *Seriousness of the violation.*

(1) If the amount fraudulently received is less than \$5,000, the sanction level shall be determined according to paragraphs "a" and "b."

(2) If the amount fraudulently received is \$5,000 or more, and the sanction determined according to paragraphs "a" and "b" is review of provider claims, the sanction imposed shall be suspension from receipt of child care assistance payment.

(3) If the amount fraudulently received is \$5,000 or more, and the sanction determined according to paragraphs "a" and "b" is suspension from receipt of child care assistance payment, the sanction imposed shall be ineligibility to receive payment under child care assistance.

d. *Extent of the violation.*

(1) If the fraudulent claims involve five invoices or less or five months or less, the sanction level shall be determined according to paragraphs "a" and "b."

(2) If the fraudulent claims involve at least six invoices or six months, and the sanction determined according to paragraphs "a" and "b" is review of provider claims, the sanction imposed shall be suspension from receipt of child care assistance payment.

(3) If the fraudulent claims involve at least six invoices or six months, and the sanction determined according to paragraphs "a" and "b" is suspension from receipt of child care assistance payment, the sanction imposed shall be ineligibility to receive payment under child care assistance.

170.7(4) Mitigating factors.

a. If the sanction determined according to subrule 170.7(3) is suspension from or ineligibility for receipt of child care assistance payment, the department shall determine whether it is appropriate to reduce the level of a sanction for the particular case, considering:

- (1) Prior provision of provider education.
- (2) Provider willingness to obey program rules.

b. If the sanction determined according to subrule 170.7(3) is ineligibility for receipt of child care assistance payment, but consideration of the two factors in paragraph "a" indicates that a lesser sanction will resolve the violation, the sanction imposed shall be:

- (1) Suspension from receipt of child care assistance payment for six months; and
- (2) A special review of provider claims.

c. If the sanction determined according to subrule 170.7(3) is suspension from receipt of child care assistance payment, but consideration of the two factors in paragraph "a" indicates that a lesser sanction will resolve the violation, the sanction imposed shall be a special review of provider claims.

441—170.8(234) Allocation of funds. Rescinded IAB 2/6/02, effective 4/1/02.

441—170.9(237A) Child care assistance overpayments. All child care assistance overpayments shall be subject to recoupment.

170.9(1) Notification and appeals. All clients or providers shall be notified as described at subrule 170.9(6), when it is determined that an overpayment exists. Notification shall include the amount, date and reason for the overpayment. The department shall provide additional information regarding the computation of the overpayment upon the client's or provider's request. The client or provider may appeal the computation of the overpayment and any action to recover the overpayment in accordance with 441—subrule 7.5(9).

170.9(2) Determination of overpayments. All overpayments due to client, provider, or agency error or due to benefits or payments issued pending an appeal decision shall be recouped. Overpayments shall be computed as if the information had been acted upon timely.

170.9(3) Benefits or payments issued pending appeal decision. Recoupment of overpayments resulting from benefits or payments issued pending a decision on an appeal hearing shall not occur until after a final appeal decision is issued affirming the department.

170.9(4) Failure to cooperate. Failure by the client to cooperate in the investigation of alleged overpayments shall result in ineligibility for the months in question and the overpayment shall be the total amount of assistance received during those months. Failure by the provider to cooperate in the investigation of alleged overpayments shall result in payments being recouped for the months in question.

170.9(5) Payment agreement. The client or provider may choose to make a lump-sum payment or make periodic installment payments as agreed to on the notification form issued pursuant to subrule 170.9(6). Failure to negotiate an approved payment agreement may result in further collection action as outlined in 441—Chapter 11.

170.9(6) Procedures for recoupment.

a. When the department determines that an overpayment exists, the department shall refer the case to the department of inspections and appeals for investigation, recoupment, or referral for possible prosecution.

b. The department of inspections and appeals shall initiate recoupment by notifying the debtor of the overpayment on Form 470-4530, Notice of Child Care Assistance Overpayment.

c. When financial circumstances change, the department of inspections and appeals has the authority to revise the recoupment plan.

d. Recoupment for overpayments due to client error or due to an agency error that affected eligibility shall be made from the parent who received child care assistance at the time the overpayment occurred. When two parents were in the home at the time the overpayment occurred, both parents are equally responsible for repayment of the overpayment.

e. Recoupment for overpayments due to provider error or due to an agency error that affected benefits shall be made from the provider.

f. Recoupment for overpayments caused by both the provider and client shall be collected from both the provider and client equally, 50 percent from the client and 50 percent from the provider.

170.9(7) Suspension and waiver: Recoupment will be suspended on nonfraud overpayments when the amount of the overpayment is less than \$35. Recoupment will be waived on nonfraud overpayments of less than \$35 which have been held in suspense for three years.

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[Prior to 12/14/88, see Health Department[470] Ch 51]
[Prior to 8/8/90, see Public Health[641] Ch 51]

481—51.1(135B) Definitions. As used in this chapter, unless the context otherwise requires, the following definitions apply:

“*Critical access hospital*” means any hospital located in a rural area and certified by the Iowa department of public health as being a necessary provider of health care services to residents of the area. A “critical access hospital” makes available 24-hour emergency care, is a designated provider in a rural health network, and meets the criteria specified pursuant to 481—51.53(135B). If swing-bed approval has been granted, all 25 beds may be used interchangeably for acute or skilled nursing facility level of care services.

“*Department*” means the Iowa department of inspections and appeals.

“*Governing board*” means the board of trustees, the owner or the person or persons designated by the owner as the governing authority who shall have supreme authority in the hospital and be responsible for the management, control, and appointment of the medical staff.

“*Governmental unit*” means the state, or any county, municipality, or other political subdivision, or any department, division, board or other agency of any of the foregoing.

“*Hospital*” or “*general hospital*” means an institution, place, building, or agency represented and held out to the general public as ready, willing and able to furnish care, accommodations, facilities and equipment for the diagnosis or treatment, over a period exceeding 24 hours, of two or more nonrelated individuals suffering from illness, injury, infirmity or deformity, or other physical or mental condition for which medical, surgical and obstetrical care services are provided. The term “hospital” does not include the following:

1. Any institution for well children, day nursery and child care center, foster boarding homes or houses, and homes for disabled children. However, such institutions that have a dual function, including nursing and medical care, and care of the sick are required to be licensed.

2. Homes, houses or institutions for aged persons which limit their functions to room and board and provide no medical or nursing care and house no bedridden person.

3. Dispensary or first-aid stations maintained for the care of employees, students, customers, and members of any commercial or industrial plant, educational institution, or convent.

“*Long-term acute care hospital*” means any hospital that has an average inpatient length of stay greater than 25 days, and that provides extended medical and rehabilitative care for patients who are clinically complex and who may suffer from multiple acute or chronic conditions. Services provided by a long-term acute care hospital include but are not limited to comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. A long-term acute care hospital shall meet the requirements for a general hospital including emergency services, except that obstetrical facilities are not required, and, if the long-term acute care hospital is located within a separately licensed hospital and does not provide its own emergency services, the long-term acute care hospital shall contract for emergency services with the host general hospital.

“*Medical staff*” means an organized body that is composed of individuals appointed by the hospital governing board, that operates under bylaws approved by the governing board and that is responsible for the quality of medical care provided to patients by the hospital. All members of the medical staff, one of whom shall be a licensed physician, shall be licensed to practice in the state of Iowa.

“*Person*” means any individual, firm, partnership, corporation, company, association, or joint stock association and includes any trustee, receiver, assignee, or other similar representative.

“*Premises*” means any or all designated portions of a building or structure, enclosures or places in the building, or real estate when the distinct and clearly identifiable parts provide separate care and services. The definition of “premises” shall not be construed to permit the existence of a separately licensed specialty hospital within the physical structure of a general hospital. A specialty hospital shall be

defined pursuant to 42 CFR Section 411.351 and any amendments thereto, or pursuant to any regulations promulgated by the Secretary of Health and Human Services.

“Registered nurse” means a person who has graduated from an accredited school of nursing and who is registered in the state of Iowa.

“Specialized hospital” means any hospital devoted primarily to the specialized care and treatment of persons with chronic or long-term illness, injury, or infirmity. The diagnosis, treatment or care shall be administered by or performed under the direction of persons especially qualified in the diagnosis and treatment of the particular illness, injury, or infirmity. A specialized hospital shall meet the requirements for a general hospital. “Specialized hospital” as defined in this rule does not include a specialty hospital defined pursuant to 42 CFR Section 411.351.

481—51.2(135B) Classification, compliance and license.

51.2(1) Classification. For the purpose of administering the hospital licensing law, all institutions subject to licensure shall be classified as a critical access hospital, general hospital, long-term acute care hospital, or specialized hospital. The license issued by the department shall clearly identify the classification of the hospital.

51.2(2) Compliance requirements for each classification. A hospital shall comply with all of the general regulations for hospitals and shall comply with regulations pertaining to specialized services, if specialized services are provided in the hospital.

51.2(3) Separate license required. A separate license shall be required for each hospital even though more than one is operated under the same management. A separate license is not required for separate buildings of a hospital located on separate parcels of land, which are not adjoining but provide elements of the hospital’s full range of services for the diagnosis, care, and treatment of human illness, including convalescence and rehabilitation, and which are organized under a single owner or governing board with a single designated administrator and medical staff.

51.2(4) Posting of license. The license shall be conspicuously posted on the premises.

51.2(5) The department shall recognize, in lieu of its own licensure inspection, the comparable inspections and inspection findings of The Joint Commission (JC), the American Osteopathic Association (AOA), Det Norske Veritas (DNV), or the Center for Improvement in Healthcare Quality (CIHQ) if the department is provided with copies of all requested materials relating to the inspection process. In cases of the initial licensure, the department may require its own inspection when needed in addition to comparable accreditations to allow the hospital to begin operations. The department may also initiate its own inspection when it is determined that the inspection findings of the JC, AOA, DNV, or CIHQ are insufficient to address concerns identified as possible licensure issues.

51.2(6) Hospitals not accredited by the JC, AOA, DNV, or CIHQ shall be inspected by the department utilizing the current Medicare conditions of participation found in Title XVIII of the federal Social Security Act and 42 CFR Part 482, Subparts A, B, C, D, and E, or 42 CFR Part 485, Subpart F, as of October 1, 2006. Licensed-only hospitals shall be inspected utilizing the requirements of this chapter. The department may promulgate additional standards. The department may recognize, in lieu of its own licensure inspection, the comparable inspection and inspection findings of a Medicare conditions of participation survey.

This rule is intended to implement Iowa Code chapter 135B.

[ARC 9253B, IAB 12/1/10, effective 1/5/11; ARC 1305C, IAB 2/5/14, effective 3/12/14]

481—51.3(135B) Quality improvement program. There shall be an ongoing hospitalwide quality improvement program. This program is to be designed to improve, as needed, the quality of patient care by:

1. Assessing clinical patient care;
2. Assessing nonclinical and patient-related services within the hospital;
3. Developing remedial action as needed;
4. Ongoing monitoring and evaluating of the progress of remedial action taken.

51.3(1) The governing body shall ensure there is an effective hospitalwide patient-oriented quality improvement program.

51.3(2) The quality improvement program shall involve active participation of physician members of the hospital's medical staff and other health care professionals, as appropriate. Evidence of this participation will include ongoing case review and assessment of other patient care problems which have been identified through the quality improvement process.

51.3(3) There shall be a written plan for the quality improvement program that:

a. Describes the program's objectives, organization, scope, and mechanisms for overseeing the effectiveness of monitoring, evaluation, and problem-solving activities;

b. Ensures participation from all departments, services (including services provided both directly and under contract), and disciplines;

c. Provides for assessment of participation through a quality improvement committee meeting on an established periodic basis;

d. Provides for coordination of quality improvement activities;

e. Ensures communication, reporting and documentation of all quality improvement activities on a regular basis to the governing board, the medical staff, and the hospital administrator;

f. Provides for an annual evaluation by the governing board of the effectiveness of the quality improvement program; and

g. Addresses accessibility and confidentiality of materials relating to, generated by or part of the quality improvement process.

This rule is intended to implement Iowa Code chapter 135B.

481—51.4(135B) Long-term acute care hospital located within a general hospital.

51.4(1) If a long-term acute care hospital occupies the same building, premises or physical location of a general hospital, all treatment facilities and administrative offices for each hospital shall be clearly marked and separated from each other, and located within the licensed premises of each licensee.

a. Treatment facilities shall be sufficient to meet the medical needs of the patients.

b. Administrative offices shall include, but not be limited to, record rooms and personnel offices.

c. There shall be clearly identifiable and distinguishable signs for each hospital.

51.4(2) If a long-term acute care hospital occupies the same building, premises or physical location of a general hospital, each hospital shall have its own entrance. The separate entrance shall have appropriate signs and shall be clearly identifiable as belonging to a particular hospital. Nothing shall prohibit a long-term acute care hospital that is occupying the same building, premises or physical location as a general hospital from utilizing the entrance, hallway, stairs, elevators or escalators of the general hospital to provide access to the long-term acute care hospital's separate entrance.

51.4(3) A long-term acute care hospital located within a general hospital shall have sufficient staff to meet the patients' needs. No nursing services staff of either the long-term acute care hospital or the host general hospital shall be simultaneously assigned patient duties in both licensed hospitals.

51.4(4) Each long-term acute care hospital located within a general hospital and the host general hospital shall have a separate and distinct governing board, which shall be in control of the respective hospital. No more than one board member shall serve in a common capacity on the governing board of each licensed hospital. For the purposes of this rule, control exists if an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

51.4(5) A long-term acute care hospital located within a general hospital may contract with the host general hospital for the provision of services, including but not limited to pharmaceutical, radiological, laboratory, food and dietetic, surgical, anesthesia, emergency, housekeeping, laundry and environmental, or other services necessary to maintain a clean and safe physical environment. The contract shall be executed by the governing boards of the long-term acute care hospital and the host general hospital. All contracts shall clearly delineate the responsibilities of and services provided by the long-term acute care hospital and the host general hospital.

51.4(6) Any life safety code violation identified by the state fire marshal during an inspection of a licensee may be a life safety code violation for both the long-term acute care hospital and the general hospital.

481—51.5(135B) Medical staff.

51.5(1) A roster of medical staff members shall be kept.

51.5(2) All hospitals shall have one or more licensed physicians designated for emergency call service at all times.

51.5(3) A hospital shall not deny clinical privileges to physicians and surgeons, podiatrists, osteopaths or osteopathic surgeons, dentists, certified health service providers in psychology, physician assistants or advanced registered nurse practitioners licensed under Iowa Code chapter 148, 148C, 149, 150, 150A, 152, or 153 or section 154B.7 solely by reason of the license held by the practitioner or solely by reasons of the school or institution in which the practitioner received medical schooling or postgraduate training if the medical schooling or postgraduate training was accredited by an organization recognized by the council on postsecondary accreditation or an accrediting group recognized by the United States Department of Education.

51.5(4) A hospital shall establish and implement written criteria for the granting of clinical privileges. The written criteria shall include, but not be limited to, consideration of the:

- a. Ability of the applicant to provide patient care services independently or appropriately in the hospital;
- b. License held by the applicant to practice;
- c. Training, experience, and competence of applicant;
- d. Relationship between the applicant's request for privileges and the hospital's current scope of patient care services;
- e. Applicant's ability to provide comprehensive, appropriate and cost-effective services.

481—51.6(135B) Patient rights and responsibilities. The hospital governing board shall adopt a statement of principles relating to patient rights and responsibilities. In developing a statement of principles, the hospital may use reference statements of patient rights and responsibilities developed by the American Hospital Association, The Joint Commission (JC), the American Osteopathic Association (AOA), Det Norske Veritas (DNV), the Center for Improvement in Healthcare Quality (CIHQ), and other appropriate sources.

51.6(1) The statement of principles shall be made available to patients of the hospital.

51.6(2) The statement of principles regarding patient rights shall, at a minimum, address:

- a. Access to treatment regardless of race, creed, sex, national origin, diagnosis, or source of payment for care;
- b. Preservation of individual dignity and protection of personal privacy in receipt of care;
- c. Confidentiality of medical and other appropriate information;
- d. Assurance of reasonable safety within the hospital;
- e. Knowledge of the identity of the physician or other practitioner primarily responsible for the patient's care as well as identity and professional status of others providing services to the patient while in the hospital;
- f. Nature of patient's right to information regarding the patient's medical condition unless medically contraindicated, to consult with a specialist at the patient's request and expense, and to refuse treatment to the extent authorized by law;
- g. Access to and explanation of patient billings; and
- h. Process for patient pursuit of grievances.

51.6(3) The statement of principles regarding patient responsibilities shall, at a minimum, address:

- a. Need of patient to provide accurate and complete information regarding the patient's health status;
- b. Need of patient to follow recommended treatment plans;

c. Requirement that patient abide by hospital rules and regulations affecting patient care and conduct and be considerate of the rights of other patients and hospital personnel; and

d. Obligation to fulfill the patient's financial obligations as soon as possible following discharge.

This rule is intended to implement Iowa Code chapter 135B.

[ARC 9253B, IAB 12/1/10, effective 1/5/11; ARC 1305C, IAB 2/5/14, effective 3/12/14]

481—51.7(135B) Abuse.

51.7(1) Definitions.

a. Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation.

b. Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment.

c. Sexual abuse includes, but is not limited to, the exposing of pubes to a patient, and the exposure of a patient's genitals, pubes, breasts or buttocks, fondling or touching the inner thigh, groin, buttocks, anus, or breast of a patient or the clothing covering these areas for sexual satisfaction, sexually suggestive comments or remarks made to a patient, a genital-to-genital or oral-to-genital contact or the commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2.

d. Domestic abuse, as defined in Iowa Code section 236.2, means the commission of assault under either of the following circumstances:

(1) The assault is between family or household members who resided together at the time of the assault; or

(2) The assault is between separated spouses or persons divorced from each other and not residing together at the time of the assault.

e. Family or household members, as defined in Iowa Code section 236.2, are spouses, persons cohabiting, parents, or other persons related by consanguinity or affinity, except children under the age of 18.

51.7(2) Abuse prohibited. Each patient shall receive kind and considerate care at all times and shall be free from mental, physical, and sexual abuse.

a. Restraints shall be applied only when they are necessary to prevent injury to the patient or to others and shall be used only when alternative measures are not sufficient to accomplish their purposes.

b. There must be a written order signed by the attending physician approving the use of restraints either at the time they are applied or as soon thereafter as possible.

c. Careful consideration shall be given to the methods by which the restraints can be speedily removed in case of fire or other emergency.

51.7(3) Domestic abuse. Each hospital shall establish and implement protocols with respect to victims of domestic abuse.

a. The policies and procedures shall at a minimum provide for:

(1) An interview with the victim in a place that ensures privacy;

(2) Confidentiality of the person's treatment and information;

(3) Sharing of information regarding the domestic abuse hotline and programs; and

(4) Education of appropriate emergency department staff to assist in the identification of victims of domestic abuse.

b. The treatment records of victims of domestic abuse shall include:

(1) An assessment of the extent of abuse to the victim specifically describing the location and extent of the injury and reported pain;

(2) Evidence that the victim was informed of the telephone numbers for the domestic abuse hotline and domestic abuse programs, and the victim's response;

(3) A record of the treatment and intervention by health care provider personnel;

(4) A record of the need for follow-up care and specification of the follow-up care to be given (e.g., X-rays, surgery, consultation, similar care); and

(5) The victim's statement of how the injury occurred.

51.7(4) Child abuse and dependent adult abuse. Each hospital shall ensure that written policies and procedures cover all requirements for the mandatory reporting of abuse pursuant to the Iowa Code. Each hospital shall provide that the treatment records of victims of child abuse or dependent adult abuse include a statement that the department of human services protective services was contacted.

481—51.8(135B) Organ and tissue—requests and procurement.

51.8(1) Each hospital licensed in accordance with Iowa Code chapter 135B shall have in place written policies and protocols for organ and tissue donation. Hospital policies and protocols for organ and tissue donation shall require that the patient, or appropriate person able to consent on behalf of the patient, be made aware of the option to donate as well as the option to refuse donation and the ability, if any, to revoke consent once given.

a. Hospitals shall be familiar with the uniform anatomical gift law, Iowa Code chapter 142C, and shall develop policies and protocols for consent to organ and tissue donation by either the patient or an appropriate person to consent on the patient's behalf consistent with that law's provisions.

b. Hospital policies and protocols for organ and tissue donation shall set forth the responsibilities of the attending physician or physicians, nursing staff, and other appropriate hospital staff persons in the organ and tissue donation process. At a minimum, the policies shall set forth who in particular is authorized to make an organ or tissue donor request and that all such requests shall be made only in accordance with clearly delineated written protocol approved by the hospital's medical staff and governing board.

c. Hospital policies and protocols for organ and tissue donation shall provide that the attending physician inform appropriate family members or others of impending death or that death has occurred prior to an organ or tissue donor request.

d. Hospital policies and protocols for organ and tissue donation shall set forth those situations in which donation shall not be made including, but not necessarily limited to, the following:

(1) Where the patient is not medically suitable, as determined by the organ or tissue procurement organization;

(2) Where the hospital lacks the appropriate facilities or equipment for maintaining the patient or the organs for the time and in the manner necessary to facilitate appropriate procurement of the organ(s);

(3) Where the medical examiner has refused to release the body, except a donor request may be made where the medical examiner indicates that the body will be available at a time where the patient remains medically suitable for organ or tissue donation;

(4) Where the hospital has appropriate documentation that the patient or the appropriate person to consent on behalf of the patient does not want to consider the donation option;

(5) Rescinded IAB 8/6/03, effective 9/10/03.

e. Hospital policies and protocols for organ and tissue donation shall require documentation in the patient's medical record of the fact that a donor request was made and either accepted or refused, stating to whom the request was made and who accepted or refused; or that a donor request was not made, stating the reason why no request was made; or that a consent previously given was subsequently revoked.

f. Method and manner of consent, where consent to organ or tissue donation has been given, shall be noted in the patient's medical record. Where revocation of consent, if applicable, occurs, the manner and method of revocation shall also be noted in the patient's medical record.

g. Where the patient has validly executed a donation prior to death, attempt will be made to notify appropriate family members, if reasonably available, of the donation before the procurement process begins.

h. Hospital policies and protocols for organ and tissue donation shall provide for ongoing communication with the patient's family or other appropriate representatives regarding the donation process, the present status of that process and unexpected delays in the process, and family rights and responsibilities following organ or tissue donation.

51.8(2) Determination of death.

a. No organ or tissue shall be removed from a donor until death has been determined according to the requirements of Iowa law and generally acceptable standards of medical practice.

b. Death is defined by Iowa Code section 702.8 as a condition determined by the following standards:

A person will be considered dead if in the announced opinion of a physician licensed pursuant to Iowa Code chapter 148, 150, or 150A, a physician assistant licensed pursuant to Iowa Code chapter 148C, or a registered nurse or a licensed practical nurse licensed pursuant to Iowa Code chapter 152, based on ordinary standards of medical practice, that person has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of two physicians, based on ordinary standards of medical practice, that person has experienced an irreversible cessation of spontaneous brain functions. Death will have occurred at the time when the relevant functions ceased.

c. The surgeon performing the organ removal shall not participate in the determination of brain death.

d. The patient's medical record shall include documentation of the date and time of death and identification of the practitioner or practitioners who determined death, as provided in 51.8(2) "b."

51.8(3) Determination of medical suitability.

a. At or near the time of the patient's death or when death has occurred, no organ and tissue donor request shall be made until the patient has been determined by the designated organ or tissue procurement organization to be medically suitable for organ or tissue donation.

b. Each hospital shall consult with a recognized organ and tissue procurement program or programs in establishing medical requirements for organ and tissue donation and in evaluating a particular patient's suitability for donation. Where required by federal law, hospitals shall work only with organ or tissue procurement organizations designated by the Department of Health and Human Services (DHHS). Organ and tissue procurement programs maintain guidelines for determining medical suitability and generally will provide a hospital with a copy of those guidelines which may be incorporated into the hospital's own policies and protocol for organ and tissue donation.

51.8(4) Organ and tissue procurement.

a. Hospital policies and protocol for organ and tissue donation shall set forth the process to be used for contacting an organ procurement organization (OPO).

b. Hospitals with an agreement with the designated OPO shall take into account the terms and conditions of the agreement in developing their policies and protocols. Hospitals shall contact only the OPO designated by the federal Department of Health and Human Services.

c. Generally an OPO will assume the costs of procuring medically suitable organs and tissues, including costs borne by the donating hospital in maintaining the patient until organ retrieval can occur as well as in the retrieval process itself. A hospital shall be familiar with its financial obligations, if any, in the procurement process and with cost accounting/reporting responsibilities it bears, if any, under Medicare and Medicaid. In situations, if any, where the patient or the patient's family may be liable for certain costs associated with organ donation or procurement, the patient or person able to consent for the patient shall be fully informed of the potential financial obligations at the time of request and before consent is either given or refused.

d. When an organ or tissue is retrieved for transplantation purposes, the hospital shall ensure that the medical records of the donor and, if applicable, the recipient fulfill the requirements for any surgical inpatient medical record. Medical record documentation shall include the method of maintenance of the patient while awaiting organ or tissue retrieval and operative report documentation (including an autopsy if an autopsy has been performed) regarding the removal of the organ or tissue.

e. The procurement process shall not occur until necessary consent by the patient or appropriate person to consent on behalf of the patient is received and documented. Also, in cases requiring the involvement of the medical examiner, release of the body must be authorized by the medical examiner and documented.

f. Where a donor specifies to whom the organ or tissue donation is to be made, the hospital shall first contact the named donee to determine whether the donee accepts the donation. Where the donee refuses the donation or is unable for other reasons to accept, then the hospital shall document in the medical record the fact that the donation was not accepted. The hospital shall then notify the appropriate consenting party that the donation was not accepted and determine whether the consenting party desires to make further donation. A hospital shall make good faith effort to cooperate in the donation/procurement process where a specific donee has been named but shall not be required to participate in the donation process where procurement for a specific donee would result in undue burden or unreasonable cost to the hospital; in such situations, the hospital shall notify the appropriate consenting party and determine whether the consenting party desires to make further donation.

g. Where consent has been given for organ or tissue donation, revocation of prior consent, if applicable, shall not be effective once surgical procedures have begun on either the donor or the recipient.

51.8(5) Informed consent. Hospital policies and protocols for organ and tissue donation shall be consistent with informed consent provisions provided by the organ or tissue procurement organization.

51.8(6) Confidentiality. Hospital policies and protocols for organ and tissue donation shall provide that donor and recipient patient-identifying information shall be kept confidential except and only to the extent necessary to assist and complete the procurement and transplant process.

51.8(7) Training of hospital personnel. Hospital policies and protocols for organ and tissue donation shall include provisions for initial and ongoing training of hospital medical, nursing, and other appropriate staff persons regarding the various aspects of the organ and tissue donation and procurement process. The type and extent of training will vary from hospital to hospital, based on factors such as likelihood of medically suitable donors, capabilities for maintaining organ donors/patients, referral sources for potential organ and tissue donor candidates, and overall participation in organ and tissue procurement and transplants.

This rule is intended to implement Iowa Code section 135B.7.

481—51.9(135B) Nursing services.

51.9(1) The hospital shall have an organized nursing service which shall provide complete and efficient nursing care to each patient. The authority, responsibility and function of each nurse shall be clearly defined.

51.9(2) Registered nurse(s) shall utilize the nursing process in the provision of nursing care to each patient. The nursing process includes:

- a.* Nursing assessment about the health status of the patient, analysis of the data, and formation of a nursing diagnosis;
- b.* Planning of nursing care which includes determining goals and priorities for actions which are based on the nursing diagnosis;
- c.* Nursing interventions implementing the plan of care;
- d.* Evaluation of patient status in relation to established goals and the plan of care.

51.9(3) Licensed practical nurse(s) shall participate in the nursing process as described in subrule 51.9(2) consistent with accepted practice by assisting the registered nurse or physician.

51.9(4) All nurses employed in a hospital who practice nursing as a registered nurse or licensed practical nurse shall be licensed in Iowa.

51.9(5) There shall be a director of nursing service with administrative and executive competency who shall be a registered nurse licensed in the state of Iowa.

51.9(6) Supervisors and head nurses shall have had preparation courses and experience in accordance with hospital policy commensurate with the responsibility of the specific assignment.

51.9(7) All nonprofessional workers performing patient-care service shall be under the supervision of a registered nurse. Their duties shall be defined in writing by the hospital and they shall be instructed in all duties assigned to them.

51.9(8) The nursing service shall have adequate numbers of licensed registered nurses, licensed practical nurses, and other personnel to provide nursing care essential for the proper treatment, well-being, and recovery of the patient.

51.9(9) Written policies and procedures shall be established for the administrative and technical guidance of the personnel in the hospital. Each employee shall be familiar with these policies and procedures.

51.9(10) Each hospital shall have a minimum of one registered nurse on duty at all times.

481—51.10(135B) Water supply. Rescinded IAB 12/22/93, effective 1/26/94.

481—51.11(135B) Sewage disposal. Rescinded IAB 12/22/93, effective 1/26/94.

481—51.12(135B) Records and reports.

51.12(1) *Medical records.* Accurate and complete medical records shall be written for all patients and signed by the attending physician. These records shall be filed and stored in an accessible manner in the hospital and in accordance with the statute of limitations as specified in Iowa Code chapter 614.

51.12(2) Hospital records.

a. *Admission records.* A register of all admissions to the hospital shall be maintained.

b. *Death records.* A record of all deaths in the hospital shall be kept, including all information required on a standard death certificate as specified in Iowa Code chapter 144.

c. *Birth records.* A record of all births in the hospital shall be kept, including all information required on a standard birth certificate as specified in Iowa Code chapter 144.

d. *Controlled substance records.* Controlled substance records shall be maintained in accordance with state and federal laws, rules and regulations.

51.12(3) *Annual reports.* Annual reports shall be filed with the Iowa department of public health within three months after termination of each fiscal year in accordance with Iowa Code section 135.75.

481—51.13(135B) Sterilizing equipment. Rescinded IAB 12/22/93, effective 1/26/94; see 481—51.50(135B).

481—51.14(135B) Pharmaceutical service.

51.14(1) *General requirements.* Hospital pharmaceutical services shall be licensed in accordance with Iowa board of pharmacy examiners rules in 657—Chapter 7.

51.14(2) *Medication administration.* All drugs and biologicals must be administered by, or under the supervision of, nursing or other trained personnel in accordance with hospital policies and procedures. The person assigned the responsibility of medication administration must complete the entire procedure by personally preparing the dose from a multiple-dose container or using a prepackaged unit dose, personally administering it to the patient, and observing the act of the medication being taken.

51.14(3) *Medication orders.* All verbal orders must be authenticated in writing and signed by the prescribing practitioner within a period not to exceed 30 days following a patient's discharge.

When telephone, oral or electronic mechanisms are used to transmit medication orders, they must be accepted only by personnel that are authorized to do so by hospital policies and procedures in a manner consistent with federal and state law.

51.14(4) *Standing orders.* Standing orders for drugs may be used for specified patients when authorized by the prescribing practitioner. These standing orders shall be in accordance with policies and procedures established by the appropriate committee within each hospital. At a minimum, the standing orders shall:

a. Specify the circumstances under which the drug is to be administered;

b. Specify the types of medical conditions of the patients for whom the standing orders are intended;

c. Be reviewed and revised by the prescribing practitioner on a regular basis as specified by hospital policies and procedures;

d. Be specific as to the drug, dosage, route, and frequency of administration; and

e. Be dated, signed by the prescribing practitioner within a period not to exceed 30 days following a patient's discharge, and included in the patient's medical record.

51.14(5) Self-administration of medications. Patients shall only be permitted to self-administer medications when specifically ordered by the prescribing practitioner and the prescribing practitioner has determined this practice is safe for the specific patient. The hospital shall develop policies and procedures regarding storage and documentation of the administration of drugs.

481—51.15(135B) Screens. Rescinded IAB 12/22/93, effective 1/26/94; see 481—51.50(135B).

481—51.16(135B) Radiological services.

51.16(1) The hospital must maintain, or have available, radiological services to meet the needs of the patients.

51.16(2) All radiological services including diagnostic, fluoroscopy, mammography, therapeutic, and nuclear medicine furnished by the hospital or its agent shall be furnished in compliance with 641 IAC Chapters 38 to 42.

481—51.17(135B) Laundry. Rescinded IAB 12/22/93, effective 1/26/94; see 481—51.50(135B).

481—51.18(135B) Laboratory service.

51.18(1) The hospital must maintain, or have available, adequate laboratory and pathology services and facilities to meet the needs of its patients. The medical staff shall determine which laboratory tests are necessary to be performed on site to meet the needs of the patients.

51.18(2) Emergency laboratory services must be available 24 hours a day.

51.18(3) The hospital must ensure that all laboratory services provided to its patients are performed in a laboratory certified and operating in accordance with the Code of Federal Regulations in 42 CFR Part 493.

[ARC 1751C, IAB 12/10/14, effective 1/14/15]

481—51.19 Reserved.

481—51.20(135B) Food and nutrition services.

51.20(1) Food and nutrition service definition. “Food service” means providing safe, satisfying, and nutritionally adequate food for patients through the provision of appropriate staff, space, equipment, and supplies. “Nutrition service” means providing assessment and education to ensure that the nutritional needs of the patients are met.

51.20(2) General requirements.

a. All food shall be handled, prepared, served, and stored in compliance with the requirements of the 2005 Food and Drug Administration Food Code with Supplement adopted under provisions of Iowa Code section 137F.2.

b. The food service shall provide food of the quality and quantity to meet the patient’s needs in accordance with the qualified health practitioner’s orders and, to the extent medically possible, to meet the current Recommended Dietary Allowances, adopted by the Food and Nutrition Board of the National Research Council, National Academy of Sciences, and the following:

(1) Not less than three meals shall be served daily unless contraindicated.

(2) Not more than 14 hours shall elapse between the evening meal and breakfast of the following day.

(3) Nourishment between meals shall be available to all patients unless contraindicated by the qualified health care practitioner.

(4) Patient food preferences shall be respected as much as possible, and substitutes shall be offered through use of appropriate food groups.

(5) When food is provided by a contract food service, all applicable requirements set forth herein shall be met. The hospital shall maintain adequate space, equipment, and staple food supplies to provide patient food service in emergencies.

c. Policies and procedures shall be developed and maintained in consultation with representatives of the medical staff, nursing staff, food and nutrition service staff, pharmacy staff, and administration to

govern the provision of food and nutrition services. Policies and procedures shall be approved by the medical staff, administration, and governing body.

d. A current diet manual approved by the dietitian and the medical staff shall be used as the basis for diet orders and for planning therapeutic diets. The diet manual shall be reviewed, revised and updated at least every five years. Copies of the diet manual shall be readily available to all medical, nursing, and food service personnel.

e. Therapeutic diets shall be provided as prescribed by the qualified health care practitioner and shall be planned, prepared, and served with supervision or consultation from the licensed dietitian. Persons responsible for therapeutic diets shall have sufficient knowledge of food to make appropriate substitutions when necessary.

f. The patient's diet card shall state likes, dislikes, food allergies, and other pertinent information.

g. Menus.

(1) Menus for regular and therapeutic diets shall be written, approved, dated and available in the food service area at least one week in advance.

(2) If meals served vary from the planned menu, the change shall be noted in writing as part of the available menu. A copy of the menu as served shall be kept on file for at least 30 days.

(3) Menus should be planned with consideration for cultural and religious background and food habits of patients.

(4) Standardized recipes with nutritional analysis adjusted to number of portions shall be maintained and used in food preparation.

h. Food shall be prepared by methods that conserve nutritive value, flavor, and appearance. Food shall be served attractively at appropriate and safe temperatures and in a form to meet individual needs.

i. Nutritional care.

(1) Nutrition screening shall be conducted by qualified hospital staff to determine the patient's need for a comprehensive nutrition assessment by the licensed dietitian.

(2) Nutritional care shall be integrated in the patient care plan, as appropriate, based upon the patient's diagnosis and length of stay.

(3) The licensed dietitian shall record in the patient's medical record any observations and information pertinent to medical nutrition therapy.

(4) Pertinent dietary records shall be included in the patient's transfer discharge record to ensure continuity of nutritional care.

(5) Upon discharge, nutrition counseling and education shall be provided to the patient and family as ordered by the qualified health care practitioner, requested by the patient or deemed appropriate by the licensed dietitian.

j. In-service training, in accordance with hospital policies, shall be provided for all food and nutrition service personnel. A record of subject areas covered, date and duration of each session, and attendance lists shall be maintained. In-service records shall be kept for a minimum of one year.

k. On the nursing units, a separate patient food storage area shall be maintained that ensures proper temperature control.

51.20(3) *Food and nutrition service staff.*

a. A licensed dietitian shall be employed on a full-time, part-time or consulting basis. Part-time or consultant services shall be provided on the premises at appropriate times on a regularly scheduled basis. These services shall be of sufficient duration and frequency to provide continuing liaison with medical and nursing staffs, advice to the administrator, patient counseling, guidance to the supervisor and staff of the food and nutrition service, approval of all menus, and participation in the development or revision of departmental policies and procedures and in planning and conducting in-service education programs.

b. If a licensed dietitian is not employed full-time, then one must be employed on a part-time or consultation basis with an additional full-time person who has completed a 250-hour dietary manager course and who shall be employed to be responsible for the operation of the food service.

c. Sufficient food service personnel shall be employed, oriented, trained, and their working hours scheduled to provide for the nutritional needs of the patients and to maintain the food service areas. If

food service employees are assigned duties in other service areas, those duties shall not interfere with the sanitation, safety, or time required for food service work assignments.

51.20(4) Food service equipment and supplies. Equipment necessary for preparation and maintenance of menus, records, and references shall be provided. At least one week's supply of staple foods and a reasonable supply of perishable foods shall be maintained on the premises. Supplies shall be appropriate to meet the requirements of the menu.

[ARC 9252B, IAB 12/1/10, effective 1/5/11]

481—51.21 Reserved.

481—51.22(135B) Equipment for patient care. Hospital equipment shall be selected, maintained and utilized in accordance with the needs of the patients.

51.22(1) Furnishings, supplies and equipment. Rescinded IAB 12/1/99, effective 1/5/00.

51.22(2) Hot water bags. Rescinded IAB 12/1/99, effective 1/5/00.

51.22(3) Restraints. Rescinded IAB 3/30/94, effective 5/4/94. See rule 51.7(135B).

51.22(4) Signals. Rescinded IAB 12/1/99, effective 1/5/00.

51.22(5) Screens. Rescinded IAB 12/1/99, effective 1/5/00.

51.22(6) Storage space. Rescinded IAB 12/1/99, effective 1/5/00.

481—51.23 Reserved.

481—51.24(135B) Infection control. There shall be proper policies and procedures for the prevention and control of communicable diseases. The hospital shall provide for compliance with the rules for the control of communicable disease as provided by the state department of public health in 641—Chapter 1, 1987 and 1988 Centers for Disease Control (CDC) guidelines on universal precautions and 1985 CDC guidelines for hand washing.

51.24(1) Segregation. There shall be proper arrangement of areas, rooms and patients' beds to provide for the prevention of cross-infections and the control of communicable diseases.

a. There shall be proper procedures for the cleansing of rooms and surgeries, immediately following the care of a communicable case.

b. Segregation of communicable cases shall include policies for the medical, nursing and lay staffs, providing for proper isolation technique in order to prevent cross-infection.

51.24(2) Visitors. The governing authority of the hospital shall establish proper policies for the control of visitors to all services in the hospital in accordance with hospital practice. In the maternity area, each hospital should develop its own criteria, control measures, and protocols to ensure against introduction of infection in this critical area. These criteria should be reviewed and approved by the committee of the hospital.

51.24(3) Health examinations. Health examinations for all personnel shall be required at the commencement of employment and thereafter at least every four years. The examination shall include, at a minimum, the health status of the employee. Consideration shall be given to requiring health examinations at shorter intervals for those employees working in high-risk areas. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59.

51.24(4) Notification. Prior to removal of a deceased resident/patient from a facility, the funeral director or person responsible for transporting the body shall be notified by the facility staff of any special precautions that were followed by the facility having to do with the mode of transmission of a known or suspected communicable disease.

This rule is intended to implement Iowa Code section 135B.7.

[ARC 0484C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

481—51.25 Reserved.

481—51.26(135B) Surgical services. All hospitals providing surgical services shall be properly organized and equipped to provide for the safe and aseptic treatment of surgical patients.

51.26(1) Written policies and procedures shall be implemented governing surgical services that are consistent with the needs of the patient and the resources of the hospital. Policies and procedures shall be developed in consultation with and the approval of the hospital's medical staff. At a minimum, the policies and procedures shall provide for:

- a. Surgical services under the direction of a qualified doctor of medicine or osteopathy.
- b. Delineation of the privileges and qualifications of individuals authorized to provide surgical services as set forth in the hospital's medical staff bylaws and in accordance with subrule 51.5(4). The surgical service must maintain a roster of these individuals specifying the surgical privileges of each. Surgical privileges shall be reviewed and updated at least once every two years.
- c. Immediate availability of at least one registered nurse for the operating room suites to respond to emergencies.
- d. The qualifications and job descriptions of nursing personnel, surgical technicians, and other support personnel and continuing education required.
- e. Appropriate staffing for surgical services including physician and anesthesia coverage and other support personnel.
- f. Availability of ancillary services for surgical patients including, but not limited to: blood banking, laboratory, radiology, and anesthesia.
- g. Infection control and disease prevention, including aseptic surveillance and practice, identification of infected and noninfected cases, sterilization and disinfection procedures, and ongoing monitoring of infections and infection rates.
- h. Housekeeping requirements.
- i. Safety practices.
- j. Ongoing quality assessment, performance improvement, and process improvement.
- k. Provisions for the pathological examination of tissue specimens either directly or through contractual arrangements.
- l. Appropriate preoperative teaching and discharge planning.

Reference sources to guide hospitals in the development of policies and procedures are: "Statement of Principles," March 1994 Edition, American College of Surgeons; and "Standards and Recommended Practices," 1995 Edition, Association of Operating Room Nurses.

51.26(2) Policies and procedures may be adjusted as appropriate to reflect the provision of surgical services in inpatient, outpatient or one-day surgical settings.

51.26(3) There must be an appropriate history and physical workup documented and a properly executed consent form in the chart of each patient prior to surgery, except in the event of an emergency.

51.26(4) An operative report must be written or dictated promptly following surgery and signed by the individual conducting the surgery.

51.26(5) Equipment available in the operating room, recovery room, outpatient surgical areas, and for postsurgical care, must be consistent with the needs of the patient.

51.26(6) The surgical facilities shall be constructed in accordance with 481—51.50(135B).

481—51.27 Reserved.

481—51.28(135B) Anesthesia services.

51.28(1) There shall be written policies and procedures governing anesthesia services which are consistent with the needs and resources of the hospital.

- a. Policies and procedures shall be developed in consultation with and with the approval of the hospital's medical staff.
- b. At a minimum, the policies and procedures shall provide:
 - (1) Anesthesia services shall be provided under the direction of a qualified doctor of medicine or osteopathy.
 - (2) Delineation of the qualifications of individuals authorized to administer anesthesia as set out in the hospital's medical staff bylaws or medical staff rules and regulations.

(3) For preanesthesia evaluation, appraisal of a patient's current condition, preparation of an intraoperative anesthesia record, and discharge criteria for patients.

(4) For equipment functioning and safety, including ensuring that a qualified medical doctor, osteopathic physician and surgeon or anesthetist checks, prior to the administration of anesthesia, the readiness, availability, cleanliness, and working condition of all equipment to be used in the administration of anesthetic agents.

(5) For minimizing electrical hazards in all anesthetizing areas.

(6) Quality assurance which shall at least include infection control procedures; integration of anesthesia services into various areas of the hospital; and ongoing monitoring, review, and evaluation of anesthesia services, processes, and procedures.

51.28(2) Policies and procedures may be adjusted as appropriate to reflect provision of anesthesia services in inpatient, outpatient, or one-day surgery settings.

This rule is intended to implement Iowa Code section 135B.7.

481—51.29 Reserved.

481—51.30(135B) Emergency services. All hospitals shall provide for emergency service which offers reasonable care within the medical capabilities of the facility in determining whether an emergency exists, renders care appropriate to the facility and at a minimum renders lifesaving first aid and makes appropriate referral to a facility that is capable of providing needed services.

51.30(1) The hospital has written policies and procedures specifying the scope and conduct of patient care to be provided in the emergency service.

a. The policies specify the mechanism for providing physician coverage at all times as defined by the medical staff bylaws.

b. The policies provide for a planned, formal training program required of all personnel providing patient care in the emergency service. This program shall cover emergency care for patients of all ages.

c. The policies require that a medical record be kept on every patient given treatment in the emergency service and establish the medical record documentation. The documentation should include at a minimum appropriate information regarding the medical screening provided, except where the person refuses, then notation of patient refusal; physician documentation of the presence or absence of an emergency medical condition or active labor; physician documentation of transfer or discharge, stating the basis for transfer or discharge; and where transfer occurs, identity of the facility of transfer, acceptance of the patient by the facility of transfer, and means of transfer of the patient.

d. The policies and procedures are reviewed and approved annually by the governing board.

51.30(2) Hospital policies and procedures shall be developed in accordance with the hospital's medical, technological, personnel and equipment capabilities.

481—51.31 Reserved.

481—51.32(135B) Obstetric and neonatal services.

51.32(1) All general or specialized hospitals providing for the obstetrical care of maternity patients shall be properly organized and equipped to provide accommodations for mothers and newborn infants. The supervision of the maternity area shall be under the direction of a qualified registered nurse, and there shall be accommodations for the isolation of infected cases.

51.32(2) Written policies and procedures shall be implemented governing obstetric and neonatal services that are consistent with the needs of the patient and resources of the hospital. Policies and procedures shall be developed in consultation with and with the approval of the hospital's medical staff. At a minimum, the policies and procedures shall provide for:

a. Obstetric and neonatal services under the direction of a qualified doctor of medicine or osteopathy.

b. Delineation of the privileges and qualifications of individuals authorized to provide obstetrical/gynecological service as set out in the hospital's medical staff bylaws.

- c. The qualifications of nursing personnel and continuing education required.
- d. Adequate staffing for obstetrical and newborn services.
- e. Location and arrangement of obstetric and newborn services.
- f. Infection control and disease prevention.
- g. Ongoing quality assessment.

Reference sources to guide hospitals in the development of policies and procedures are: 641—Chapter 150, Iowa Regionalized System of Perinatal Health Care, Iowa Administrative Code, and Guidelines for Perinatal Care, Fourth Edition, American Academy of Pediatrics, American College of Obstetrics and Gynecology.

481—51.33 Reserved.

481—51.34(135B) Pediatric services.

51.34(1) All general or specialized hospitals providing pediatric care shall be properly organized and equipped to provide appropriate accommodations for children. The supervision of the pediatric area shall be under the direction of a qualified registered nurse.

51.34(2) Written policies and procedures shall be implemented governing pediatric services that are consistent with the needs of the child and resources of the hospital. Policies and procedures shall be developed in consultation with and the approval of the hospital's medical staff. At a minimum, the policies and procedures shall provide for:

- a. Pediatric services under the medical direction of a qualified doctor of medicine or osteopathy.
- b. Delineation of the privileges and qualifications of individuals authorized to provide pediatric services as set out in the hospital's medical staff bylaws.
- c. The qualifications of nursing personnel and continuing education required, including care in the event of emergency situations.
- d. Adequate staffing and equipment for pediatric services including ancillary services. Staff participating in the care of pediatric patients shall have an interest in pediatrics and shall have specialized education appropriate to their profession for the care of pediatric patients.
- e. Ancillary services for pediatric patients shall be available and include, but not be limited to, pharmaceutical care, laboratory services, respiratory therapy, physical therapy and speech therapy.
- f. Ongoing quality assessment.
- g. Written protocol for transfer of pediatric patients in the event the hospital does not have capability to provide care for these patients.

Reference sources to guide hospitals in the development of policies and procedures are American Academy of Pediatrics' 1994 Policy Reference Guide and policy statements which are published on a monthly basis in "Pediatrics" and "Pediatric Dosage Handbook," Third Edition, American Pharmaceutical Association.

51.34(3) There shall be proper facilities and procedures for the isolation of pediatric patients with communicable diseases.

481—51.35 Reserved.

481—51.36(135B) Psychiatric services.

51.36(1) Any institution operating as a psychiatric hospital or operating a designated psychiatric unit shall:

- a. Be a hospital or unit primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of persons with psychiatric illnesses/disorders;
- b. Meet the general and specialized rules of this chapter pertaining to general hospitals. If medical and surgical diagnostic and treatment services are not available within the institution, the institution shall have an agreement with an outside source of these services to ensure they are immediately available;

c. Have policies and procedures for informing patients of their rights and responsibilities and for ensuring the availability of a patient advocate; and

d. Have sufficient numbers of qualified professionals and support staff to evaluate patients, formulate written individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning.

51.36(2) Personnel.

a. *Director of inpatient psychiatric services.* The director of inpatient psychiatric services shall be a doctor of medicine or osteopathy qualified to meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. The number and qualifications of doctors of medicine or doctors of osteopathy on staff must be adequate to provide essential psychiatric and medical services.

b. *Director of psychiatric nursing services.* The director of psychiatric nursing services shall:

- (1) Be a registered nurse who has a master's degree in psychiatric or mental health nursing; or
- (2) Be qualified by education and two years' experience in the care of persons with mental disorders.

c. *Psychological services.* Psychological services shall be provided or available which are in compliance with Iowa Code chapter 154B.

d. *Social services.* Social services shall provide, or have available by contract, at least one staff member who has:

- (1) A master's degree from an accredited school of social work; or
- (2) A bachelor's degree in social work with two years' experience in the care of persons with mental disorders.

e. *Therapeutic services.* Therapeutic activities shall be provided by qualified therapists. The activities shall be appropriate to the needs and interests of the patients.

51.36(3) Individual written plan of care. An individual written plan of care shall be developed by an interdisciplinary team of a physician and other personnel who are employed by, or who provide service under contract to patients in the facility. The plan of care shall:

a. Be based on a diagnostic and psychiatric evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the patient. The initial diagnostic and psychiatric evaluation shall be completed within 60 hours of admission;

b. Be developed by an interdisciplinary team in consultation with the patient, the patient's legal guardian, and others who are currently providing services or who will provide care upon discharge;

c. State treatment objectives through measurable and obtainable outcomes;

d. Prescribe an integrated program of therapies, activities, and experiences designed to meet those objectives;

e. Include an appropriate postdischarge plan with coordination of services to provide continuity of care following discharge; and

f. Be reviewed as needed or at least every 30 days by the interdisciplinary team for the continued appropriateness of the plan and for a determination of needed changes.

481—51.37 Reserved.

481—51.38(135B) Long-term care service.

51.38(1) Long-term care service definition. Long-term care service means any building or distinct part of a building utilized by the hospital for the provision of a service (except as provided by 51.38(2) below) that falls within the definition of a health care facility as specified in Iowa Code chapter 135C and Iowa Code section 135C.1(12), nursing facility, as it would be applied were it not operating as part of a hospital licensed under Iowa Code chapter 135B.

51.38(2) Long-term care service general requirements. The general requirements for the hospital's long-term care service shall be the same as required by Iowa Code chapter 135C and the rules promulgated under its authority for the category of health care facility involved. Exceptions to those

rules requiring distinct parts to be established may be waived where it is found to be in the best interest of the long-term care resident and of no detriment to the patients in the hospital.

Requests for variances to other rules for which equivalent health, safety and welfare provisions are provided may be made in accordance with the appropriate health care facility rules. In any case where a distinct part has been established for long-term residents or where the department has given approval for the intermingling of such residents with acute care patients, the same provisions and rules promulgated under Iowa Code chapter 135C shall be applicable. These rules include, but are not limited to, the same restrictions, obligations, programs of care, personal and rehabilitative services and all of the conveniences and considerations which the residents would normally have received in a licensed health care facility.

51.38(3) Long-term care service staff. The staffing requirements for the hospital's long-term care service shall be the same as required by Iowa Code chapter 135C and the rules promulgated under its authority for the category of health care facility involved. Where a hospital operates a freestanding nursing care facility, it shall be under the administrative authority of a licensed nursing home administrator who will be responsible to the hospital's administrator. Where a hospital operates a distinct part long-term care unit under the auspices of the hospital license, a licensed nursing home administrator is not required.

51.38(4) Long-term care service equipment and supplies. The equipment and supplies required for the hospital's long-term care service shall be the same as required by Iowa Code chapter 135C and the rules promulgated under its authority for the category of health care facility involved.

51.38(5) Long-term care service space. The space requirements for the various areas and resident rooms of the hospital's long-term care service shall be the same as required by Iowa Code chapter 135C and the rules promulgated under its authority for the category of health care facility involved.

481—51.39(135B) Penalty and enforcement. See Iowa Code sections 135B.14 to 135B.16.

481—51.40(135B) Validity of rules. If any provision of these rules or the application thereof to any person or circumstances shall be held invalid, such validity shall not affect the provisions or application of these rules which can be given effect without the invalid provision or application, and to this end the provisions of these rules are declared to be severable.

481—51.41(135B) Criminal, dependent adult abuse, and child abuse record checks.

51.41(1) Definitions. The following definitions apply for the purposes of this rule.

“Background check” or “record check” means criminal history, child abuse and dependent adult abuse record checks.

“Direct services” means services provided through person-to-person contact. “Direct services” excludes services provided by individuals such as building contractors, repair workers, or others who are in a hospital for a very limited purpose, who are not in the hospital on a regular basis, and who do not provide any treatment or services for the patients of the hospital.

“Employee” means any individual who is paid, either by the hospital or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors).

“Evaluation” means review by the department of human services to determine whether a founded child abuse, dependent adult abuse or criminal conviction warrants the person’s being prohibited from employment in a hospital.

“Indirect services” means services provided without person-to-person contact such as those provided by administration, dietary, laundry, and maintenance.

51.41(2) Requirements for employer prior to employing an individual. Prior to employment of a person in a hospital, the hospital shall request that the department of public safety perform a criminal history check and that the department of human services perform child and dependent adult abuse record checks of the person in this state.

a. *Informing the prospective employee.* A hospital shall ask each person seeking employment by the hospital, “Do you have a record of founded child or dependent adult abuse or have you ever been

convicted of a crime in this state or any other state?" The person shall also be informed that a background check will be conducted. The person shall indicate, by signature, that the person has been informed that the background check will be conducted.

b. Conducting a background check. The hospital may access the single contact repository (SING) to perform the required background check. If the SING is used, the hospital shall submit the person's maiden name, if applicable, with the background check request. If SING is not used, the hospital must obtain a criminal history check from the department of public safety and a check of the child and dependent adult abuse registries from the department of human services.

c. If a person considered for employment has been convicted of a crime. If a person being considered for employment in a hospital has been convicted of a crime under a law of any state, the department of public safety shall notify the hospital that upon the request of the hospital the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the hospital.

d. If a person considered for employment has a record of founded child abuse or dependent adult abuse. If a department of human services child or dependent adult abuse record check shows that a person being considered for employment in a hospital has a record of founded child or dependent adult abuse, the department of human services shall notify the hospital that upon the request of the hospital the department of human services will perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of employment in the hospital.

e. Employment pending evaluation. The hospital may employ a person for not more than 60 calendar days pending the completion of the evaluation by the department of human services if all of the following apply. The 60-day period begins on the first day of the person's employment.

(1) The person is being considered for employment other than employment involving the operation of a motor vehicle;

(2) The person does not have a record of founded child or dependent adult abuse;

(3) The person has been convicted of a crime that is a simple misdemeanor offense under Iowa Code section 123.47 or a first offense of operating a motor vehicle while intoxicated under Iowa Code section 321J.2, subsection 1; and

(4) The hospital has requested an evaluation to determine whether the crime warrants prohibition of the person's employment.

f. Validity of background check results. The results of a background check conducted pursuant to this rule shall be valid for a period of 30 calendar days from the date the results of the background check are received by the hospital.

51.41(3) Employment prohibition. A person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a hospital unless an evaluation has been performed by the department of human services.

51.41(4) Transfer of an employee to another hospital owned or operated by the same person. If an employee transfers from one hospital to another hospital owned or operated by the same person, without a lapse in employment, the hospital is not required to request additional criminal and child and dependent adult abuse record checks of that employee.

51.41(5) Transfer of ownership of a hospital. If the ownership of a hospital is transferred, at the time of transfer the background check required by this rule shall be performed for each employee for whom there is no documentation that such background check has been performed. The hospital may continue to employ such employee pending the performance of the background check and any related evaluation.

51.41(6) Change of employment—person with criminal or abuse record—exception to record check evaluation requirements. A person with a criminal or abuse record who is or was employed by a certified hospital and is hired by another certified hospital shall be subject to the background check.

a. A reevaluation of the latest record check is not required, and the person may commence employment with the other hospital if the following requirements are met:

(1) The department of human services previously performed an evaluation concerning the person's criminal or abuse record and concluded the record did not warrant prohibition of the person's employment;

(2) The latest background check does not indicate a crime was committed or founded abuse record was entered subsequent to the prior evaluation;

(3) The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed;

(4) Any restrictions placed on the person's employment in the previous evaluation by the department of human services and still applicable shall remain applicable in the person's subsequent employment; and

(5) The person subject to the background check has maintained a copy of the previous evaluation and provided it to the subsequent employer, or the previous employer provides the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, a current record check evaluation shall be performed.

b. For purposes of this subrule, a position is "substantially the same or has the same job responsibilities" if the position requires the same certification, licensure, or advanced training. For example, a licensed nurse has substantially the same or the same job responsibilities as a director of nursing; a certified nurse aide does not have substantially the same or the same job responsibilities as a licensed nurse.

c. The subsequent employer must maintain the previous evaluation in the employee's personnel file for verification of the exception to the requirement for a record check evaluation.

d. The subsequent employer may request a reevaluation of the background check and may employ the person while the reevaluation is being performed, even though an exemption under paragraph 51.41(6)"a" may be authorized.

51.41(7) Employee notification of criminal convictions or founded abuse after employment. If a person employed by an employer that is subject to this rule is convicted of a crime or has a record of founded child or dependent adult abuse entered in the abuse registry after the person's employment application date, the person shall inform the employer of such information within 48 hours of the criminal conviction or entry of the record of founded child or dependent adult abuse.

a. The employer shall act to verify the information within seven calendar days of notification. "Verify," for purposes of this subrule, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online Web site, or to contact the county clerk of court office and obtain a copy of relevant court documents.

b. If the information is verified, the hospital shall follow the requirements of paragraphs 51.41(2)"c" and "d."

c. The employer may continue to employ the person pending the performance of an evaluation by the department of human services.

d. A person who is required by this subrule to inform the person's employer of a conviction or entry of an abuse record and fails to do so within the required period commits a serious misdemeanor under Iowa Code section 135C.33.

e. The employer may notify the county attorney for the county where the employer is located of any violation or failure by an employee to notify the employer of a criminal conviction or entry of an abuse record within the period required under this subrule.

51.41(8) Hospital receipt of credible information that an employee has been convicted of a crime or founded for abuse. If the hospital receives credible information, as determined by the hospital, from someone other than the employee, that the employee has been convicted of a crime or a record of founded child or dependent adult abuse has been entered in the abuse registry after employment, and the employee has not informed the employer of the information within the time required by subrule 51.41(7), the hospital shall take the following actions:

a. The hospital shall act to verify credible information within seven calendar days of receipt. "Verify," for purposes of this subrule, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to

request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online Web site, or to contact the county clerk of court office and obtain a copy of relevant court documents.

b. If the information is verified, the hospital shall follow the requirements of paragraphs 51.41(2) "c" and "d."

51.41(9) Proof of background checks for temporary employment agencies and contractors. Proof of background checks may be kept in the files maintained by temporary employment agencies and contractors. Facilities may require temporary employment agencies and contractors to provide a copy of the result of the background checks. Copies of such results shall be made available to the department upon request.

This rule is intended to implement Iowa Code sections 135B.7 and 135B.34 and 2013 Iowa Acts, Senate File 347.

[ARC 0963C, IAB 8/21/13, effective 9/25/13; ARC 1304C, IAB 2/5/14, effective 3/12/14; ARC 1751C, IAB 12/10/14, effective 1/14/15]

481—51.42 to 51.49 Reserved.

481—51.50(135B) Minimum standards for construction.

51.50(1) Minimum standards. Hospitals and off-site premises licensed under this chapter shall be built in accordance with the following construction standards.

a. Construction shall be in accordance with the standards set forth in the Guidelines for Design and Construction of Hospitals and Outpatient Facilities, 2014 edition, produced by the Facility Guidelines Institute.

b. A critical access hospital as defined in rule 481—51.1(135B) shall meet the standards for construction set forth in Part 2.4 of the Guidelines for Design and Construction of Hospitals and Outpatient Facilities, 2014 edition, produced by the Facility Guidelines Institute.

c. Existing hospitals, critical access hospitals, and off-site premises built in compliance with prior editions of the hospital construction guidelines will be deemed in compliance with subsequent regulations, with the exception of any new structural renovations, additions, functional alterations, or changes in utilization to existing facilities, which shall meet the standards specified in this subrule.

d. The design and construction of a hospital or off-site premises shall be in conformance with the provisions of 661—Chapter 205.

e. In jurisdictions without a local building code enforcement program, the construction shall be in conformance with the state building code, as authorized by Iowa Code section 103A.7, in effect at the time of plan submittal for review and approval. In jurisdictions with a local building code enforcement program, local building code enforcement must include both the adoption and enforcement of a local building code through plan reviews and inspections.

In any case in which an applicable requirement of 661—Chapter 205 is inconsistent with an applicable requirement of the state building code, the hospital or off-site premises shall be deemed to be in compliance with the state building code requirement if the requirement of 661—Chapter 205 is met.

51.50(2) Submission of construction documents.

a. Submissions of architectural technical documents, engineering documents, and plans and specifications to the building code commissioner are the responsibility of the owner of the building or facility, although the actual submission may be completed by an authorized agent of the owner or the responsible design professional.

b. Submissions shall comply with the provisions of rule 661—300.4(103A).

c. The responsible design professional shall certify that the building plans meet the requirements specified in subrule 51.50(1), unless a variance has been granted pursuant to subrule 51.50(3).

51.50(3) Variances. The director of the department may grant variances to building and construction guidelines as contained in the Guidelines for Design and Construction of Hospitals and Outpatient Facilities, 2014 edition. The hospital or off-site premises must submit a variance request in writing to the director. The request must demonstrate how patient safety and the quality of care offered will not be compromised by the variance. The facility must demonstrate its ability to completely fulfill all

other requirements of the service. The director shall make a written determination of the request. In determining whether a variance request shall be granted, the director shall give consideration to the following conditions and to any other conditions the director deems relevant:

- a. The design and planning for the specific property shall offer improved or compensating features which provide equivalent desirability and utility;
- b. Alternate or special construction methods, techniques, and mechanical equipment shall offer equivalent durability; utility; safety; structural strength and rigidity; sanitation; odor control; protection from corrosion, decay and insect attack; and quality of workmanship;
- c. The health, safety or welfare of any patient shall not be endangered;
- d. The variance shall be limited to the specific project under consideration and shall not be construed as establishing a precedent for similar acceptance in other cases;
- e. Occupancy and function of the building shall be considered; and
- f. The type of licensing shall be considered.

[ARC 9251B, IAB 12/1/10, effective 1/5/11; ARC 0135C, IAB 5/30/12, effective 7/4/12; ARC 2157C, IAB 9/30/15, effective 11/4/15]

481—51.51(135B) Minimum standards for construction after July 8, 1998, and prior to May 22, 2002. Rescinded IAB 12/1/10, effective 1/5/11.

481—51.52(135B) Minimum standards for construction after May 22, 2002. Rescinded IAB 12/1/10, effective 1/5/11.

481—51.53(135B) Critical access hospitals. Critical access hospitals shall meet the following criteria:

51.53(1) The hospital shall be no less than 35 miles from another hospital or no less than 15 miles over secondary roads or shall be designated by the department of public health as a necessary provider of health care prior to January 1, 2006.

51.53(2) The hospital shall be a public or nonprofit hospital and shall be located in a county in a rural area. Rural counties do not include Black Hawk, Johnson, Linn, Polk, Pottawattamie, Scott and Woodbury Counties. All other counties are considered to be in rural areas for purposes of this subrule.

51.53(3) The hospital shall provide 24-hour emergency care services as described in 481 IAC 51.30(135B).

51.53(4) The hospital shall maintain no more than 25 acute care inpatient beds. However, if the hospital provides inpatient psychiatric services in a distinct part unit or inpatient rehabilitation services in a distinct part unit, no more than 10 beds shall be maintained in the distinct part unit. The beds in the distinct part unit are excluded from the 25 inpatient-bed count limit specified in 42 CFR 485.620(a).

51.53(5) The hospital shall meet the Medicare conditions of participation as a critical access hospital as described in 42 CFR Part 485, Subpart F, as of October 1, 2004.

51.53(6) The hospital shall continue to comply with all general hospital license requirements as defined in 481 IAC 51.

51.53(7) The department shall recognize, in lieu of its own inspection, the comparable inspections and inspections findings of The Joint Commission (JC), the American Osteopathic Association (AOA), Det Norske Veritas (DNV), or the Center for Improvement in Healthcare Quality (CIHQ) if the department is provided with copies of all requested materials relating to the inspections and the inspection process.

[ARC 9253B, IAB 12/1/10, effective 1/5/11; ARC 1305C, IAB 2/5/14, effective 3/12/14]

These rules are intended to implement Iowa Code chapter 135B.

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◊ Two or more ARCs

¹ Hospital Protocol for Donor Requests as it appeared in IAC 641—Chapter 180 prior to 4/4/90.

² January 16, 2013, effective date of 51.24(3) [ARC 0484C] delayed 70 days by the Administrative Rules Review Committee at its meeting held January 8, 2013.

CHAPTER 56
FINING AND CITATIONS
[Prior to 7/15/87, Health Department[470] Ch 56]

481—56.1(135C) Authority for citations. Pursuant to the authority vested in the director of the department of inspections and appeals to issue citations and assess penalties for violations of the statutes or departmental rules relating to the health care facilities, the following rules indicate the method by which citations may be issued when a particular statute or departmental rule is violated by a facility.

481—56.2(135C) Classification of violations—classes. There are three classifications for violations of statutes or departmental rules which may result in the issuance of a citation by the director of inspections and appeals and the assessment of a penalty therefor.

56.2(1) Class I. A class I violation is one which presents an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility in which the violation occurs. A physical condition or one or more practices in a facility may constitute a class I violation;

56.2(2) Class II. A class II violation is one that has a direct or immediate relationship to the health, safety, or security of residents of a health care facility, but which presents no imminent danger nor substantial probability of death or physical harm to them. A physical condition or one or more practices within a facility, including either physical abuse of any resident or failure to treat any resident with consideration, respect, and full recognition of the resident's dignity and individuality, in violation of a specific rule adopted by the department, may constitute a class II violation;

56.2(3) Class III. A class III violation is one which is not classifiable in the department's rules nor classifiable under the criteria stated in those rules as a class I or class II violation.

481—56.3(135C) Fines. Citations which are issued by the director of the department of inspections and appeals for violations of the statutes or rules relating to health care facilities will subject the facility to the following penalties.

56.3(1) Citation for a class I violation. The penalty shall not be less than \$2,000 nor more than \$10,000. The penalty for a class I violation shall be doubled when the violation is due to an intentional act by the facility in violation of a provision of Iowa Code chapter 135C or a rule adopted pursuant thereto.

56.3(2) Citation for a class II violation. The penalty shall not be less than \$100 nor more than \$500. Using the criteria established in paragraph 56.3(2) "a," the director of the department of inspections and appeals may, upon written request, waive the penalty if the class II violation is corrected within the time specified in the citation. The director shall not waive penalties related to the items listed in subrule 56.3(4).

a. Criteria for waiving the penalty for a class II violation. The director shall consider the following criteria, among others, when deciding whether to grant a waiver of a class II penalty.

(1) The past history of the facility within the last 24 months of the violation as it relates to the nature of the violation;

(2) The rights of residents to make informed decisions with their doctor(s) and family/legal representative(s); and

(3) The financial hardship the fine will cause the facility.

b. Process for requesting a waiver of the penalty for a class II violation.

(1) A facility shall submit documentation that supports the waiver request.

(2) If the facility has requested a waiver based on financial hardship, the facility must provide proof of the hardship for the individual facility, along with the parent corporation, if any. Supporting documentation shall, at minimum, include the facility's, and the parent corporation's, if any, most recent profit and loss statement and balance sheet.

(3) Requests for a waiver shall be submitted within ten working days of receipt by the facility of the notice that the violation has been corrected.

(4) The department shall make a decision on the waiver request or request additional information, if necessary, within ten working days of receipt of a waiver request and shall notify the facility in writing of the department's determination by personal service, by electronic mail, or by certified mail. If additional information is requested, such information shall be provided by the facility within five working days. If additional information is necessary, the department shall make a decision on the waiver request within ten working days of receipt of the additional information requested by the department.

(5) If the waiver request is granted and the facility has paid the penalty, the facility shall be refunded the amount of the penalty paid that was subject to the approved waiver request.

c. *Denial of penalty waiver request for a class II violation.* The director's decision to deny a waiver request is not subject to appeal. The underlying citation or state statement of deficiencies is eligible for appeal.

56.3(3) Citation for a class III violation. No penalty shall be assessed for a class III violation except as provided in rule 481—56.5(135C).

56.3(4) Self-identification and correction of a class II or class III violation prior to the on-site inspection. If a facility self-identifies a deficient practice prior to the on-site visit inspection, there has been no complaint filed with the department related to that specific deficient practice, and the facility corrects such practice prior to an inspection, no citation shall be issued or fine assessed for class II or III violations except for those penalties arising pursuant to paragraphs "a" to "f":

a. Abuse.

- (1) Rule 481—57.39(135C);
- (2) Rule 481—58.43(135C);
- (3) 481—subrules 62.23(23) to 62.23(25);
- (4) Rule 481—63.37(135C);
- (5) Rule 481—64.33(235B);
- (6) Rule 481—65.15(135C);
- (7) 481—subrules 65.25(3) to 65.25(5); and
- (8) 42 CFR Section 483.420(d).

b. Personnel histories.

- (1) Iowa Code section 135C.33;
- (2) 481—subrule 57.12(3);
- (3) 481—subrule 58.11(3);
- (4) 481—subrule 62.9(5);
- (5) 481—subrule 63.11(3);
- (6) Rule 481—64.34(135C); and
- (7) 481—subrule 65.9(5).

c. Failure to implement physician's orders as required.

- (1) 481—paragraph 57.12(2) "d";
- (2) 481—paragraph 58.19(2) "h";
- (3) 481—paragraph 62.15(1) "a";
- (4) 481—paragraph 63.11(2) "d"; and
- (5) 42 CFR Section 483.460(c)(4).

d. Failure to notify the physician of any accident, injury, or adverse change in a resident's condition.

- (1) 481—subrule 57.15(5);
- (2) 481—subrule 58.14(5); and
- (3) 481—paragraph 62.19(2) "c."

e. Failure to administer all medications as ordered by the resident's physician.

- (1) 481—paragraph 57.12(2) "d";
- (2) 481—paragraph 58.19(2) "a";
- (3) 481—paragraph 63.11(2) "d";
- (4) 481—subrule 64.4(9); and
- (5) 42 CFR Section 483.460(c)(4).

f. Failure to meet the fire safety rules and regulations promulgated by the state fire marshal.

- (1) 481—paragraph 58.28(1) “a”;
- (2) 481—subrule 62.19(7);
- (3) 481—paragraph 63.23(1) “a”; and
- (4) 42 CFR Section 483.470(j).

g. Process for documenting self-identification. If, during the inspection, an area of concern is identified to the facility that was self-identified and corrected by the facility prior to the inspection, no complaint has been filed, and the violation does not fall in the exemptions listed in 481—paragraphs 56.3(4) “a” to “f,” the facility shall complete a “Self-Identification and Correction Form” and submit it to the inspector(s) prior to the conclusion of the inspection, or to the department within two working days of the exit interview via E-mail, facsimile, or overnight courier. The documentation shall include:

- (1) The nature of the problem;
- (2) The date the problem was identified;
- (3) Who identified the problem, i.e., family, resident, staff, physician, pharmacist;
- (4) Action steps taken to correct the problem;
- (5) Date the facility determined correction was completed; and
- (6) All documentation that substantiates the above information.

56.3(5) State penalty dismissed if the corresponding federal deficiency or citation is dismissed or removed. Any state penalty, including a fine or citation, issued as a result of a joint state and federal survey and certification process shall be dismissed if the corresponding federal deficiency or citation is dismissed or removed.

a. If the federal deficiency is dismissed or removed during the federal informal dispute resolution process, the department shall remove any corresponding state fine, citation or deficiency within 20 working days of issuance of the decision.

b. If the federal deficiency is dismissed or removed at the conclusion of the federal administrative hearing process, the facility shall submit to the department a copy of the decision, along with a written request for the removal of the corresponding state fine, citation, or deficiency.

c. Any state penalty, including a fine or citation, shall be retained or reinstated if the federal deficiency is retained or reinstated.

56.3(6) Reduction of fine amount by 35 percent. If a facility has been assessed a penalty, does not request a formal hearing pursuant to Iowa Code section 135C.43 and rule 481—56.17(135C), or withdraws its request for a formal hearing within 30 days of the date that the penalty was assessed, and the penalty is paid within 30 days of receipt of notice or service, the amount of the civil penalty shall be reduced by 35 percent.

[ARC 843B, IAB 12/30/09, effective 2/3/10; ARC 2158C, IAB 9/30/15, effective 11/4/15]

481—56.4(135C) Time for compliance. Citations which are issued by the director of the department of inspections and appeals for violations of the statutes or rules related to health care facilities shall specify the length of time permitted for the violation to be abated or eliminated, as follows:

56.4(1) Citation for a class I violation: The violation shall be abated or eliminated immediately, unless the department determines that a stated period of time, specified in the citation, is required to correct the violation;

56.4(2) Citation for a class II violation: The violation shall be corrected within a stated period of time determined by the department and specified in the citation. The stated period of time specified in the citation may subsequently be modified by the department for good cause shown;

56.4(3) Citation for a class III violation: The violation shall be corrected within a reasonable time specified by the department in the citation.

481—56.5(135C) Failure to correct a violation within the time specified—penalty. Failure to correct any class of violation within the time specified in the citation, unless the licensee shows that the failure was due to circumstances beyond the licensee’s control, shall subject the facility to a further penalty of \$50 for each day that the violation continues after the time specified for correction.

481—56.6(135C) Treble and double fines.

56.6(1) Treble fines for repeated violations. The director of the department of inspections and appeals shall treble the penalties specified in rule 481—56.3(135C) for any second or subsequent class I or class II violation occurring within any 12-month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor.

56.6(2) Double fines for intentional class I violations. The director of the department of inspections and appeals shall double the penalties specified in subrule 56.3(1) when the violation is due to an intentional act by the facility in violation of a provision of Iowa Code chapter 135C or rule adopted pursuant thereto.

a. For purposes of this subrule, “intentional” means doing an act voluntarily, not by mistake or accident, and doing the act with a specific purpose in mind.

b. The facts and circumstances surrounding the act shall be considered when determining whether the act was done intentionally.

c. It is assumed that a person intends the natural results of the person’s act(s).

[ARC 8433B, IAB 12/30/09, effective 2/3/10]

481—56.7(135C) Notation of classes of violations. All rules relating to health care facilities, other than those which are informational in character, shall be followed by a notation at the end of each rule, or pertinent part thereof. This notation shall consist of a Roman numeral or numerals in parentheses. These Roman numerals refer to the class (either class I, class II, or class III) of violation which may be cited by the commissioner when that rule, or part of a rule carrying the notation is violated by the facility.

481—56.8(135C) Notation for more than one class of violation. In those instances where a particular rule, or part of a rule is followed by a notation consisting of more than one Roman numeral in parentheses, at the discretion of the director of the department of inspections and appeals, the director may issue a citation for a violation of that rule, or part thereof, designating any one of the multiple classes of violations specified in the notation.

481—56.9(135C) Factors determining selection of class of violation. In determining which class of violation will be designated in the citation, where more than one class is specified in the notation following the rule, the director of the department of inspections and appeals shall consider evidence of the circumstances surrounding the violation, including, but not limited to, the following factors:

56.9(1) The frequency and length of time the violation occurred, i.e., whether the violation was an isolated or a widespread occurrence, practice, or condition;

56.9(2) The past history of the facility within 24 months of the violation as it relates to the nature of the violation;

56.9(3) The culpability of the facility as it relates to the reasons the violation occurred;

56.9(4) The extent of any harm to the residents or the effect on the health, safety, or security of the residents which resulted from the violation;

56.9(5) The relationship of the violation to any other types of violations which have occurred in the facility;

56.9(6) The actions of the facility after the occurrence of the violation, including when corrective measures, if any, were implemented and whether the facility notified the director as required;

56.9(7) The accuracy and extent of records kept by the facility which relate to the violation, and the availability of such records to the department;

56.9(8) The rights of residents to make informed decisions with their doctor(s) and family/legal representative(s); and

56.9(9) Whether the facility made a good-faith effort to address a high-risk resident’s specific needs, and whether the evidence substantiates this effort.

481—56.10(135C) Factors determining imposition of citation and fine. The director of the department of inspections and appeals may consider evidence of the circumstances surrounding the violation including, but not limited to, those factors set out in rule 481—56.9(135C) when:

1. Determining whether a violation will be subject to a fine or citation; and
2. Determining the monetary amount of the penalty to be specified in the citation, when such a fine is authorized to be levied for a particular class of violation.

481—56.11(135C) Class I violation not specified in the rules. The director of the department of inspections and appeals may issue a citation for a class I violation when a physical condition or one or more practices exist in a facility which are not in violation of a specific statute or rule, but which constitute an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility.

481—56.12(135C) Class I violation as a result of multiple lesser violations. The director of the department of inspections and appeals may issue a citation for a class I violation when a physical condition or one or more practices exist in a facility which are a result of multiple lesser violations of the statutes or rules, but which taken as a whole constitute an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility.

481—56.13(135C) Form of citations. Each citation issued by the director of the department of inspections and appeals shall contain the following information:

56.13(1) A description of the nature of the violation;

56.13(2) A statement of the Code section or subsection or the rule or standard violated. (In the case of class I violations as described in 481—56.11(135C), a statement of the specific physical condition or one or more practices may be made in lieu of this statement.);

56.13(3) A statement of the classification of the violation, as specified in 481—56.2(135C);

56.13(4) When appropriate, a statement of the period of time allowed for correction of the violation, which shall in each case be the shortest period of time the department deems feasible; and

56.13(5) A statement that the fine may be reduced by 35 percent pursuant to Iowa Code section 135C.43A and subrule 56.3(6).

[ARC 8433B, IAB 12/30/09, effective 2/3/10]

481—56.14(135C) Licensee's response to a citation. Within 20 business days after service of a citation, the facility shall respond in the following manner, according to the type of citation issued.

56.14(1) If the facility does not desire to seek an informal conference or contest the citation, the facility shall remit to the department of inspections and appeals the amount specified by the department of inspections and appeals in the citation unless:

a. The violation was issued in conjunction with a federal civil money penalty, and the department holds the fine issued pursuant to this chapter in abeyance pursuant to Iowa Code section 249A.57, or

b. The class II violation for which the penalty was imposed has been waived pursuant to subrule 56.3(2).

56.14(2) For each class II or class III violation, the facility shall send a written response to the department of inspections and appeals, acknowledging that the citation has been received and stating that the violation will be corrected within the specified period of time allowed by the citation.

56.14(3) If the facility desires to contest a citation for a class I, class II or class III violation, the facility shall notify the department of inspections and appeals in writing that the facility desires to contest such citation and shall do one of the following:

a. Request an informal conference with an independent reviewer pursuant to rule 481—56.15(135C); or

b. Request a contested case hearing in the manner provided by Iowa Code chapter 17A for contested cases.

[ARC 8433B, IAB 12/30/09, effective 2/3/10; ARC 1047C, IAB 10/2/13, effective 1/1/14; ARC 2158C, IAB 9/30/15, effective 11/4/15]

481—56.15(135C) Informal conference. An informal conference will be held concurrently with any informal dispute resolution held pursuant to 42 CFR Section 488.331 for those health care facilities certified under Medicare or the medical assistance program.

56.15(1) Definition. For purposes of these rules, “independent reviewer” means an attorney licensed in the state of Iowa who is not currently employed by the department, has not been employed by the department in the past eight years, and has not appeared in front of the department on behalf of a health care facility in the past eight years. Preference shall be given to an attorney with background knowledge, experience or training in long-term care.

56.15(2) Request for informal conference. The request for an informal conference must be in writing, addressed to the compliance officer and include the following:

- a. Identification of the citation(s) being disputed;
- b. The type of informal conference requested: face-to-face or telephone conference; and
- c. A request for surveyor worksheets for the citation(s) being disputed, if desired.

56.15(3) Submission of documentation. Within the same ten-day period required for submission of a plan of correction pursuant to 481—subrule 50.10(7), the facility shall submit the following:

- a. The names of those who will be attending the informal conference, including legal counsel; and
- b. Documentation supporting the facility’s position. The facility must highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Supporting documentation that is not submitted within the required time frame will not be considered, except as otherwise permitted by the independent reviewer upon good cause shown. “Good cause” means substantial or adequate grounds for failing to submit documentation in a timely manner. In determining whether the facility has shown good cause, the independent reviewer shall consider what circumstances kept the facility from submitting the supporting documentation within the required time frame.

56.15(4) Face-to-face or telephone conference. A face-to-face or telephone conference, if requested, will be scheduled to occur within ten business days of the receipt by the department of the written request, all supporting documentation, and the plan of correction required by 481—subrule 50.10(7).

- a. Failure to submit supporting documentation will not delay scheduling.
- b. The conference will be scheduled for one hour to allow the facility to informally present information and explanation concerning the contested deficiencies. Due to the confidential nature of the conference, attendance may be limited.
- c. If additional information is requested during the informal conference, the facility will have two business days to deliver the additional materials to the department.
- d. When extenuating circumstances preclude a face-to-face conference, a telephone conference will be held or the facility may be given one opportunity to reschedule the face-to-face conference.

56.15(5) Results. The results of the informal conference will generally be sent to the facility within ten business days after the date of the informal conference or, if additional information is requested, within ten business days after the department’s receipt of the additional information.

- a. The independent reviewer may affirm or modify or dismiss the citation. The independent reviewer shall state in writing the specific reasons for the affirmation, modification or dismissal of the citation.
- b. The department will issue an amended (changes in factual content) or corrected (correction of typographical/data errors) citation if changes result from the informal conference.

c. The facility must submit to the department a new plan of correction for the amended or corrected citation within ten calendar days from the date of the letter conveying the results of the informal conference.

[ARC 8433B, IAB 12/30/09, effective 2/3/10; ARC 1047C, IAB 10/2/13, effective 1/1/14; ARC 2158C, IAB 9/30/15, effective 11/4/15]

481—56.16(135C) Procedure for facility after informal conference. After the conclusion of an informal conference requested by the licensee and provided pursuant to 56.14(3):

56.16(1) If the facility does not desire to further contest an affirmed or modified citation for a class I, class II or class III violation, the facility shall, within five business days after the informal conference,

or within five business days after receipt of the written decision and explanation of the independent reviewer, whichever occurs later, comply with the provisions of subrule 56.14(1).

56.16(2) If the facility does desire to further contest an affirmed or modified citation for a class I, class II or class III violation, the facility shall, within five business days after receipt of the written explanation of the independent reviewer, notify the department of inspections and appeals in writing of the facility's intent to formally contest the citation.

[ARC 8433B, IAB 12/30/09, effective 2/3/10; ARC 1047C, IAB 10/2/13, effective 1/1/14; ARC 2158C, IAB 9/30/15, effective 11/4/15]

481—56.17(135C) Formal contest. The procedures for contested cases, as set out in Iowa Code chapter 17A, and the rules adopted by the department of inspections and appeals shall be followed in all cases where proper notice has been made to the department of inspections and appeals of the intent to formally contest any citation.

These rules are intended to implement Iowa Code chapters 10A and 135C.

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¹ Effective date of Ch 56 delayed by the Administrative Rules Review Committee until 12/6/76, pursuant to Iowa Code section 17A.4 as amended by 66 GA, SF 1288, section 2, to allow further time to study and examine the rules.

² See IAB Inspections and Appeals Department.

CHAPTER 108
MEDICAL RESIDENCY TRAINING STATE MATCHING GRANTS PROGRAM

641—108.1(135) Scope and purpose. The medical residency training state matching grants program is established to provide greater access to health care by increasing the number of practicing physicians in Iowa through the expansion of residency positions in Iowa. The department shall provide funding to sponsors of accredited graduate medical education residency programs for the establishment, expansion, or support of medical residency training programs that will increase the number of residents trained. Funding for the program may be provided through the health care workforce shortage fund, medical residency training account, and is specifically dedicated to the medical residency training state matching grants program as established in Iowa Code section 135.176. These rules shall be implemented only to the extent funding is available.

[ARC 1480C, IAB 6/11/14, effective 7/16/14]

641—108.2(135) Definitions. For the purposes of these rules, the following definitions shall apply:

“*Accredited medical residency training program*” means a graduate medical education program approved by the Accreditation Council for Graduate Medical Education (ACGME) or by the American Osteopathic Association (AOA).

“*Department*” means the Iowa department of public health.

“*Director*” means the director of the Iowa department of public health.

“*Health professional shortage areas*” means federal designations that are based on general health professional shortage area (HPSA) designation criteria, plus additional criteria and guidelines specific to each of the three types of designations from the Health Resources and Services Administration Federal Office of Shortage Designations. The three types of designations include primary care, dental and mental health.

“*In excess of the federal residency cap*” means a residency position for which no federal Medicare funding is available because the residency position is a position beyond the cap for residency positions established by the federal Balanced Budget Act of 1997, Pub. L. No. 105-33.

“*New or alternative campus accredited medical residency training program*” means a program that is accredited by a recognized entity approved for such purpose by the ACGME or the AOA with the exception that a new medical residency training program that, by reason of an insufficient period of operation is not eligible for accreditation on or before the date of submission of an application for a grant, may be deemed accredited if the ACGME or the AOA finds, after consultation with the appropriate accreditation entity, that there is reasonable assurance that the program will meet the accreditation standards of the entity prior to the date of graduation of the initial class in the program.

“*Sponsor*” means a hospital, school, or consortium located in Iowa that sponsors and maintains primary organizational and financial responsibility for a graduate medical education residency program in Iowa and is accountable to the accrediting body.

[ARC 1480C, IAB 6/11/14, effective 7/16/14]

641—108.3(135) Eligibility criteria. To be eligible for a matching grant, a sponsor shall satisfy the following requirements and qualifications:

108.3(1) A sponsor shall be financially and organizationally responsible for a residency training program that is accredited by the ACGME or by the AOA.

108.3(2) A sponsor shall demonstrate through documented financial information that funds have been budgeted and will be expended by the sponsor in the amount required to provide matching funds for each residency proposed in the request for state matching funds. A sponsor shall document this requirement by providing with its request a line-item budget showing sponsor funding amounts and state matching funds requested.

108.3(3) A sponsor shall demonstrate a need for such residency program in the state by providing with its request for state matching funds objective evidence of such need including:

- a. Workforce data, including state and federal workforce data and data from tracking databases;
- b. Population data, including community health needs assessments;

- c. Supply and demand data, including health professional shortage area designations; and
- d. Other related research including unique community- or state-level factors which establish a need for such residency program.

108.3(4) A sponsor shall submit with its request for state matching funds a recruitment and retention plan to encourage residents to enter practice in Iowa with a preference for health professional shortage areas and to demonstrate over time the impact on Iowa's workforce.
[ARC 1480C, IAB 6/11/14, effective 7/16/14; ARC 2179C, IAB 9/30/15, effective 1/13/16]

641—108.4(135) Amount of grant.

108.4(1) The department shall award funds based upon the funds budgeted as demonstrated in the request, as identified in subrule 108.3(2).

108.4(2) The total amount of a grant awarded to a sponsor proposing the establishment of a new or alternative campus accredited medical residency training program shall be limited to no more than 100 percent of the amount of funds the sponsor has budgeted as demonstrated through a line-item budget for each residency sponsored for the purpose of the residency program.

The total amount of a grant awarded to a sponsor proposing the provision of a new residency position within an existing accredited medical residency or fellowship training program, or a sponsor funding residency positions which are in excess of the federal residency cap, shall be limited to no more than 25 percent of the amount of funds the sponsor has budgeted as demonstrated through a line-item budget for each residency position sponsored for the purpose of the residency program.

108.4(3) A sponsor, if awarded, shall enter into a contract with the department over a minimum of a three-year project period to include approximately one-year (12-month) renewable contract periods. Annual contracts shall include annual budgets and, upon approval of annual performance measures, renewal applications for the project period. Annual contract periods shall be renewed based on the availability of funds.

108.4(4) A sponsor shall receive funds based on budgeted expenses that include but are not limited to:

- a. Stipends and fringe benefits for residents and fellows;
- b. The portion of teaching physician salaries and fringe benefits associated with teaching and supervision of residents and fellows;
- c. Other direct costs that can be attributed to medical education (e.g., clerical salaries, telephone, office supplies).

108.4(5) An individual sponsor that establishes a new or alternative campus accredited medical residency training program shall not receive more than 50 percent of the state matching funds available each year to support the program. An individual sponsor proposing the provision of a new residency position within an existing accredited medical residency or fellowship training program, or a sponsor funding residency positions which are in excess of the federal residency cap, shall not receive more than 25 percent of the state matching funds available each year to support the program.
[ARC 1480C, IAB 6/11/14, effective 7/16/14; ARC 2179C, IAB 9/30/15, effective 1/13/16]

641—108.5(135) Review process.

108.5(1) The department shall follow requirements for competitive selection contained in 641—Chapter 176 in awarding these funds.

108.5(2) The department shall establish a request for proposal process for sponsors eligible to receive funding. The request for proposal and review process and review criteria for preference in awarding the grants shall be described in the request for proposal, including preference in the residency specialty. This preference may be reflective of a subspecialty where particular demands for services have been demonstrated, of geographic areas of preference, or of other particular preferences that advance the objectives of the program.

108.5(3) Each request for proposal issued by the department will identify one or more of the following purposes for use of the funding:

- a. The establishment of new or alternative campus accredited medical residency training programs;

b. The provision of new residency positions within existing accredited medical residency or fellowship training programs; or

c. The funding of residency positions which are in excess of the federal residency cap.

108.5(4) An applicant may appeal the denial of a properly submitted request for proposal. Appeals shall be governed by rule 641—176.8(135,17A).

[ARC 1480C, IAB 6/11/14, effective 7/16/14]

These rules are intended to implement Iowa Code section 135.176.

[Filed ARC 1480C (Notice ARC 1392C, IAB 4/2/14), IAB 6/11/14, effective 7/16/14]

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