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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

Administrative Services Department[11]

- Replace Chapter 1
- Replace Chapters 4 to 9
- Replace Chapters 41 and 42
- Replace Chapter 48
- Replace Chapters 55 and 56
- Replace Chapters 58 and 59
- Replace Chapters 61 and 62
- Replace Chapters 64 to 66
- Replace Chapter 71
- Replace Chapters 100 to 103
- Replace Chapter 119

Banking Division[187]

- Replace Analysis
- Replace Chapters 1 and 2
- Replace Chapters 7 to 9
- Replace Chapters 11 and 12
- Remove Reserved Chapters 20 to 24
- Insert Chapter 20 and Reserved Chapters 21 to 24

Corrections Department[201]

- Replace Chapter 20

Economic Development Authority[261]

- Replace Analysis
- Remove Reserved Chapters 403 to 410
- Insert Chapter 403 and Reserved Chapters 404 to 410

Human Services Department[441]

- Replace Chapter 7
- Replace Chapter 79
- Replace Chapters 81 and 82
- Replace Chapter 87

Inspections and Appeals Department[481]

- Replace Chapter 51

Natural Resource Commission[571]

Replace Analysis

Replace Chapter 15

Public Health Department[641]

Replace Analysis

Replace Chapter 9

Replace Chapter 76

Replace Chapter 110

Replace Chapter 139 with Reserved Chapter 139

Replace Chapter 154

Pharmacy Board[657]

Replace Chapter 15

Regents Board[681]

Replace Chapter 1

Labor Services Division[875]

Replace Chapter 10

TITLE I
GENERAL DEPARTMENTAL PROCEDURES
CHAPTER 1
DEPARTMENT ORGANIZATION

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

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

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—1.2(8A) Location. The department’s primary office is located in the Hoover State Office Building, Third Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0150. Office hours are 8 a.m. to 4:30 p.m., Monday through Friday, excluding holidays. The department’s website at das.iowa.gov provides information about the department’s organization and services.

[ARC 1485C, IAB 6/11/14, effective 7/16/14; ARC 4053C, IAB 10/10/18, effective 11/14/18]

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

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

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

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

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

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

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

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

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

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

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

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

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

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

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

1.4(3) State accounting enterprise. The state accounting enterprise was created to provide for the efficient management and administration of the financial resources of state government. The chief operating officer, appointed by the director, heads the enterprise. The following have been established within the state accounting enterprise:

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

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

1.4(4) Central administration.

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

b. Marketing, communications and customer council support. Marketing, communications and customer council support provides the department's media, public relations, and employee

communications services; supports product and service marketing within each of the department's enterprises; and coordinates customer council activities for the department.

1.4(5) *Customer management, finance, and internal operations.* Customer management, finance, and internal operations provides customer management, finance, and internal operations oversight, administration, and support in a manner that provides accurate and timely information, safeguards assets, and facilitates fiscally responsible, employee-centered and customer-focused decision making for the department.

1.4(6) *Central procurement and fleet services enterprise.* The chief operating officer of the enterprise is appointed by the director and directs the work of the enterprise.

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

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

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

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15; ARC 4053C, IAB 10/10/18, effective 11/14/18]

These rules are intended to implement Iowa Code chapter 8A and sections 7E.1 through 7E.5 and 17A.3.

11—1.5 and 1.6 Reserved.

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

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

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

[Filed emergency 2/1/05—published 3/2/05, effective 2/1/05]

[Filed 4/7/05, Notice 3/2/05—published 4/27/05, effective 6/1/05]

[Filed emergency 6/15/05—published 7/6/05, effective 7/1/05]

[Filed 9/22/05, Notice 7/6/05—published 10/12/05, effective 11/16/05]

[Filed without Notice 7/28/06—published 8/16/06, effective 9/20/06]

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

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

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

[Filed ARC 4053C (Notice ARC 3937C, IAB 8/15/18), IAB 10/10/18, effective 11/14/18]

CHAPTER 4
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

11—4.1(8A,22) Definitions. As used in this chapter:

“*Confidential record*” means a record that is not available as a matter of right for examination and copying by members of the public under applicable provisions of law. Confidential records include records or information contained in records that the department is prohibited by law from making available for examination by members of the public, and records or information contained in records that are specified as confidential by Iowa Code section 22.7, or other provision of law, but that may be disclosed upon order of a court, the lawful custodian of the record, or by another person duly authorized to release the record. Mere inclusion in a record of information declared confidential by an applicable provision of law does not necessarily make that entire record a confidential record.

“*Custodian*” means the department, director, or another person lawfully delegated authority by the department to act for the department in implementing Iowa Code chapter 22.

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

“*Open record*” means a record other than a confidential record.

“*Personally identifiable information*” or “*individual identifiers*” means information about or pertaining to an individual in a record which identifies the individual and which is contained in a record system.

“*Record*” means the whole or a part of a “public record” as defined in Iowa Code section 22.1 that is owned by or in the physical possession of the department.

“*Record system*” means any group of records under the control of the department from which a record may be retrieved by a personal identifier such as the name of an individual, number, symbol, or other unique retriever assigned to an individual.

11—4.2(8A,17A,22) Statement of policy, purpose and scope. The purpose of this chapter is to facilitate broad public access to open records by establishing rules, policies and procedures to implement the fair information practices Act, Iowa Code chapter 22. Chapter 4 seeks to facilitate sound department determinations with respect to the handling of confidential records. The department is committed to complying with Iowa Code chapter 22; department staff shall cooperate with members of the public in implementing the provisions of that chapter.

11—4.3(8A,22) Requests for access to records.

4.3(1) Location of record. A request for access to a record under the jurisdiction of the department shall be directed to the office where the record is kept. If the location of the record is not known by the requester, the request shall be directed to the Iowa Department of Administrative Services, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319. The department will forward the request appropriately. If a request for access to a record is misdirected, department personnel will forward the request to the appropriate person within the department.

4.3(2) Office hours. Open records shall be made available during all customary office hours, which are from 8 a.m. to 4:30 p.m., Monday through Friday, except legal holidays.

4.3(3) Request for access. Requests for access to open records may be made in writing, by telephone or in person. Requests shall identify the particular records sought by name or other personal identifier and description in order to facilitate the location of the record. Requests shall include the name and address of the person requesting the information. A person shall not be required to give a reason for requesting an open record.

4.3(4) Response to requests. The custodian of records under the jurisdiction of the department is authorized to grant or deny access to a record according to the provisions of this chapter and directions from the department. The decision to grant or deny access may be delegated to one or more designated employees.

Access to an open record shall be granted upon request. Unless the size or nature of the request requires time for compliance, the custodian shall respond to the request as soon as feasible. However,

access to an open record may be delayed for one of the purposes authorized by Iowa Code subsection 22.8(4) or 22.10(4). The custodian shall promptly inform the requester of the reason for the delay and an estimate of the length of that delay and, upon request, shall promptly provide that notice to the requester in writing.

The custodian of a record may deny access to the record by members of the public only on the grounds that a denial is warranted under Iowa Code subsection 22.8(4) or 22.10(4), or that it is a confidential record, or that its disclosure is prohibited by a court order. Access by members of the public to a confidential record is limited by law and, therefore, may generally be provided only in accordance with the provisions of rule 11—4.4(8A,17A,22) and other applicable provisions of law.

4.3(5) Security of record. No person may, without permission from the custodian, search or remove any record from department files. The custodian or a designee of the custodian shall supervise examination and copying of department records. Records shall be protected from damage and disorganization.

4.3(6) Copying. A reasonable number of copies of an open record may be made in the department's office unless printed copies are available. If copying equipment is not available in the office where an open record is kept, the custodian shall permit its examination in that office and shall arrange to have copies promptly made elsewhere, subject to costs.

4.3(7) Fees.

a. When charged. The department is authorized to charge fees in connection with the examination or copying of records in accordance with Iowa Code section 22.3. To the extent permitted by applicable provisions of law, the payment of fees may be waived when the imposition of fees is inequitable or when a waiver is in the public interest.

b. Copying and postage costs. Price schedules for regularly published records and for copies of records supplied by the department shall be posted in the department. Copies of records may be made by or for members of the public on department photocopy machines or from electronic storage systems at cost, as determined by and posted in department offices by the custodian. A charge assessed to a current employee for copies of records in the employee's own official personnel file shall not exceed \$5 per request. When the mailing of copies of records is requested, the actual costs of mailing may be charged to the requester.

c. Supervisory fee. An hourly fee may be charged for actual department expenses in supervising the examination and copying of requested records when the supervision time required is in excess of one-half hour. The custodian shall prominently post in department offices the hourly fees to be charged for supervision of records during examination and copying. That hourly fee shall not be in excess of the hourly wage of a department clerical employee who ordinarily would be appropriate and suitable to perform this supervisory function.

d. Search fees. If the request requires research or if the record or records cannot reasonably be readily retrieved, the requester will be advised of this fact. Reasonable search fees may be charged when appropriate. In addition, all costs for retrieval and copying of information stored in electronic storage systems may be charged to the requester.

e. Advance deposits.

(1) When the estimated total fee chargeable under this subrule exceeds \$25, the custodian may require a requester to make an advance payment to cover all or a part of the estimated fee. Upon completion, the actual fee will be calculated and the difference refunded or collected.

(2) When a requester has previously failed to pay a fee chargeable under this subrule, the custodian may require advance payment of the full amount of any estimated fee before the custodian processes a new or pending request for access to records from that requester.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—4.4(8A,17A,22) Access to confidential records. Under Iowa Code section 22.7 or other applicable provisions of law, the lawful custodian may disclose certain confidential records to one or more members of the public. Other provisions of law authorize or require the custodian to release specified confidential records under certain circumstances or to particular persons. In requesting the custodian to permit the

examination or copying of such a confidential record, the following procedures apply and are in addition to those specified for requests for access to records in rule 11—4.3(8A,22).

4.4(1) *Proof of identity.* A person requesting access to a confidential record may be required to provide proof of identity or authority satisfactory to the custodian to secure access to the record.

4.4(2) *Requests.* The custodian may require a request to examine and copy a confidential record to be in writing. A person requesting access to such a record may be required to sign a certified statement or affidavit enumerating the specific reasons alleged to justify access to the confidential record and to provide any proof necessary to establish relevant facts.

4.4(3) *Notice to subject of record and opportunity to obtain injunction.* After the custodian receives a request for access to a confidential record, and before the custodian releases that record, the custodian may make reasonable efforts to notify promptly any person who is a subject of that record, is identified in that record, and whose address or telephone number is contained in that record. To the extent such a delay is practicable and in the public interest, the custodian shall give the subject of that confidential record to whom notification is transmitted a reasonable opportunity to seek an injunction under Iowa Code section 22.8, and indicate to the subject of that record the specified period of time during which disclosure will be delayed for that purpose.

4.4(4) *Request denied.* When the custodian denies a request for access to a confidential record, in whole or in part, the custodian shall promptly notify the requester in writing. The denial shall be signed by the custodian of the record and shall include:

- a. The name and title of the person responsible for the denial; and
- b. A citation to the provision of law vesting authority in the custodian to deny disclosure of the record; or
- c. A citation to the statute vesting discretion in the custodian to deny disclosure of the record and a brief statement of the reasons for the denial to the requester.

4.4(5) *Request granted.* When the custodian grants a request for access to a confidential record to a particular person, the custodian shall notify that person and shall indicate any lawful restrictions imposed by the custodian on that person's examination and copying of the record.

11—4.5(8A,17A,22) Requests for treatment of a record as a confidential record and its withholding from examination. The custodian may treat a record as a confidential record and withhold it from examination only to the extent that the custodian is authorized by Iowa Code section 22.7, another applicable provision of law, or a court order, to refuse to disclose that record to members of the public.

4.5(1) *Persons who may request.* Any person who would be aggrieved or adversely affected by disclosure of a record under the jurisdiction of the department to members of the public and who asserts that Iowa Code section 22.7, another applicable provision of law, or a court order authorizes the custodian to treat the record as a confidential record may request the custodian to treat that record as a confidential record and to withhold it from public inspection. Failure of a person to request confidential record treatment for all or part of a record does not preclude the department from designating it and treating it as a confidential record.

4.5(2) *Request.* A request that a record be treated as a confidential record and be withheld from public inspection shall be in writing and shall be filed with the director. The request must set forth the legal and factual basis justifying such confidential record treatment for that record, and the name, address, and telephone number of the person authorized to respond to any inquiry or action of the custodian concerning the request. A person requesting treatment of a record as a confidential record may also be required to sign a certified statement or affidavit enumerating the specific reasons justifying the treatment of that record as a confidential record and to provide any proof necessary to establish relevant facts. Requests for treatment of a record as such a confidential record for a limited time period shall also specify the precise period of time for which that treatment is requested.

A person filing such a request shall, if possible, accompany the request with a copy of the record in question in which portions for which such confidential record treatment has been requested have been deleted. If the original record is being submitted to the department by the person requesting such

confidential treatment at the time the request is filed, the person shall indicate conspicuously on the original record that all or portions of it are confidential.

4.5(3) *Failure to request.* Failure of a person to request confidential record treatment for a record does not preclude the custodian from treating it as a confidential record. However, if a person who has submitted information to the department does not request that it be withheld from public inspection under Iowa Code sections 22.7(3) and 22.7(6) for all or part of that information, the custodian of records containing that information may proceed as if that person has no objection to its disclosure to members of the public.

4.5(4) *Timing of decision.* A decision by the custodian with respect to the disclosure of all or part of a record under its jurisdiction to members of the public may be made when a request for its treatment as a confidential record that is not available for public inspection is filed, or when the custodian receives a request for access to the record by a member of the public.

4.5(5) *Request granted or deferred.* If a request for confidential record treatment is granted, or if action on such a request is deferred, a copy of the record in which the material in question has been deleted and a copy of the decision to grant the request or to defer action upon the request will be made available for public inspection in lieu of the original record. If the custodian subsequently receives a request for access to the original record, the custodian will make reasonable and timely efforts to notify any person who has filed a request for its treatment as a confidential record that is not available for public inspection of the pendency of that subsequent request.

4.5(6) *Request denied and opportunity to seek injunction.* If a request that a record be treated as a confidential record and be withheld from public inspection is denied, the custodian shall notify the requester in writing of that determination and the reasons therefor. On application by the requester, the custodian may, in good faith, reasonably delay examination of the record so that the requester may seek injunctive relief under the provisions of Iowa Code section 22.8, or other applicable provision of law. However, such a record shall not be withheld from public inspection for any period of time if the custodian determines that the requester had no reasonable grounds to justify the treatment of that record as a confidential record. The custodian shall notify the requester in writing of the time period allowed to seek injunctive relief or the reasons for the determination that no reasonable grounds exist to justify the treatment of that record as a confidential record. The custodian may extend the period of good faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief only if no request for examination of that record has been received, or if a court directs the custodian to treat it as a confidential record, or to the extent permitted by another applicable provision of law, or with the consent of the person requesting access.

11—4.6(8A,22) Procedure by which a person who is the subject of a record may have additions, dissents, or objections entered into a record. Except as otherwise provided by law, a person may file a request with the custodian to review, and to have a written statement of additions, dissents, or objections entered into, a record containing personally identifiable information pertaining to that person. However, this does not authorize a person who is a subject of such a record to alter the original copy of that record or to expand the official record of any department proceeding. Requester shall send the request to review such a record or the written statement of additions, dissents, or objections to the custodian. The request to review such a record or the written statement of such a record of additions, dissents, or objections must be dated and signed by requester, and shall include the current address and telephone number of the requester or the requester's representative.

11—4.7(8A,17A,22) Consent to disclosure by the subject of a confidential record. To the extent permitted by any applicable provision of law, a person who is the subject of a confidential record under the jurisdiction of the department may consent to have a copy of the portion of that record concerning the subject disclosed to a third party except as provided in subrule 4.12(1). The consent must be in writing and must identify the particular record that may be disclosed, the particular person or class of persons to whom the record may be disclosed, and, where applicable, the time period during which the record may

be disclosed. The subject and, where applicable, the person to whom the record is to be disclosed, must provide proof of identity.

11—4.8(8A,17A,22) Notice to suppliers of information. When a person is requested to supply information about that person that will become part of a record under the jurisdiction of the department, the department shall notify that person of the use that will be made of the information, which persons outside the department might routinely be provided the information, which parts of the requested information are required and which are optional, and the consequences of not providing the information requested. This notice may be given in rules, on the written form used to collect the information, on a separate fact sheet or letter, in brochures, in formal agreements, in contracts, in handbooks, in manuals, verbally, or by other appropriate means.

11—4.9(8A,22) Disclosures without the consent of the subject.

4.9(1) Open records are routinely disclosed without the consent of the subject.

4.9(2) To the extent allowed by law, disclosure of confidential records may occur without the consent of the subject. Following are instances where disclosure, if lawful, will generally occur without notice to the subject:

a. For a routine use as defined in rule 11—4.10(8A,22) or in any notice for a particular record system.

b. To a recipient who has provided the department with advance written assurance that the record will be used solely as a statistical research or reporting record; provided that the record is transferred in a form that does not identify the subject.

c. To another government agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if an authorized representative of the government agency or instrumentality has submitted a written request to the agency specifying the record desired and the law enforcement activity for which the record is sought.

d. To an individual following a showing of compelling circumstances affecting the health or safety of any individual if a notice of the disclosure is transmitted to the last-known address of the subject.

e. To the legislative services agency.

f. Disclosures in the course of employee disciplinary proceedings.

g. In response to a court order or subpoena.

11—4.10(8A,22) Routine use.

4.10(1) Defined. “Routine use” means the disclosure of a record without the consent of the subject or subjects for a purpose which is compatible with the purpose for which the record was collected. “Routine use” includes disclosures required to be made by statute other than the public records law, Iowa Code chapter 22.

4.10(2) To the extent allowed by law, the following uses are considered routine uses of all records under the jurisdiction of the department:

a. Disclosure to those officers, employees, and agents of the agency who have a need for the record in the performance of their duties. The custodian of the record may upon request of any officer or employee, or on the custodian’s own initiative, determine what constitutes legitimate need to use confidential records.

b. Disclosure of information indicating an apparent violation of the law to appropriate law enforcement authorities for investigation and possible criminal prosecution, civil court action, or regulatory order.

c. Disclosure to the department of inspections and appeals for matters in which it is performing services or functions on behalf of the department.

d. Transfers of information within the department, to other state agencies, or to local units of government as appropriate to administer the program for which the information is collected.

- e.* Information released to staff of federal and state entities for audit purposes or for purposes of determining whether the department is operating a program lawfully.
- f.* Any disclosure specifically authorized by the statute under which the record was collected or maintained.
- g.* Distribution of lists of state employees to other than governmental entities.
- h.* Distribution of represented employees' payroll records to unions.

11—4.11(8A,22) Consensual disclosure of confidential records.

4.11(1) *Consent to disclosure by a subject individual.* To the extent permitted by law, the subject may consent in writing to department disclosure of confidential records as provided in rule 11—4.7(8A,17A,22).

4.11(2) *Complaints to public officials.* A letter from a subject of a confidential record to a public official which seeks the official's intervention on behalf of the subject in a matter that involves a record under the jurisdiction of the department may to the extent permitted by law be treated as an authorization to release sufficient information about the subject to the official to resolve the matter.

11—4.12(8A,22) Release to subject.

4.12(1) The subject of a confidential record may file a written request to review confidential records about that person as provided in rule 11—4.6(8A,22). However, the department need not release the following records to the subject:

- a.* The identity of a person providing information to the department when the information is authorized to be held confidential pursuant to Iowa Code section 22.7(18) or other provision of law.
- b.* Records that are the work product of an attorney or are otherwise privileged.
- c.* Peace officers' investigative reports except as required by the Iowa Code. (See Iowa Code section 22.7(5).)
- d.* As otherwise authorized by law.

4.12(2) Where a record has multiple subjects with interest in the confidentiality of the record, the department may take reasonable steps to protect confidential information relating to other subjects in the record.

11—4.13(8A,22) Availability of records.

4.13(1) *Open records.* Department records are open for public inspection and copying unless otherwise provided by rule or law.

4.13(2) *Confidential records.* The following records under the jurisdiction of the department may be withheld from public inspection. Records are listed by category, according to the legal basis for withholding them from public inspection.

a. The department is a depository for the records of other public bodies. Records are maintained on paper, audiotape, microform, and electronic information storage and media systems. Although these records are in the physical possession of the department, the responsibility for compliance with Iowa Code chapter 22 remains with the "lawful custodian." The public body requesting creation or storage of the record by the department is the lawful custodian (see Iowa Code section 22.1, definition of "lawful custodian"). All such records are confidentially maintained while in the possession of the department. Requests for access to any such records must be directed to the lawful custodian. Any records maintained by the department concerning the content, location, or disposition of such records are confidential in order to maintain security for access to confidential records pursuant to Iowa Code section 22.7.

- b.* Sealed bids received prior to the time set for public opening of bids. (Iowa Code section 72.3)
- c.* Procurement proposals prior to completion of the evaluation process and the issuance of a notice of intent to award a contract by the appropriate procurement authority. (11—subrule 105.19(3), Iowa Administrative Code)
- d.* Tax records made available to the department. (Iowa Code sections 422.20 and 422.72)
- e.* Records which are exempt from disclosure under Iowa Code section 22.7.
- f.* Minutes of closed meetings of a government body. (Iowa Code section 21.5(4))

g. Identifying details in final orders, decisions, and opinions to the extent required to prevent a clearly unwarranted invasion of personal privacy or trade secrets under Iowa Code section 17A.3(1) "e."

h. Those portions of department staff manuals, instructions, or other statements issued which set forth criteria or guidelines to be used by department staff in auditing, in making inspections, in settling commercial disputes or negotiating commercial arrangements, or in the selection or handling of cases, such as operational tactics or allowable tolerances of criteria for the defense, prosecution, or settlement of cases, when disclosure of these statements would:

- (1) Enable law violators to avoid detection;
- (2) Facilitate disregard of requirements imposed by law; or
- (3) Give a clearly improper advantage to persons who are in an adverse position to the department.

(See Iowa Code sections 17A.2 and 17A.3.)

i. Records which constitute attorney work product, attorney-client communications, or which are otherwise privileged. Attorney work product is confidential under Iowa Code sections 22.7(4), 602.10112, 622.10 and 622.11, Iowa R. Civ. P. 1.503(3), Fed. R. Civ. P. 26(b)(3), and case law.

j. Reports to government agencies which, if released, would give advantage to competitors and serve no public purpose. (Iowa Code section 22.7)

k. Vehicle accident reports submitted to the department by drivers and peace officers. (Iowa Code section 321.271)

- (1) However, access shall be granted to those persons authorized by Iowa Code section 321.271.

- (2) Pursuant to Iowa Code section 22.7, the lawful custodian may release the following information from peace officers' accident reports even though the reports are confidential: date, time, and location of accident; names of parties to the accident; owners and descriptions of the motor vehicles involved; name of investigating officer; names of injured; locations where motor vehicles and injured were transported; and the identification and owners of damaged property other than motor vehicles.

l. Confidential assignments of state vehicles by the state vehicle dispatcher. These records include letters/memos detailing driver assignments and plate numbers for selected vehicles pursuant to Iowa Code sections 8A.362 and 321.19(1).

m. Computer resource security files containing names, identifiers, and passwords of users of computer resources. This file must be kept confidential to maintain security for access to confidential records pursuant to Iowa Code section 22.7.

n. Personal information in confidential personnel records of public bodies including but not limited to cities, boards of supervisors, and school districts.

o. Communications not required by law, rule, or procedure that are made to a government body or to any of its employees by identified persons outside of government, to the extent that the government body receiving those communications from such persons outside of government could reasonably believe that those persons would be discouraged from making communications to that government body if the communications were available for general public examination. (See Iowa Code section 22.7.)

p. Information contained in records of the centralized employee registry created in Iowa Code chapter 252G, except to the extent that disclosure is authorized pursuant to Iowa Code chapter 252G. (See Iowa Code section 22.7.)

q. Data processing software, as defined in Iowa Code section 22.3A, which is developed by a government body.

r. Log-on identification passwords, Internet protocol addresses, private keys, or other records containing information which might lead to the disclosure of private keys used in a digital signature or other similar technologies as provided in Iowa Code chapter 554D.

s. Records which if disclosed might jeopardize the security of an electronic transaction pursuant to Iowa Code chapter 554D.

- t. Any other records made confidential by law.

4.13(3) Authority to release confidential records. The department may have discretion to disclose some confidential records which are exempt from disclosure under Iowa Code section 22.7 or other law. Any person may request permission to inspect these records withheld from inspection under a statute which authorizes limited or discretionary disclosure as provided in rule 11—4.4(8A,17A,22). If the

department initially determines that it will release such records, the department may, where appropriate, notify interested persons and withhold the records from inspection as provided in subrule 4.4(3).

[ARC 1568C, IAB 8/6/14, effective 9/10/14; ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—4.14(8A,22) Personally identifiable information. This rule describes the nature and extent of personally identifiable information which is collected, maintained, and retrieved by the department by personal identifier in record systems as defined in rule 11—4.1(8A,22). Unless otherwise stated, the authority to maintain the record is provided by Iowa Code chapter 8A.

4.14(1) Retrieval. Personal identifiers may be used to retrieve information from any of the systems of records that the department maintains that contain personally identifiable information.

4.14(2) Means of storage. Paper, microfilm, microfiche, and various electronic means of storage are used to store records containing personally identifiable information.

4.14(3) Comparison. Electronic or manual data processing may be used to match, to collate, or to compare personally identifiable information in one system with personally identifiable information in another system of records or with personally identifiable information within the same system.

4.14(4) Comparison with data from outside the department. Personally identifiable information in systems of records maintained by the department is retrievable through the use of personal identifiers and may be compared with information from outside the department when specified by law. This comparison is allowed in situations including:

a. Determination of any offset of a debtor's income tax refund or rebate for child support recovery or foster care recovery (Iowa Code section 8A.504);

b. Calculation of any offset against an income tax refund or rebate for default on a guaranteed student loan (Iowa Code section 8A.504);

c. Offset from any tax refund or rebate for any liability owed a state agency (Iowa Code section 8A.504);

d. Offset for any debt which is in the form of a liquidated sum due, owing, and payable to the clerk of district court as a criminal fine, civil penalty surcharge, or court costs (Iowa Code section 8A.504).

4.14(5) Nature and extent. All of the record systems listed in subrule 4.14(6) contain personally identifiable information concerning matters such as income and social security numbers.

4.14(6) Record systems with personally identifiable retrieval. The department maintains the systems or records that contain personally identifiable and confidential information as described in the following paragraphs. The legal authority for the collection of the information is listed with the description or the system.

a. *Personnel files.* Personnel files are maintained by the department and the employee's appointing authority. An employee may have several files depending on the purpose of the file and the records maintained within the file. Personnel files consist of records that concern individual state employees and their families, as well as applicants for state employment.

(1) Personnel files contain personal, private, and otherwise confidential records related to a state employee's employment, performance and discipline and will be maintained as confidential in accordance with Iowa Code section 22.7(11) and any other applicable law.

(2) These records are collected in accordance with Iowa Code chapters 8A, 19B, 20, 70A, 85, 85A, 85B, 91A, and 509A and are confidential records under Iowa Code section 22.7(11) and other law.

b. *Employee payroll records.* The payroll records system consists of records that concern individual state employees and their families.

(1) Records under the jurisdiction of the department are collected in accordance with Iowa Code chapters 8A, 19B, 20, 70A, 85, 85A, 85B, 91A, and 509A, and portions are confidential records under Iowa Code section 22.7 and other law.

(2) These records contain names, social security numbers, and other identifying numbers and are collected in the form of paper, microfilm, tape, and electronic records. Electronic records permit the comparison of personally identifiable information in one record system with that in another system.

c. *Vehicle dispatcher files.* Vehicle assignments and credit card records may be accessed by personal identifier or by vehicle identification number. Other records which may contain personally

identifiable information, but are not retrievable by it, are: mileage reports, auction information, automobile insurance premiums, pool car billings, departmental billing, motor fuel tax refund, and motor oil claims. Records are stored on paper, electronically, and on microfilm.

d. Capitol complex parking files. The general services enterprise maintains records concerning parking assignments, decals, gate cards, after-hours building passes, parking tickets, departmental parking coordinators, and hearings and appeals. All records except those related to hearings and appeals may be retrieved by personal identifier data. Records related to hearings and appeals are filed by date of hearing only. Records are stored on paper and electronically. Records relating to hearings and appeals are also stored on audio tapes.

e. Annual bid bonds. The printing division maintains a file of annual bid bonds for vendors eligible to bid on printing contracts. The file is alphabetical by vendor name and contains only those papers necessary for execution of the bond. This record is stored on paper only.

f. Telephone directory of state employees. The information technology enterprise maintains a telephone directory of state employees. The directory contains names, department names, business addresses and telephone numbers. The publication also includes private industry information and advertising containing business names, addresses and telephone numbers. This record is stored on both paper and electronically.

g. Contracts. These are records pertaining to training, consultants, and other services. These records are collected in accordance with Iowa Code chapters 8A and 19B, and portions are confidential records under Iowa Code section 22.7. These records contain names, social security numbers, and other identifying numbers and are collected in the form of paper, microfilm, tape, and electronic records. Electronic records permit the comparison of personally identifiable information in one record system with that in another system.

h. Vendor files. The department maintains files of vendors eligible to do business with the state of Iowa. Files may contain applications, vendor information booklets, vendor codes, commodity codes, minority-owned vendor identification information, and mailing lists. Records are stored on paper and electronically.

4.14(7) Releasable information on state employees. The following information that is maintained in the state payroll system or a personnel file shall be released to the public without the consent of the employee because the information is not considered to be confidential information:

- a.* The name and compensation paid to the state employee.
- b.* The dates on which the state employee was employed by state government.
- c.* The position or positions that the state employee holds or has held with state government.
- d.* The state employee's qualifications for the position or positions that the state employee holds or has held including, but not limited to, educational background and work experience.
- e.* The fact that the state employee resigned in lieu of termination, was discharged, or was demoted as the result of disciplinary action and the documented reasons and rationale for the resignation in lieu of termination, the discharge, or the demotion.
- f.* Personnel settlement agreements between the state employee and the state employee's employer.

[ARC 1568C, IAB 8/6/14, effective 9/10/14; ARC 3215C, IAB 7/19/17, effective 7/1/17]

11—4.15(8A,22) Other groups of records. This rule describes groups of records maintained by the department other than record systems retrieved by individual identifiers as defined in rule 11—4.1(8A,22). The records listed may contain information about individuals. These records are routinely available to the public, subject to costs. Unless otherwise designated, the authority for the department to maintain the record is provided by Iowa Code chapter 8A. All records may be stored on paper, microfilm, tape or in automated data processing systems unless otherwise noted.

4.15(1) Rule-making records. Official documents executed during the promulgation of department rules and public comments. This information is collected pursuant to Iowa Code chapter 17A.

4.15(2) Board and commission records. Agendas, minutes, and materials presented to boards and commissions within the department are available from the department except those records concerning

closed sessions which are exempt from disclosure under Iowa Code section 21.5(4) or which are otherwise confidential by law. These records may identify individuals who participate in meetings. This information is collected pursuant to Iowa Code section 21.3. These records may also be stored on audiotapes.

4.15(3) Publications. Publications include but are not limited to news releases, annual reports, project reports, and newsletters which describe various department programs.

4.15(4) Information about individuals. Department news releases, final project reports, and newsletters may contain information about individuals, including staff or members of boards or commissions.

4.15(5) Statistical reports. Periodic reports of activity for various department programs are available from the department.

4.15(6) Appeal decisions and advisory opinions. All final orders, decisions and opinions are open to the public except for information that is confidential according to rule 11—4.5(8A,17A,22) or subrule 4.13(2). These records, collected under the authority of Iowa Code chapters 8A, 19B, 20, 70A, 85, 85A, 85B, 91A, 97A, 97B, 97C, and 509A, may contain confidential information about individuals.

4.15(7) Published materials. The department uses many legal and technical publications in its work. The public may inspect these publications upon request. Some of these materials may be protected by copyright laws.

4.15(8) Published manuals. The department uses many legal and technical publications in its work. The public may inspect these publications upon request. Some of these materials may be protected by copyright law.

4.15(9) Mailing lists and contact lists. The department maintains lists including names, mailing addresses, and telephone numbers of state employees, commission members, officials in government of other states, and members of the general public. These lists may be used for distribution of informational material, such as newsletters, policy directives, or educational bulletins. These lists are also used to provide contacts for coordination of services or as reference information sources.

4.15(10) Authorized user lists. The information technology enterprise maintains a list of persons authorized to use their on-line services.

4.15(11) Publication sales files. The general services enterprise maintains records of persons purchasing legal publications. Records are used to produce mailing lists for renewal notification and publication mailings. Records are maintained by ZIP code. These are paper records except for mailing list production.

4.15(12) Bid/purchasing process. The department maintains records of specifications, proposals, bid documents, awards, contracts, agreements, leases, performance bonds, requisitions, purchase orders, printing orders, supply orders, and correspondence.

4.15(13) Project files. The department maintains plans, specifications, contracts, studies, drawings, photos, blueprints, requests for services, abstracts, lease/rental files, 28E agreements, space administration, and facilities records.

4.15(14) Property/equipment files. The department maintains records of inventory, assignments, distribution, maintenance, requests, operations, shipping/receiving reports, and adjustments.

4.15(15) Education program records. Educational records include a library of training courses and reference materials, a library of course documentation, TSO data sets, Iowa interagency training system, class registrations of state employees, and files of course evaluations.

4.15(16) Data processing files. Data processing files include operations logs, database user requests, job number maintenance/update, data entry format book, integrated data dictionary, computer output forms designations, system software, hardware/software configurations, problem determination/resolution records, and incident reports.

4.15(17) Federal surplus property records. Donee files include applications for eligibility and records of distribution, transfer orders of property from other federal agencies, and auction files. Auction records are filed by auction date only, but award forms may contain names of individuals purchasing property.

4.15(18) Administrative records. Administrative records include the following:

- a. Reports: weekly, monthly, annual, biennial, statistical, analysis, activity.
- b. Correspondence: public, interdepartmental, internal.
- c. Policies and procedures.
- d. Organizational charts or table of authorized positions.
- e. Memberships: professional/technical organizations.
- f. Budget and financial records.
- g. Accounting records: accounts receivable, accounts payable, receipts, invoices, claims, vouchers, departmental billings.
- h. Requisition of equipment and supplies.

4.15(19) *Legislative files.* Legislative files include pending bills, enrolled bills, legislative proposals, and copies of amendments.

4.15(20) *Printing files.* Printing files include print requisition, plates, negatives, samples, typesetting, artwork, and production logs.

4.15(21) *All other records.* Records are open if not exempted from disclosure by law.
[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—4.16(8A,22) Data processing systems. Some of the data processing systems used by this department may permit the comparison of personally identifiable information in one record system with personally identifiable information in another record system.

11—4.17(8A,22) Applicability. This chapter does not:

1. Require the department to index or retrieve records which contain information about a person by that person's name or other personal identifier.
2. Make available to the general public records which would otherwise not be available under the public records law, Iowa Code chapter 22.
3. Govern the maintenance or disclosure of, notification of or access to, records in the possession of the department that are governed by the regulations of another agency.
4. Apply to grantees, including local governments or subdivisions thereof, administering state-funded programs unless otherwise provided by law or agreement.
5. Make available records compiled in reasonable anticipation of court litigation or formal administrative proceedings. Applicable legal and constitutional principles, statutes, rules of discovery, evidentiary privileges, the Code of Professional Responsibility, and applicable regulations shall govern the availability of such records to the general public or to any subject individual or party to such litigation or proceedings.

11—4.18(8A) Agency records.

4.18(1) Each agency shall maintain a file of personnel records on each employee and each applicant for employment as specified by the department in rule or policy. All employee and applicant records are under the jurisdiction of the department.

4.18(2) The appointing authority shall give each employee copies of all materials placed in the employee's file unless determined otherwise by the department. The appointing authority shall provide copies of records to the department as requested.

4.18(3) When an employee is transferred, promoted or demoted from one agency to another agency, the employee's personnel records shall be sent to the receiving appointing authority by the former appointing authority.

4.18(4) The director shall prescribe the forms to be used for collecting and recording information on employees and applicants for employment, as well as the procedures for the completion, processing, and release of those forms and records, as well as the information contained on them.

[ARC 1568C, IAB 8/6/14, effective 9/10/14]

These rules are intended to implement Iowa Code chapters 8A and 22.

[Filed 12/17/03, Notice 11/12/03—published 1/7/04, effective 2/11/04]

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[Filed Emergency After Notice ARC 3215C (Notice ARC 3072C, IAB 5/24/17), IAB 7/19/17,
effective 7/1/17]

[Filed ARC 4053C (Notice ARC 3937C, IAB 8/15/18), IAB 10/10/18, effective 11/14/18]

CHAPTER 5
PETITIONS FOR RULE MAKING

11—5.1(17A) Petition for rule making.

5.1(1) Filing. Any person or agency may file a petition for adoption of rules or request for review of rules with the Department of Administrative Services, Office of the Director, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319. A petition is deemed filed when it is received by the department. The department shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the department an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

DEPARTMENT OF ADMINISTRATIVE SERVICES	
Petition by (Name of Petitioner) for the (adoption, amendment, or repeal) of rules relating to (state the subject matter).	} PETITION FOR RULE MAKING

The petition must provide the following information:

- a.* A statement of the specific rule-making action sought by the petitioner including the text or a summary of the contents of the proposed rule or amendment to a rule and, if it is a petition to amend or repeal a rule, a citation and the relevant language to the particular portion or portions of the rule proposed to be amended or repealed.
- b.* A citation to any law deemed relevant to the department's authority to take the action urged or to the desirability of that action.
- c.* A brief summary of petitioner's arguments in support of the action urged in the petition.
- d.* A brief summary of any data supporting the action urged in the petition.
- e.* The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by or interested in, the proposed action which is the subject of the petition.
- f.* Any request by petitioner for a meeting provided for by rule 5.4(17A).

5.1(2) Content. The petition must be dated and signed by the petitioner or the petitioner's representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.

5.1(3) Denial. The director may deny a petition because it does not substantially conform to the required form.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—5.2(17A) Briefs. The petitioner may attach a brief to the petition in support of the action urged in the petition. The director may request a brief from the petitioner or from any other person concerning the substance of the petition.

11—5.3(17A) Inquiries. Inquiries concerning the status of a petition for rule making may be made to the director at the offices of the department.

11—5.4(17A) Department consideration.

5.4(1) Within 14 days after the filing of a petition, the department must submit a copy of the petition and any accompanying brief to the administrative rules coordinator and to the administrative rules review committee. Upon request by petitioner in the petition, the department must schedule a brief and informal meeting between the petitioner and the department to discuss the petition. The department may request the petitioner to submit additional information or argument concerning the petition. The department may also solicit comments from any person on the substance of the petition. Also, comments on the substance of the petition may be submitted to the department by any person.

5.4(2) Within 60 days after the filing of the petition, or within any longer period agreed to by the petitioner, the department must, in writing, deny the petition, and notify petitioner of its action and the

specific grounds for the denial, or grant the petition and notify petitioner that it has instituted rule-making proceedings on the subject of the petition. The petitioner shall be deemed notified of the denial or grant of the petition on the date when the department mails or delivers the required notification to the petitioner.

5.4(3) Denial of a petition because it does not substantially conform to the required form does not preclude the filing of a new petition on the same subject that seeks to eliminate the grounds for the department's rejection of the petition.

These rules are intended to implement Iowa Code chapters 8A and 17A.

[Filed 11/6/03, Notice 10/1/03—published 11/26/03, effective 2/11/04]

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

[Filed ARC 4053C (Notice ARC 3937C, IAB 8/15/18), IAB 10/10/18, effective 11/14/18]

CHAPTER 6
AGENCY PROCEDURE FOR RULE MAKING

11—6.1(17A) Applicability. Except to the extent otherwise expressly provided by statute, all rules adopted by the department are subject to the provisions of Iowa Code chapter 17A, the Iowa administrative procedure Act, and the provisions of this chapter.

11—6.2(17A) Advice on possible rules before notice of proposed rule adoption. In addition to seeking information by other methods, the department may, before publication of a Notice of Intended Action under Iowa Code section 17A.4(1) “a,” solicit comments from the public on a subject matter of possible rule making by the department by causing notice to be published in the Iowa Administrative Bulletin of the subject matter and indicating where, when, and how persons may comment. Notwithstanding the foregoing, except as otherwise provided by law, the department may use its own experience, specialized knowledge, and judgment in the adoption of a rule.

11—6.3(17A) Public rule-making docket.

6.3(1) Docket maintained. The department shall maintain a current public rule-making docket.

6.3(2) Anticipated rule making. The rule-making docket shall list each anticipated rule-making proceeding. A rule-making proceeding is deemed “anticipated” from the time a draft of proposed rules is distributed for internal discussion within the department. For each anticipated rule-making proceeding, the docket shall contain a listing of the precise subject matter which may be submitted for consideration by the department for subsequent proposal under the provisions of Iowa Code section 17A.4(1) “a,” the name and address of department personnel with whom persons may communicate with respect to the matter, and an indication of the present status within the agency of that possible rule. The department may also include in the docket other subjects upon which public comment is desired.

6.3(3) Pending rule-making proceedings. The rule-making docket shall list each pending rule-making proceeding. A rule-making proceeding is pending from the time it is commenced, by publication in the Iowa Administrative Bulletin of a Notice of Intended Action pursuant to Iowa Code section 17A.4(1) “a,” to the time it is terminated, by publication of a Notice of Termination in the Iowa Administrative Bulletin or the rule’s becoming effective. For each rule-making proceeding, the docket shall indicate:

- a. The subject matter of the proposed rule;
- b. A citation to all published notices relating to the proceeding;
- c. Where written submissions on the proposed rule may be inspected;
- d. The time during which written submissions may be made;
- e. The names of persons who have made written requests for an opportunity to make oral presentations on the proposed rule, where those requests may be inspected, and where and when oral presentations may be made;
- f. Whether a written request for the issuance of a regulatory analysis, or a concise statement of reasons, has been filed; whether such an analysis or statement or a fiscal impact statement has been issued; and where any such written request, analysis, or statement may be inspected;
- g. The current status of the proposed rule and any department determination with respect thereto;
- h. Any known timetable for department decisions or other action in the proceeding;
- i. The date of the rule’s adoption;
- j. The date of the rule’s filing, indexing, and publication;
- k. The date on which the rule will become effective; and
- l. Where the rule-making record may be inspected.

11—6.4(17A) Notice of proposed rule making.

6.4(1) Contents. At least 35 days before the adoption of a rule, the department shall cause a Notice of Intended Action to be published in the Iowa Administrative Bulletin. The Notice of Intended Action shall include:

- a. A brief explanation of the purpose of the proposed rule;
- b. The specific legal authority for the proposed rule;
- c. Except to the extent impracticable, the text of the proposed rule;
- d. Where, when, and how persons may present their views on the proposed rule; and
- e. Where, when, and how persons may demand an oral proceeding on the proposed rule if the notice does not already provide for one.

Where inclusion of the complete text of a proposed rule in the Notice of Intended Action is impracticable, the department shall include in the notice a statement fully describing the specific subject matter of the omitted portion of the text of the proposed rule, the specific issues to be addressed by that omitted text of the proposed rule, and the range of possible choices being considered by the department for the resolution of each of those issues.

6.4(2) *Incorporation by reference.* A proposed rule may incorporate other materials by reference only if it complies with all of the requirements applicable to the incorporation by reference of other materials in an adopted rule that are contained in subrule 6.12(2) of this chapter.

6.4(3) *Copies of notices.* Persons desiring to receive copies of future Notices of Intended Action by subscription must file with the department a written request indicating the name and address to which such notices should be sent. Within seven days after submission of a Notice of Intended Action to the administrative rules coordinator for publication in the Iowa Administrative Bulletin, the agency shall mail or electronically transmit a copy of that notice to subscribers who have filed a written request for either mailing or electronic transmittal with the agency for Notices of Intended Action. The written request shall be accompanied by payment of the subscription price which may cover the full cost of the subscription service, including its administrative overhead and the cost of copying and mailing the Notices of Intended Action for a period of one year. Inquiries regarding the subscription price should be directed to the Department of Administrative Services, Office of the Director, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—6.5(17A) Public participation.

6.5(1) *Written comments.* For at least 20 days after publication of the Notice of Intended Action, persons may submit argument, data, and views, in writing, on the proposed rule. Such written submissions should identify the proposed rule to which they relate and should be submitted to the person designated in the Notice of Intended Action at the address designated in the Notice of Intended Action.

6.5(2) *Oral proceedings.* The department may, at any time, schedule an oral proceeding on a proposed rule. The department shall schedule an oral proceeding on a proposed rule if, within 20 days after the published Notice of Intended Action, a written request for an opportunity to make oral presentations is submitted to the department by the administrative rules review committee, a governmental subdivision, an agency, an association having not less than 25 members, or at least 25 persons. That request must also contain the following additional information:

- a. A request by one or more individual persons must be signed by each of them and include the address and telephone number of each of them.
- b. A request by an association must be signed by an officer or designee of the association and must contain a statement that the association has at least 25 members and the address and telephone number of the person signing that request.
- c. A request by an agency or governmental subdivision must be signed by an official having authority to act on behalf of the entity and must contain the address and telephone number of the person signing that request.

6.5(3) *Conduct of oral proceedings.*

a. *Applicability.* This subrule applies only to those oral rule-making proceedings in which an opportunity to make oral presentations is authorized or required by Iowa Code section 17A.4(1) “b” or this chapter.

b. *Scheduling and notice.* An oral proceeding on a proposed rule may be held in one or more locations and shall not be held earlier than 20 days after notice of its location and time is published in

the Iowa Administrative Bulletin. That notice shall also identify the proposed rule by ARC number and citation to the Iowa Administrative Bulletin.

c. Presiding officer. The director or another person designated by the director who will be familiar with the substance of the proposed rule, shall preside at the oral proceeding on a proposed rule. If the director does not preside, the presiding officer shall prepare a memorandum for consideration by the director summarizing the contents of the presentations made at the oral proceeding unless the director determines that such a memorandum is unnecessary because the director will personally listen to or read the entire transcript of the oral proceeding.

d. Conduct of proceeding. At an oral proceeding on a proposed rule, persons may make oral statements and make documentary and physical submissions, which may include data, views, comments or arguments concerning the proposed rule. Persons wishing to make oral presentations at such a proceeding are encouraged to notify the director at least one business day prior to the proceeding and indicate the general subject of their presentations. At the proceeding, those who participate shall indicate their names and addresses, identify any persons or organizations they may represent, and provide any other information relating to their participation deemed appropriate by the presiding officer. Oral proceedings shall be open to the public and shall be recorded by stenographic or electronic means.

(1) At the beginning of the oral proceeding, the presiding officer shall give a brief synopsis of the proposed rule, a statement of the statutory authority for the proposed rule, and the reasons for the agency decision to propose the rule. The presiding officer may place time limitations on individual oral presentations when necessary to ensure the orderly and expeditious conduct of the oral proceeding. To encourage joint oral presentations and to avoid repetition, additional time may be provided for persons whose presentations represent the views of other individuals as well as their own views.

(2) Persons making oral presentations are encouraged to avoid restating matters which have already been submitted in writing.

(3) To facilitate the exchange of information, the presiding officer may, where time permits, open the floor to questions or general discussion.

(4) The presiding officer shall have the authority to take any reasonable action necessary for the orderly conduct of the meeting.

(5) Physical and documentary submissions presented by participants in the oral proceeding shall be submitted to the presiding officer. Such submissions become the property of the department.

(6) The presiding officer may continue the oral proceeding at a later time without notice other than by announcement at the hearing.

(7) Participants in an oral proceeding shall not be required to take an oath or submit to cross-examination. However, the presiding officer in an oral proceeding may question participants and permit the questioning of participants by other participants about any matter relating to that rule-making proceeding, including any prior written submissions made by those participants in that proceeding; but no participant shall be required to answer any question.

(8) The presiding officer in an oral proceeding may permit rebuttal statements and request the filing of written statements subsequent to the adjournment of the oral presentations.

6.5(4) Additional information. In addition to receiving written comments and oral presentations on a proposed rule according to the provisions of this rule, the department may obtain information concerning a proposed rule through any other lawful means deemed appropriate under the circumstances.

6.5(5) Accessibility. The department shall schedule oral proceedings in rooms accessible to and functional for persons with physical disabilities. Persons who have special requirements should contact the person designated in the Notice of Intended Action at the telephone number or address provided in the Notice of Intended Action in advance to arrange access or other needed services.

11—6.6(17A) Regulatory analysis.

6.6(1) Definition of small business. A “small business” is defined in Iowa Code section 17A.4A(7).

6.6(2) Mailing list. Small businesses or organizations of small businesses may be registered on the department’s small business impact list by making a written application addressed to the rules administrator. The application for registration shall state:

- a. The name of the small business or organization of small businesses;
- b. Its address;
- c. The name of a person authorized to transact business for the applicant;
- d. A description of the applicant's business or organization. An organization representing 25 or more persons who qualify as a small business shall indicate that fact;
- e. Whether the registrant desires copies of Notices of Intended Action at cost, or desires advance notice of the subject of all or some specific category of proposed rule making affecting small business.

The department may at any time request additional information from the applicant to determine whether the applicant is qualified as a small business or as an organization of 25 or more small businesses. The department may periodically send a letter to each registered small business or organization of small businesses asking whether that business or organization wishes to remain on the registration list. The name of a small business or organization of small businesses will be removed from the list if a negative response is received, or if no response is received within 30 days after the letter is sent.

6.6(3) *Time of mailing.* Within seven days after submission of a Notice of Intended Action to the administrative rules coordinator for publication in the Iowa Administrative Bulletin, the department shall mail to all registered small businesses or organizations of small businesses, in accordance with their request, either a copy of the Notice of Intended Action or notice of the subject of that proposed rule making. In the case of a rule that may have an impact on small business adopted in reliance upon Iowa Code section 17A.4(2), the department shall mail notice of the adopted rule to registered businesses or organizations prior to the time the adopted rule is published in the Iowa Administrative Bulletin.

6.6(4) *Qualified requesters for regulatory analysis—economic impact.* The department shall issue a regulatory analysis of a proposed rule that conforms to the requirements of Iowa Code section 17A.4A(2) "a" after a proper request from:

- a. The administrative rules coordinator;
- b. The administrative rules review committee.

6.6(5) *Qualified requesters for regulatory analysis—business impact.* The agency shall issue a regulatory analysis of a proposed rule that conforms to the requirements of Iowa Code section 17A.4A(2) "b" after a proper request from:

- a. The administrative rules coordinator;
- b. The administrative rules review committee;
- c. At least 25 or more persons who sign the request provided that each represents a different small business;
- d. An organization representing at least 25 small businesses. That organization shall list the name, address and telephone number of not less than 25 small businesses it represents.

6.6(6) *Time period for analysis.* Upon receipt of a timely request for a regulatory analysis the department shall adhere to the time lines described in Iowa Code section 17A.4A(4).

6.6(7) *Contents of request.* A request for a regulatory analysis is made when it is mailed or delivered to the agency. The request shall be in writing and satisfy the requirements of Iowa Code section 17A.4A(1).

6.6(8) *Contents of concise summary.* The contents of the concise summary shall conform to the requirements of Iowa Code sections 17A.4A(4) and (5).

6.6(9) *Publication of a concise summary.* The department shall make available, to the maximum extent feasible, copies of the published summary in conformance with Iowa Code section 17A.4A(5).

6.6(10) *Regulatory analysis contents—rules review committee or rules coordinator.* When a regulatory analysis is issued in response to a written request from the administrative rules review committee, or the administrative rules coordinator, the regulatory analysis shall conform to the requirements of Iowa Code section 17A.4A(2) "a," unless a written request expressly waives one or more of the items listed in the section.

6.6(11) *Regulatory analysis contents—substantial impact on small business.* When a regulatory analysis is issued in response to a written request from the administrative rules review committee, the administrative rules coordinator, at least 25 persons signing that request who each qualify as a small

business or by an organization representing at least 25 small businesses, the regulatory analysis shall conform to the requirements of Iowa Code section 17A.4A(2) "b."

11—6.7(17A,25B) Fiscal impact statement.

6.7(1) A proposed rule that mandates additional combined expenditures exceeding \$100,000 by all affected political subdivisions, or agencies and entities which contract with political subdivisions to provide services shall be accompanied by a fiscal impact statement outlining the costs associated with the rule. A fiscal impact statement shall satisfy the requirements of Iowa Code section 25B.6.

6.7(2) If the department determines at the time it adopts a rule that the fiscal impact statement upon which the rule is based contains errors, the department shall, at the same time, issue a corrected fiscal impact statement and publish the corrected fiscal impact statement in the Iowa Administrative Bulletin.

11—6.8(17A) Time and manner of rule adoption.

6.8(1) *Time of adoption.* The department shall not adopt a rule until the period for making written submissions and oral presentations has expired. Within 180 days after the later of the publication of the Notice of Intended Action, or the end of oral proceedings thereon, the department shall adopt a rule pursuant to the rule-making proceeding or terminate the proceeding by publication of a notice to that effect in the Iowa Administrative Bulletin.

6.8(2) *Consideration of public comment.* Before the adoption of a rule, the department shall consider fully all of the written submissions and oral submissions received in that rule-making proceeding or any memorandum summarizing such oral submissions, and any regulatory analysis or fiscal impact statement issued in that rule-making proceeding.

6.8(3) *Reliance on agency expertise.* Except as otherwise provided by law, the department may use its own experience, technical competence, specialized knowledge, and judgment in the adoption of a rule.

11—6.9(17A) Variance between adopted rule and published notice of proposed rule adoption.

6.9(1) The department shall not adopt a rule that differs from the rule proposed in the Notice of Intended Action on which the rule is based unless:

- a. The differences are within the scope of the subject matter announced in the Notice of Intended Action and are in character with the issues raised in that notice; and
- b. The differences are a logical outgrowth of the contents of that Notice of Intended Action and the comments submitted in response thereto; and
- c. The Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question.

6.9(2) In determining whether the Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question, the department shall consider the following factors:

- a. The extent to which persons who will be affected by the rule should have understood that the rule-making proceeding on which it is based could affect their interests;
- b. The extent to which the subject matter of the rule or the issues determined by the rule are different from the subject matter or issues contained in the Notice of Intended Action.

6.9(3) The department shall commence a rule-making proceeding within 60 days of its receipt of a petition for rule making seeking the amendment or repeal of a rule that differs from the proposed rule contained in the Notice of Intended Action upon which the rule is based, unless the department finds that the differences between the adopted rule and the proposed rule are so insubstantial as to make such a rule-making proceeding wholly unnecessary. A copy of any such finding and the petition to which it responds shall be sent to the petitioner, the administrative rules coordinator, and the administrative rules review committee, within three days of its issuance.

6.9(4) Concurrent rule-making proceedings. Nothing in this rule disturbs the discretion of the department to initiate, concurrently, several different rule-making proceedings on the same subject with several different published Notices of Intended Action.

11—6.10(17A) Exemptions from public rule-making procedures.

6.10(1) *Omission of notice and comment.* To the extent the department for good cause finds that public notice and participation are unnecessary, impracticable, or contrary to the public interest in the process of adopting a particular rule, the department may adopt that rule without publishing advance Notice of Intended Action in the Iowa Administrative Bulletin and without providing for written or oral public submissions prior to its adoption. The department shall incorporate the required finding and a brief statement of its supporting reasons in each rule adopted in reliance upon this subrule.

6.10(2) *Categories exempt.* The following narrowly tailored categories of rules are exempted from the usual public notice and participation requirements because those requirements are unnecessary, impracticable, or contrary to the public interest with respect to each and every member of the defined class: rules mandated by either state or federal law.

6.10(3) *Public proceedings on rules adopted without them.* The department may, at any time, commence a standard rule-making proceeding for the adoption of a rule that is identical or similar to a rule it adopts in reliance upon subrule 6.10(1). Upon written petition by a governmental subdivision, the administrative rules review committee, an agency, the administrative rules coordinator, an association having not less than 25 members, or at least 25 persons, the department shall commence a standard rule-making proceeding for any rule specified in the petition that was adopted in reliance upon subrule 6.10(1). Such a petition must be filed within one year of the publication of the specified rule in the Iowa Administrative Bulletin as an adopted rule. The rule-making proceeding on that rule must be commenced within 60 days of the receipt of such a petition. After a standard rule-making proceeding commenced pursuant to this subrule, the department may either readopt the rule it adopted without benefit of all usual procedures on the basis of subrule 6.10(1), or may take any other lawful action, including the amendment or repeal of the rule in question, with whatever further proceedings are appropriate.

11—6.11(17A) Concise statement of reasons.

6.11(1) *General.* When requested by a person, either prior to the adoption of a rule or within 30 days after its publication in the Iowa Administrative Bulletin as an adopted rule, the department shall issue a concise statement of reasons for the rule. Requests for such a statement must be in writing and be delivered to the Rules Administrator, Department of Administrative Services, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319. The request should indicate whether the statement is sought for all or only a specified part of the rule. Requests will be considered made on the date received.

6.11(2) *Contents.* The concise statement of reasons shall contain:

- a. The reasons for adopting the rule;
- b. An indication of any change between the text of the proposed rule contained in the published Notice of Intended Action and the text of the rule as finally adopted, with the reasons for any such change;
- c. The principal reasons urged in the rule-making proceeding for and against the rule, and the department's reasons for overruling the arguments made against the rule.

6.11(3) *Time of issuance.* After a proper request, the department shall issue a concise statement of reasons by the later of the time the rule is adopted or 35 days after receipt of the request.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—6.12(17A) Contents, style, and form of rule.

6.12(1) *Contents.* Each rule adopted by the department shall contain the text of the rule and, in addition:

- a. The date the department adopted the rule;
- b. A brief explanation of the principal reasons for the rule-making action if such reasons are required by Iowa Code section 17A.4(1) "b," or the department in its discretion decides to include such reasons;
- c. A reference to all rules repealed, amended, or suspended by the rule;
- d. A reference to the specific statutory or other authority authorizing adoption of the rule;

e. Any findings required by any provision of law as a prerequisite to adoption or effectiveness of the rule;

f. A brief explanation of the principal reasons for the failure to provide for waivers to the rule if no waiver provision is included and a brief explanation of any waiver or special exceptions provided in the rule if such reasons are required by Iowa Code section 17A.4(1)“*b*,” or the department in its discretion decides to include such reasons; and

g. The effective date of the rule.

6.12(2) *Incorporation by reference.* The department may incorporate by reference in a proposed or adopted rule, and without causing publication of the incorporated matter in full, all or any part of a code, standard, rule, or other matter if the department finds that the incorporation of its text in the department proposed or adopted rule would be unduly cumbersome, expensive, or otherwise inexpedient. The reference in the department proposed or adopted rule shall fully and precisely identify the incorporated matter by location, title, citation, date, and edition, if any; shall briefly indicate the precise subject and the general contents of the incorporated matter; and shall state that the proposed or adopted rule does not include any later amendments or editions of the incorporated matter. The department may incorporate such matter by reference in a proposed or adopted rule only if the department makes copies of it readily available to the public. The rule shall state how and where copies of the incorporated matter may be obtained at cost from the department of administrative services, and how and where copies may be obtained from the agency of the United States, this state, another state, or the organization, association, or persons, originally issuing that matter. The department shall retain permanently a copy of any materials incorporated by reference in a rule of the department of administrative services.

If the department adopts standards by reference to another publication, it shall provide a copy of the publication containing the standards to the administrative rules coordinator for deposit in the state law library and may make the standards available electronically.

6.12(3) *References to materials not published in full.* When the administrative code editor decides to omit the full text of a proposed or adopted rule because publication of the full text would be unduly cumbersome, expensive, or otherwise inexpedient, the department shall prepare and submit to the administrative code editor for inclusion in the Iowa Administrative Bulletin and Iowa Administrative Code a summary statement describing the specific subject matter of the omitted material. This summary statement shall include the title and a brief description sufficient to inform the public of the specific nature and subject matter of the proposed or adopted rules, and of significant issues involved in these rules. The summary statement shall also describe how a copy of the full text of the proposed or adopted rule, including any unpublished matter and any matter incorporated by reference, may be obtained from the department. The department will provide a copy of that full text (at actual cost) upon request and shall make copies of the full text available for review at the state law library and may make the standards available electronically.

At the request of the administrative code editor, the department shall provide a proposed statement explaining why publication of the full text would be unduly cumbersome, expensive, or otherwise inexpedient.

6.12(4) *Style and form.* In preparing its rules, the department shall follow the uniform numbering system, form, and style prescribed by the administrative rules coordinator.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—6.13(17A) Department rule-making record.

6.13(1) *Requirement.* The department shall maintain an official rule-making record for each rule it proposes or adopts by publication in the Iowa Administrative Bulletin of a Notice of Intended Action. The rule-making record and materials incorporated by reference must be available for public inspection.

6.13(2) *Contents.* The agency rule-making record shall contain:

a. Copies of all publications in the Iowa Administrative Bulletin with respect to the rule or the proceeding upon which the rule is based and any file-stamped copies of submissions to the administrative rules coordinator concerning that rule or the proceeding upon which it is based;

b. Copies of any portions of the department's public rule-making docket containing entries relating to the rule or the proceeding upon which the rule is based;

c. All written petitions, requests, and submissions received by the department, and all other written materials of a factual nature and distinguished from opinion that are relevant to the merits of the rule and that were created or compiled by the department and considered by the chief information officer, in connection with the formulation, proposal, or adoption of the rule or the proceeding upon which the rule is based, except to the extent the department is authorized by law to keep them confidential; provided, however, that when any such materials are deleted because they are authorized by law to be kept confidential, the department shall identify in the record the particular materials deleted and state the reasons for that deletion;

d. Any official transcript of oral presentations made in the proceeding upon which the rule is based or, if not transcribed, the stenographic record or electronic recording of those presentations, and any memorandum prepared by a presiding officer summarizing the contents of those presentations;

e. A copy of any regulatory analysis or fiscal impact statement prepared for the proceeding upon which the rule is based;

f. A copy of the rule and any concise statement of reasons prepared for that rule;

g. All petitions for amendment or repeal or suspension of the rule;

h. A copy of any objection to the issuance of that rule without public notice and participation that was filed pursuant to Iowa Code section 17A.4(2) by the administrative rules review committee, the governor, or the attorney general;

i. A copy of any objection to the rule filed by the administrative rules review committee, the governor, or the attorney general pursuant to Iowa Code section 17A.4(4), and any department response to that objection;

j. A copy of any significant written criticism of the rule, including a summary of any petitions for waiver of the rule; and

k. A copy of any executive order concerning the rule.

6.13(3) *Effect of record.* Except as otherwise required by a provision of law, the department rule-making record required by this rule need not constitute the exclusive basis for department action on that rule.

6.13(4) *Maintenance of record.* The department shall maintain the rule-making record for a period of not less than five years from the later of the date the rule to which it pertains became effective, the date of the Notice of Intended Action, or the date of any written criticism as described in 6.13(2) "g," "h," "i," or "j."

11—6.14(17A) *Filing of rules.* The department shall file each rule it adopts in the office of the administrative rules coordinator. The filing must be executed as soon after adoption of the rule as is practicable. At the time of filing, each rule must have attached to it any fiscal impact statement and any concise statement of reasons that was issued with respect to that rule. If a fiscal impact statement or statement of reasons for that rule was not issued until a time subsequent to the filing of that rule, the note or statement must be attached to the filed rule within five working days after the note or statement is issued. In filing a rule, the department shall use the standard form prescribed by the administrative rules coordinator.

11—6.15(17A) *Effectiveness of rules prior to publication.*

6.15(1) *Grounds.* The department may make a rule effective after its filing at any stated time prior to 35 days after its indexing and publication in the Iowa Administrative Bulletin if it finds that a statute so provides, the rule confers a benefit or removes a restriction on some segment of the public, or that the effective date of the rule is necessary to avoid imminent peril to the public health, safety, or welfare. The department shall incorporate the required finding and a brief statement of its supporting reasons in each rule adopted in reliance upon this subrule.

6.15(2) *Special notice.* When the department makes a rule effective prior to its indexing and publication in reliance upon the provisions of Iowa Code section 17A.5(2) "b"(3), the department shall

employ all reasonable efforts to make its contents known to the persons who may be affected by that rule prior to the rule's indexing and publication. The term "all reasonable efforts" requires the department to employ the most effective and prompt means of notice rationally calculated to inform potentially affected parties of the effectiveness of the rule that is justified and practical under the circumstances considering the various alternatives available for this purpose, the comparative costs to the department of utilizing each of those alternatives, and the harm suffered by affected persons from any lack of notice concerning the contents of the rule prior to its indexing and publication. The means that may be used for providing notice of such rules prior to their indexing and publication include, but are not limited to, any one or more of the following means: radio, newspaper, television, signs, mail, telephone, personal notices or electronic means.

A rule made effective prior to its indexing and publication in reliance upon the provisions of Iowa Code section 17A.5(2) "b"(3) shall include in that rule a statement describing the reasonable efforts that will be used to comply with the requirements of subrule 6.15(2).

11—6.16(17A) General statements of policy.

6.16(1) *Compilation, indexing, public inspection.* The department shall maintain an official, current, and dated compilation that is indexed by subject, containing all of its general statements of policy within the scope of Iowa Code section 17A.2(11) "a," "c," "f," "g," "h," "k." Each addition to, change in, or deletion from the official compilation must also be dated, indexed, and a record thereof kept. Except for those portions containing rules governed by Iowa Code section 17A.2(11) "f," or otherwise authorized by law to be kept confidential, the compilation must be made available for public inspection and copying.

6.16(2) *Enforcement of requirements.* A general statement of policy subject to the requirements of this subsection shall not be relied on by the department to the detriment of any person who does not have actual, timely knowledge of the contents of the statement until the requirements of subrule 6.16(1) are satisfied. This provision is inapplicable to the extent necessary to avoid imminent peril to the public health, safety, or welfare.

11—6.17(17A) Review by department of rules.

6.17(1) Any interested person, association, agency, or political subdivision may submit a written request to the administrative rules coordinator requesting the department to conduct a formal review of a specified rule. Upon approval of that request by the administrative rules coordinator, the department shall conduct a formal review of a specified rule to determine whether a new rule should be adopted instead or whether the rule should be amended or repealed. The department may refuse to conduct a review if it has conducted such a review of the specified rule within five years prior to the filing of the written request.

6.17(2) In conducting the formal review, the department shall prepare within a reasonable time a written report summarizing its findings, its supporting reasons, and any proposed course of action. The report must include a concise statement of the department's findings regarding the rule's effectiveness in achieving its objectives, including a summary of any available supporting data. The report shall also concisely describe significant written criticisms of the rule received during the previous five years, including a summary of any petitions for waiver of the rule received by the department or granted by the department. The report shall describe alternative solutions to resolve the criticisms of the rule, the reasons any were rejected, and any changes made in the rule in response to the criticisms as well as the reasons for the changes. A copy of the department's report shall be sent to the administrative rules review committee and the administrative rules coordinator. The report must also be available for public inspection.

These rules are intended to implement Iowa Code chapter 17A and 2003 Iowa Code Supplement chapter 8A.

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CHAPTER 7
CONTESTED CASES

11—7.1(8A,17A) Scope and applicability. This chapter applies to contested case proceedings conducted by the department of administrative services or by the division of administrative hearings in the department of inspections and appeals on behalf of the department. Excepted from this chapter are matters covered by rule 11—60.2(8A), disciplinary actions; rule 11—61.1(8A), grievances; 11—subrule 61.2(6), appeal of disciplinary actions; rule 11—68.6(19B), discrimination complaints, including disability-related and sexual harassment complaints; matters covered by the grievance procedure in any collective bargaining agreement with state employees; matters within the exclusive jurisdiction of the workers' compensation commissioner; and matters related to any of the department's vendors that administer group benefits if the vendor has an established complaint or appeal procedure. Further, the provisions of 11—Chapter 52, job classification, are exempt from subrules 7.5(4) to 7.5(7) and rules 11—7.6(8A,17A) and 11—7.8(8A,17A).

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—7.2(8A,17A) Definitions. Except where otherwise specifically defined by law:

“*Administrative law judge (ALJ)*” means an employee of the administrative hearings division of the department of inspections and appeals who presides over contested cases and other proceedings.

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

“*Department*” means the department of administrative services (DAS).

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

“*Division*” means the division of administrative hearings of the department of inspections and appeals (DIA).

“*Ex parte*” means a communication, oral or written, to the presiding officer or other decision maker in a contested case without notice and an opportunity for all parties to participate.

“*Filing*” is defined in subrule 7.12(4) except where otherwise specifically defined by law.

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

“*Party*” means a party as defined in Iowa Code subsection 17A.2(8).

“*Presiding officer*” means the administrative law judge (ALJ) assigned to the contested case or, in the case of an appeal pursuant to rule 11—52.5(8A), the classification appeal committee appointed by the director.

“*Proposed decision*” means the presiding officer's recommended findings of fact, conclusions of law, and decision and order in contested cases where the department did not preside.

11—7.3(8A,17A) Time requirements.

7.3(1) Time shall be computed as provided in Iowa Code subsection 4.1(34).

7.3(2) For good cause, the presiding officer may extend or shorten the time to take any action, except as provided otherwise by rule or law. Except for good cause stated in the record, before extending or shortening the time to take any action, the presiding officer shall afford all parties an opportunity to be heard or to file written arguments.

11—7.4(8A,17A) Requests for a contested case hearing. Any person claiming an entitlement to a contested case proceeding shall file a written request for such a proceeding within the time specified by the particular rules or statutes governing the subject matter or, in the absence of such law, the time specified in the department action in question.

The request for a contested case proceeding should state the name and address of the requester, identify the specific department action which is disputed, and where the requester is represented by a lawyer identify the provisions of law or precedent requiring or authorizing the holding of a contested case proceeding in the particular circumstances involved, and include a short and plain statement of the issues of material fact in dispute.

11—7.5(8A,17A) Notice of hearing.

7.5(1) Delivery. Delivery of the notice of hearing constitutes the commencement of the contested case proceeding. Notices shall be served by first-class mail, unless otherwise required by statute or rule.

7.5(2) Content. Notices of hearing shall contain the information required by Iowa Code subsection 17A.12(2), the following information and any additional information required by statute or rule.

- a. Identification of all parties including the name, address and telephone number of the person who will act as advocate for the department or the state and of parties' counsel, where known;
- b. Reference to the procedural rules governing conduct of the contested case proceeding;
- c. Reference to the procedural rules governing informal settlement; and
- d. Identification of the presiding officer, if known. If not known, a description of who will serve as presiding officer (e.g., an administrative law judge from the department of inspections and appeals, or the classification appeal committee).

7.5(3) Transmission of contested cases. In every proceeding filed by the department with the division, the department shall complete a transmittal form. The following information is required:

- a. The name of the transmitting department;
- b. The name, address and telephone number of the contact person in the transmitting department;
- c. The name or title of the proceeding, which may include a file number;
- d. Any department docket or reference number;
- e. A citation to the jurisdictional authority of the department regarding the matter in controversy;
- f. Any anticipated special features or requirements that may affect the hearing;
- g. Whether the hearing should be held in person or by telephone or video conference call;
- h. Any special legal or technical expertise needed to resolve the issues in the case;
- i. The names and addresses of all parties and their attorneys or other representatives;
- j. The date the request for a contested case hearing was received by the department;
- k. A statement of the issues involved and a reference to statutes and rules involved;
- l. Any mandatory time limits that apply to the processing of the case;
- m. The earliest appropriate hearing date; and
- n. Whether a petition or answer is required.

7.5(4) Issuance of the hearing notice. When a case is transmitted by the department to the division for hearing, the division shall issue the notice of hearing.

7.5(5) Attachments. The following documents shall be attached to the completed transmittal form when it is sent to the division:

- a. A copy of the document showing the department action in controversy; and
- b. A copy of any document requesting a contested case hearing.

7.5(6) Receipt. When a properly transmitted case is received, it is marked with the date of receipt by the division. An identifying number shall be assigned to each contested case upon receipt.

7.5(7) Scheduling. The division shall promptly schedule hearings for the department. The availability of an administrative law judge and any special circumstances shall be considered.

11—7.6(8A,17A) Presiding officer.

7.6(1) An administrative law judge shall have the following technical expertise unless waived by the department.

- a. A license to practice law in the state of Iowa;
- b. Three years' experience as an administrative law judge; and
- c. For a hearing related to procurement, knowledge of contract law.

7.6(2) Except as otherwise provided by law, all rulings by an administrative law judge acting as presiding officer are subject to appeal to the department. A party must seek any available intra-agency appeal in order to exhaust adequate administrative remedies.

7.6(3) Unless otherwise provided by law, the director, or the director's designee, when reviewing a proposed decision upon intra-agency appeal, shall have the powers of and shall comply with the provisions of this chapter which apply to presiding officers.

11—7.7(17A) Waiver of procedures. Unless otherwise precluded by law, the parties in a contested case proceeding may waive any provision of this chapter pursuant to Iowa Code section 17A.10. However, the department in its discretion may refuse to give effect to such a waiver when it deems the waiver to be inconsistent with the public interest.

11—7.8(8A,17A) Telephone/video proceedings. A prehearing conference or a hearing may be held by telephone or video conference call pursuant to a notice of hearing or an order of the presiding officer. The presiding officer shall determine the location of the parties and witnesses in telephone or video hearings. The convenience of the witnesses or parties, as well as the nature of the case, shall be considered when the location is chosen.

11—7.9(8A,17A) Disqualification.

7.9(1) A presiding officer or other person shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

- a.* Has a personal bias or prejudice concerning a party or a representative of a party;
- b.* Has personally investigated, prosecuted or advocated in connection with that case, the specific controversy underlying that case, another pending factually related contested case, or a pending factually related controversy that may culminate in a contested case involving the same parties;
- c.* Is subject to the authority, direction or discretion of any person who has personally investigated, prosecuted or advocated in connection with that contested case, the specific controversy underlying that contested case, or a pending factually related contested case or controversy involving the same parties;
- d.* Has acted as counsel to any person who is a private party to that proceeding within the past two years;
- e.* Has a personal financial interest in the outcome of the case or any other significant personal interest that could be substantially affected by the outcome of the case;
- f.* Has a spouse or relative within the third degree of relationship that: (1) is a party to the case, or an officer, director or trustee of a party; (2) is a lawyer in the case; (3) is known to have an interest that could be substantially affected by the outcome of the case; or (4) is likely to be a material witness in the case; or
- g.* Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

7.9(2) The term “personally investigated” means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term “personally investigated” does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person’s investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other department functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by Iowa Code subsection 17A.17(3) and subrules 7.9(3) and 7.23(3).

7.9(3) In a situation where a presiding officer or other person knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

7.9(4) If a party asserts disqualification on any appropriate ground, including those listed in subrule 7.9(1), the party shall file a motion supported by an affidavit pursuant to Iowa Code subsection 17A.17(7). The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party.

If, during the course of the hearing, a party first becomes aware of evidence of bias or other grounds for disqualification, the party may move for disqualification but must establish the grounds by the introduction of evidence into the record.

If the presiding officer determines that disqualification is appropriate, the presiding officer or other person shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal under rule 11—7.25(8A,17A) and seek a stay under rule 11—7.29(8A,17A).

11—7.10(8A,17A) Consolidation—severance.

7.10(1) Consolidation. The presiding officer may, upon motion by any party or the presiding officer's own motion, consolidate any or all matters at issue in two or more contested case proceedings where:

- a. The matters at issue involve common parties or common questions of fact or law;
- b. Consolidation would expedite and simplify consideration of the issues; and
- c. Consolidation would not adversely affect the rights of parties to those proceedings.

At any time prior to the hearing, any party may on motion request that the matters not be consolidated, and the motion shall be granted for good cause shown.

7.10(2) Severance. The presiding officer may, upon motion by any party or upon the presiding officer's own motion, for good cause shown, order any proceeding or portion thereof severed.

11—7.11(8A,17A) Pleadings.

7.11(1) Pleadings may be required by rule, by the notice of hearing or by order of the presiding officer.

7.11(2) Petition. When an action of the department is appealed and pleadings are required under subrule 7.11(1), the aggrieved party shall file the petition.

a. Any required petition shall be filed within 20 days of delivery of the notice of hearing, unless otherwise ordered.

b. The petition shall state in separately numbered paragraphs the following:

- (1) On whose behalf the petition is filed;
- (2) The particular provisions of the statutes and rules involved;
- (3) The relief demanded and the facts and law relied upon for relief; and
- (4) The name, address and telephone number of the petitioner and the petitioner's attorney, if any.

7.11(3) Answer. If pleadings are required, the answer shall be filed within 20 days of service of the petition or notice of hearing, unless otherwise ordered.

a. Any party may move to dismiss or apply for a more definite, detailed statement when appropriate.

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

c. The answer shall state the name, address and telephone number of the person filing the answer and of the attorney representing that person, if any.

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

7.11(4) Amendment. Any notice of hearing, petition or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed and to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

11—7.12(8A,17A) Service and filing of pleadings and other papers.

7.12(1) When service is required. Except where otherwise specifically authorized by law, every pleading, motion, document or other paper filed in the contested case proceeding and every paper relating to discovery in the proceeding shall be served upon each of the parties to the proceeding, including the originating agency. Except for the notice of the hearing and an application for rehearing

as provided in Iowa Code subsection 17A.16(2), the party filing a document is responsible for service on all parties.

7.12(2) Service—how made. Service upon a party represented by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivery or by mailing a copy to the person’s last-known address. Service by first-class mail is rebuttably presumed to be complete upon mailing, except where otherwise specifically provided by statute, rule or order.

7.12(3) Filing—when required.

a. After a matter has been assigned to the division, and until a proposed decision is issued, documents shall be filed with the division, rather than the originating agency. All papers filed after the notice is issued that are required to be served upon a party shall be filed simultaneously with the division.

b. After the notice of hearing, when a matter has not been assigned to the department of inspections and appeals for hearing, all pleadings, motions, documents or other papers in a contested case proceeding shall be filed with the Department of Administrative Services, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319. All pleadings, motions, documents or other papers that are required to be served upon a party shall be filed simultaneously with the department.

7.12(4) Filing—when made.

a. Except where otherwise provided by law, a document is deemed filed at the time it is:

(1) Delivered to the division of administrative hearings pursuant to subrule 7.12(3), paragraph “a,” or to the department of administrative services pursuant to subrule 7.12(3), paragraph “b,” and date-stamped received;

(2) Delivered to an established courier service for immediate delivery;

(3) Mailed by first-class mail or by state interoffice mail so long as there is adequate proof of mailing; or

(4) Sent by facsimile transmission (fax) as provided in subrule 7.12(4), paragraph “b.”

b. All documents filed with the division or the department pursuant to these rules, except a person’s request or demand for a contested case proceeding (see Iowa Code subsection 17A.12(9)), may be filed by facsimile transmission (fax). A copy shall be filed for each case involved. A document filed by fax is presumed to be an accurate reproduction of the original. If a document filed by fax is illegible, a legible copy may be substituted and the date of filing shall be the date the illegible copy was received. The date of filing by fax shall be the date the document is received by the division or the department. The receiving office will not provide a mailed file-stamped copy of documents filed by fax.

7.12(5) Proof of mailing. Adequate proof of mailing includes the following:

a. A legible United States Postal Service postmark on the envelope;

b. A certificate of service;

c. A notarized affidavit; or

d. A certification in substantially the following form:

I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the Department of Administrative Services, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319, and to the names and addresses of the parties listed below by depositing the same in (a United States post office mailbox with correct postage properly affixed) or (state interoffice mail).

(SIGNATURE) (DATE)

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—7.13(8A,17A) Discovery.

7.13(1) Pursuant to Iowa Code section 17A.13, discovery procedures applicable in civil actions are applicable in contested cases. Unless lengthened or shortened by rules of the department or by a ruling by the presiding officer, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

7.13(2) Any motion relating to discovery shall allege that the moving party has made a good faith attempt to resolve the issues raised by the motion with the opposing party. Motions in regard to discovery shall be ruled on by the presiding officer. Opposing parties shall be afforded the opportunity to respond within ten days of the filing of the motion unless the time is shortened as provided in subrule 7.13(1). The presiding officer may rule on the basis of the written motion and any response or may order argument on the motion.

7.13(3) Evidence obtained in discovery may be used in the contested case proceeding if that evidence would otherwise be admissible in that proceeding.

11—7.14(8A,17A) Subpoenas.

7.14(1) Issuance.

a. Pursuant to Iowa Code subsection 17A.13(1), a department subpoena shall be issued to a party on request unless subrule 7.14(1), paragraph “*d*,” applies. A request may be either oral or in writing. In the absence of good cause for permitting later action, a written request for a subpoena must be received at least three days before the scheduled hearing. The request shall include the name, address and telephone number of the requesting party.

b. Parties are responsible for service of their own subpoenas and payment of witness fees and mileage expenses.

c. When authorized by law, a presiding officer may issue a subpoena on the presiding officer’s own motion.

d. When there is reasonable ground to believe a subpoena is requested for the purpose of harassment, or that the subpoena is irrelevant, the presiding officer may refuse to issue the subpoena, or may require the requesting party to provide a statement of testimony expected to be elicited from the subpoenaed witness and a showing of relevancy. If the presiding officer refuses to issue a subpoena, the presiding officer shall provide, upon request, a written statement of the ground for refusal. A party to whom a refusal is issued may obtain a prompt hearing regarding the refusal by filing a written request to the presiding officer.

7.14(2) Motion to quash or modify.

a. A subpoena may be quashed or modified upon motion for any lawful ground in accordance with Iowa Rule of Civil Procedure 1.1701.

b. A motion to quash or modify a subpoena shall be served on all parties of record.

c. The motion shall be set for argument promptly.

11—7.15(8A,17A) Motions.

7.15(1) No technical form is required for motions. Prehearing motions, however, must be written, state the grounds for relief and state the relief sought. Any motion for summary judgment shall be filed in compliance with the requirements of Iowa Rule of Civil Procedure 1.981.

7.15(2) Any party may file a written resistance or response to a motion within 15 days after the motion is served, unless the time period is extended or shortened by rules of the department or by the presiding officer. The presiding officer may consider a failure to respond within the required time period in ruling on a motion.

7.15(3) The presiding officer may schedule oral argument on any motion on the request of any party or on the presiding officer’s own motion.

7.15(4) Except for good cause, all motions pertaining to the hearing must be filed and served at least 10 days prior to the hearing date unless the time period is shortened or lengthened by rules of the department or by the presiding officer.

11—7.16(8A,17A) Prehearing conference.

7.16(1) Any party may request a prehearing conference. A request for prehearing conference or an order for prehearing conference on the presiding officer's own motion shall be filed in writing and served on all parties of record not less than ten days prior to the hearing date. A prehearing conference shall be scheduled not less than three business days prior to the hearing date.

The presiding officer shall give notice of the prehearing conference to all parties. For good cause, the presiding officer may permit variances from this rule.

7.16(2) Each party shall bring to the prehearing conference:

a. A final list of witnesses who the party reasonably anticipates will testify at the hearing. Witnesses not listed may be excluded from testifying.

b. A final list of exhibits that the party reasonably anticipates will be introduced at the hearing. Exhibits not listed, except rebuttal exhibits, may be excluded from admission into evidence.

7.16(3) In addition to the requirements of subrule 7.16(2), the parties at a prehearing conference may:

a. Enter into stipulations of law;

b. Enter into stipulations of fact;

c. Enter into stipulations on the admissibility of exhibits;

d. Identify matters that the parties intend to request be officially noticed;

e. Unless precluded by statute, enter into stipulations for waiver of the provisions of Iowa Code chapter 17A allowed by Iowa Code section 17A.10(2) or waiver of department rules; and

f. Consider any additional matters that will expedite the hearing.

7.16(4) A prehearing conference shall be conducted by telephone or video conference call unless otherwise ordered. Parties shall exchange and receive witness and exhibit lists prior to a telephone or video prehearing conference call.

11—7.17(17A) Continuances. Unless otherwise provided, application for continuance shall be made to the presiding officer.

7.17(1) A written application for continuance shall:

a. Be made before the hearing;

b. State the specific reasons for the request; and

c. Be signed by the requesting party or the requesting party's representative.

7.17(2) If the presiding officer waives the requirement for a written motion, an oral application for continuance may be made. A written application shall be submitted no later than five days after the oral request. The presiding officer may waive the requirement for a written application. No application for continuance will be made or granted ex parte without notice except in an emergency where notice is not feasible. The department may waive notice of requests for a case or a class of cases.

7.17(3) Except where otherwise provided, a continuance may be granted at the discretion of the presiding officer. The presiding officer may consider, in addition to the grounds stated in the motion:

a. Any prior continuances;

b. The interests of all parties;

c. The likelihood of informal settlement;

d. Existence of emergency;

e. Objection to the continuance;

f. Any applicable time requirements;

g. The existence of a conflict in the schedules of counsel or parties or witnesses;

h. The timeliness of the request;

i. Any applicable state or federal statutes or regulations; and

j. Other relevant factors.

The presiding officer may require documentation of any ground for continuance.

11—7.18(8A,17A) Withdrawals. The party that requested an evidentiary hearing regarding department action may withdraw prior to the hearing only in accordance with department rules. Requests for withdrawal may be oral or written. If the request is oral, the presiding officer may require the party to

submit a written request after the oral request. Unless otherwise provided, a withdrawal shall be with prejudice.

11—7.19(8A,17A) Intervention.

7.19(1) Motion. A motion for leave to intervene shall be served on all parties and shall state the grounds for the proposed intervention, the position and interest of the proposed intervenor, and the possible impact of intervention on the proceeding. A proposed answer or petition in intervention shall be attached to the motion. Any party may file a response within 14 days of service of the motion to intervene unless the time period is extended or shortened by the presiding officer.

7.19(2) When filed. Motion for leave to intervene shall be filed as early in the proceeding as possible to avoid adverse impact on existing parties or the disposition of the proceeding. Unless otherwise ordered, a motion for leave to intervene shall be filed before the prehearing conference, if one is held, or at least 20 days before the date scheduled for hearing. Any later motion must contain a statement of good cause for the failure to file in a timely manner. The intervenor shall be bound by any agreement, arrangement or other matter previously raised in the case. Requests by untimely intervenors for continuances that would delay the hearing will be denied.

7.19(3) Grounds for intervention. The movant shall demonstrate that:

- a. Intervention would not unduly prolong the proceedings or otherwise prejudice the rights of existing parties;
- b. The movant will be aggrieved or adversely affected by a final order; and
- c. The interests of the movant are not being adequately represented by existing parties; or that the movant is otherwise entitled to intervene.

7.19(4) Effect of intervention. If appropriate, the presiding officer may order consolidation of petitions and briefs of different parties whose interests are aligned with each other and limit the number of representatives allowed to participate in the proceedings. A person granted leave to intervene is a party to the proceeding. The order granting intervention may restrict the issues to be raised or otherwise condition the intervenor's participation in the proceeding.

11—7.20(8A,17A) Hearing procedures.

7.20(1) The appointed presiding officer in a contested case proceeding shall preside at the hearing and may:

- a. Rule on motions;
- b. Require the parties to submit briefs;
- c. Issue a proposed decision; and
- d. Issue orders and rulings to ensure the orderly conduct of the proceedings.

7.20(2) All objections to procedures, admission of evidence or any other matter shall be timely made and stated on the record.

7.20(3) Parties in a contested case have the right to participate or to be represented in all hearings or prehearing conferences related to their case. Partnerships, corporations or associations may be represented by any member, officer, director or duly authorized agent.

Any party may be represented by an attorney or another person authorized by law. The cost of representation is the responsibility of the party.

7.20(4) Parties in a contested case have the right to introduce evidence on points at issue, to cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, to present evidence in rebuttal, and to submit briefs and engage in oral argument.

7.20(5) The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly or disruptive.

7.20(6) Witnesses may be sequestered during the hearing.

7.20(7) The presiding officer shall conduct the hearing in the following manner:

- a. The presiding officer shall give an opening statement briefly describing the nature of the proceeding;
- b. The parties shall be given an opportunity to present opening statements;

- c.* Parties shall present their cases in the sequence determined by the presiding officer;
- d.* Each witness shall be sworn or affirmed by the presiding officer or the court reporter, and be subject to examination and cross-examination. The presiding officer may limit questioning consistent with Iowa Code section 17A.14;
- e.* The presiding officer has the authority to fully and fairly develop the record and may inquire into the matters at issue and shall receive in evidence the testimony of witnesses and any documents which are relevant and material; and
- f.* When all parties and witnesses have been heard, parties shall be given the opportunity to present final arguments.

11—7.21(8A,17A) Evidence.

7.21(1) The presiding officer shall rule on admissibility of evidence in accordance with Iowa Code section 17A.14 and may take official notice of facts pursuant to Iowa Code subsection 17A.14(4).

7.21(2) Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

7.21(3) Evidence shall be confined to the issues on which there has been fair notice prior to the hearing. The presiding officer may take testimony on a new issue if the parties waive their right to such notice or the presiding officer determines that good cause justifies expansion of the issues. If there is objection, the presiding officer may refuse to hear the new issue and may make a decision on the original issue in the notice, or may grant a continuance to allow the parties adequate time to amend pleadings and prepare their cases on the additional issue.

7.21(4) The party seeking admission of an exhibit must provide opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents should be provided to opposing parties.

All exhibits admitted into evidence shall be appropriately marked and be made part of the record.

7.21(5) Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. The objecting party shall briefly state the grounds for the objection. The objection, the ruling on the objection and the reasons for the ruling shall be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision.

7.21(6) Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly summarize the testimony. If the evidence excluded consists of a document or exhibits, it shall be marked as part of an offer of proof and inserted in the record.

11—7.22(8A,17A) Default.

7.22(1) If a party fails to appear in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and make a decision in the absence of the party.

7.22(2) Where appropriate and not contrary to law, any party may move for default against a party who has requested the contested case proceeding and has failed to file a required pleading or has failed to appear after proper service.

7.22(3) Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final department action unless, within 15 days (unless another period of time is specifically required by statute or rule) after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided by rule 11—7.27(8A,17A). A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, which affidavit must be attached to the motion.

7.22(4) The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

7.22(5) Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party. Adverse parties shall have ten days to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to the issue of good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

7.22(6) "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

7.22(7) A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party pursuant to rule 11—7.25(8A,17A).

7.22(8) If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall issue another notice of hearing and the contested case shall proceed accordingly.

7.22(9) A default decision may award any relief consistent with the request for relief made in the petition and embraced in its issues (but, unless the defaulting party has appeared, it cannot exceed the relief demanded).

7.22(10) A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for stay under rule 11—7.29(8A,17A).

11—7.23(8A,17A) Ex parte communication.

7.23(1) Ex parte communication is prohibited as provided in Iowa Code section 17A.17. Parties or their representatives and the presiding officer shall not communicate directly or indirectly in connection with any issue of fact or law in a contested case except upon notice and an opportunity for all parties to participate. The presiding officer may communicate with persons who are not parties as provided in subrule 7.23(2).

7.23(2) However, the presiding officer may communicate with members of the department and may have the aid and advice of persons other than those with a personal interest in, or those prosecuting or advocating in the case under consideration or a factually related case involving the same parties. Persons who jointly act as presiding officer in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

7.23(3) Any party or presiding officer who receives prohibited communication shall submit the written communication or a summary of the oral communication for inclusion in the record. Copies shall be sent to all parties. There shall be opportunity to respond.

7.23(4) Prohibited communications may result in sanctions as provided in department rule. In addition, the department, through the presiding officer, may censure the person or may prohibit further appearance before the department.

11—7.24(8A,17A) Recording costs. The department shall provide a copy of the tape-recorded hearing or a printed transcript of the hearing when a record of the hearing is requested. The cost of preparing the tape or transcript shall be paid by the requesting party.

Parties who request that a hearing be recorded by certified shorthand reporters shall bear the cost, unless otherwise provided by law.

11—7.25(8A,17A) Interlocutory appeals. Upon written request of a party or on its own motion, the director or the director's designee may review an interlocutory order of the presiding officer. In determining whether to do so, the director shall weigh the extent to which the granting of the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order by the department at the time it reviews the proposed decision of the presiding officer would provide an adequate remedy. Any request for interlocutory review must be filed within

14 days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.

11—7.26(8A,17A) Decisions.

7.26(1) *Final decision of department.* When the department presides over the reception of evidence at the hearing, its decision is a final decision.

7.26(2) *Proposed decision.* When the department does not preside at the reception of evidence, the presiding officer shall make a proposed decision.

A ruling dismissing all of a party's claims or a voluntary dismissal is a proposed decision under Iowa Code section 17A.15.

7.26(3) *Contents of decision.* The proposed or final decision or order shall:

- a. Be in writing or stated in the record.
- b. Include findings of fact. Findings of fact, if set forth in statutory language, shall be accompanied by a concise and explicit statement of underlying facts supporting the findings.
- c. Include conclusions of law stated separately from findings of fact and supported by cited authority or a reasoned opinion.
- d. Be based on the record of the contested case. The record of the contested case shall include all materials specified in Iowa Code subsection 17A.12(6). This record shall include any request for a contested case hearing and other relevant procedural documents regardless of their form.

7.26(4) *Proposed decision becomes final.* The proposed decision of the presiding officer becomes the final decision of the department without further proceedings unless there is an appeal to, or review on motion of, the department within the time provided in rule 11—7.27(8A,17A).

7.26(5) *Reports.* The department shall send to the division a copy of any request for review of a proposed decision issued by a presiding officer from the department of inspections and appeals. The department shall notify the division of the results of the review, the final decision and any judicial decision issued.

11—7.27(8A,17A) Appeals and review.

7.27(1) *Appeal by party.* Any adversely affected party may appeal a proposed decision to the director within 14 days after issuance of the proposed decision.

7.27(2) *Review.* The director may initiate review of a proposed decision on the director's own motion at any time within 21 days following the issuance of such a decision.

7.27(3) *Notice of appeal.* An appeal of a proposed decision is initiated by filing a timely notice of appeal with the department. The notice of appeal must be signed by the appealing party or a representative of that party and contain a certificate of service. The notice shall specify:

- a. The parties initiating the appeal;
- b. The proposed decision or order appealed from;
- c. The specific findings or conclusions to which exception is taken and any other exceptions to the decision or order;
- d. The relief sought; and
- e. The grounds for relief.

7.27(4) *Requests to present additional evidence.* A party may request the taking of additional evidence only by establishing that the evidence is material, that good cause existed for the failure to present the evidence at the hearing, and that the party has not waived the right to present the evidence. A written request to present additional evidence must be filed with the notice of appeal or, by a nonappealing party, within 14 days of service of the notice of appeal. The director may remand a case to the presiding officer for further hearing. The director or director's designee may preside at the taking of additional evidence.

7.27(5) *Scheduling.* The department shall issue a schedule for consideration of the appeal.

7.27(6) *Briefs and arguments.* Unless otherwise ordered, within 20 days of the notice of appeal or order for review, each appealing party may file exceptions and briefs. Within 14 days thereafter, any party may file a responsive brief. Briefs shall cite any applicable legal authority and specify relevant portions

of the record in that proceeding. Written requests to present oral argument shall be filed with the briefs. The director or director's designee may resolve the appeal on the briefs or provide an opportunity for oral argument. The director or director's designee may shorten or extend the briefing period as appropriate.

11—7.28(8A,17A) Applications for rehearing.

7.28(1) *By whom filed.* Any party to a contested case proceeding may file an application for rehearing from a final order.

7.28(2) *Content of application.* The application for rehearing shall state on whose behalf it is filed, the specific grounds for rehearing, and the relief sought. In addition, the application shall state whether the applicant desires reconsideration of all or part of the department decision on the existing record and whether, on the basis of the grounds enumerated in subrule 7.27(4), the applicant requests an opportunity to submit additional evidence.

7.28(3) *Time of filing.* The application shall be filed with the department within 20 days after issuance of the final decision.

7.28(4) *Notice to other parties.* A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the department shall serve copies on all parties.

7.28(5) *Disposition.* Any application for a rehearing shall be deemed denied unless the department grants the application within 20 days after its filing.

11—7.29(8A,17A) Stays of department actions.

7.29(1) *When available.*

a. Any party to a contested case proceeding may petition the department for a stay of an order issued in that proceeding or for other temporary remedies, pending review by the department. The petition shall be filed with the notice of appeal and shall state the reasons justifying a stay or other temporary remedy. The director or director's designee may rule on the stay or authorize the presiding officer to do so.

b. Any party to a contested case proceeding may petition the department for a stay or other temporary remedies pending judicial review of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy.

7.29(2) *When granted.* In determining whether to grant a stay, the director, director's designee, or presiding officer shall consider factors listed in Iowa Code section 17A.19(5) "c."

7.29(3) *Vacation.* A stay may be vacated by the issuing authority upon application of the department's representative or any other party.

11—7.30(8A,17A) No factual dispute contested cases. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as practicable. If the parties cannot agree, any party may file and serve a motion for summary judgment pursuant to the rules governing such motions.

11—7.31(8A,17A) Emergency adjudicative proceedings.

7.31(1) *Necessary emergency action.* To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare and, consistent with the Constitution and other provisions of law, the department may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order. Before issuing an emergency adjudicative order, the department shall consider factors including, but not limited to, the following:

- a. Whether there has been a sufficient factual investigation to ensure that the department is proceeding on the basis of reliable information;
- b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;
- c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;
- d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and
- e. Whether the specific action contemplated by the department is necessary to avoid the immediate danger.

7.31(2) Issuance of order.

a. An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the department's decision to take immediate action.

b. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by utilizing one or more of the following procedures:

- (1) Personal delivery;
- (2) Certified mail, return receipt requested, to the last address on file with the department;
- (3) Certified mail to the last address on file with the department;
- (4) First-class mail to the last address on file with the department; or
- (5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that department orders be sent by fax and has provided a fax number for that purpose.

c. To the degree practicable, the department shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

7.31(3) Oral notice. Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

7.31(4) Completion of proceedings. After the issuance of an emergency adjudicative order, the department shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

Issuance of a written emergency adjudicative order shall include notification of the date on which department proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further department proceedings to a later date will be granted only in compelling circumstances upon application in writing.

These rules are intended to implement Iowa Code chapters 8A and 17A.

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CHAPTER 8
DECLARATORY ORDERS

11—8.1(17A) Petition for declaratory order. Any person may file a petition with the department of administrative services for a declaratory order as to the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the Department of Administrative Services, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319, Attn: Legal Counsel. A petition is deemed filed when it is received by that office. The department of administrative services shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the department an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

DEPARTMENT OF ADMINISTRATIVE SERVICES		
Petition by (Name of Petitioner) for a Declaratory Order on (Cite the provisions of law involved).	}	PETITION FOR DECLARATORY ORDER

The petition must provide the following information:

1. A clear and concise statement of all relevant facts on which the order is requested.
2. A citation and the relevant language of the specific statutes, rules, policies, decisions, or orders, whose applicability is questioned, and any other relevant law.
3. The questions petitioner wants answered, stated clearly and concisely.
4. The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers.
5. The reasons for requesting the declaratory order and disclosure of the petitioner's interest in the outcome.
6. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
7. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the questions presented in the petition.
8. Any request by petitioner for a meeting provided for by rule 11—8.7(17A).

The petition must be dated and signed by the petitioner or the petitioner's representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner's representative and a statement indicating the person to whom communications concerning the petition should be directed.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—8.2(17A) Notice of petition. Within 15 business days after receipt of a petition for a declaratory order, the department of administrative services shall give notice of the petition to all persons not served by the petitioner pursuant to rule 11—8.6(17A) to whom notice is required by any provision of law. The department of administrative services may also give notice to any other persons deemed appropriate.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—8.3(17A) Intervention.

8.3(1) Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 20 days of the filing of a petition for declaratory order and before the 30-day time for department action under rule 11—8.8(17A) shall be allowed to intervene in a proceeding for a declaratory order.

8.3(2) Any person who files a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the department.

8.3(3) A petition for intervention shall be filed with the department of administrative services. Such a petition is deemed filed when it is received by the department. The department of administrative services

will provide the petitioner with a file-stamped copy of the petition for intervention if the petitioner provides an extra copy for this purpose. A petition for intervention must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

DEPARTMENT OF ADMINISTRATIVE SERVICES		
Petition by (Name of Original Petitioner) for a Declaratory Order on (Cite the provisions of law cited in original petition).	}	PETITION FOR INTERVENTION

The petition for intervention must provide the following information:

1. Facts supporting the intervenor's standing and qualifications for intervention.
2. The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers.
3. Reasons for requesting intervention and disclosure of the intervenor's interest in the outcome.
4. A statement indicating whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
5. The names and addresses of any additional persons, or a description of any additional class of persons, known by the intervenor to be affected by, or interested in, the questions presented.
6. Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding.

The petition must be dated and signed by the intervenor or the intervenor's representative. It must also include the name, mailing address, and telephone number of the intervenor and intervenor's representative, and a statement indicating the person to whom communications should be directed.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—8.4(17A) Briefs. The petitioner or any intervenor may file a brief in support of the position urged. The department of administrative services may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—8.5(17A) Inquiries. Inquiries concerning the status of a declaratory order proceeding may be made to the legal counsel for the Department of Administrative Services, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—8.6(17A) Service and filing of petitions and other papers.

8.6(1) *When service required.* Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served upon each of the parties of record to the proceeding, and on all other persons identified in the petition for declaratory order or petition for intervention as affected by or interested in the questions presented, simultaneously with their filing. The party filing a document is responsible for service on all parties and other affected or interested persons.

8.6(2) *Filing—when required.* All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the Director's Office, Department of Administrative Services, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319, Attn: Legal Counsel. All petitions, briefs, or other papers that are required to be served upon a party shall be filed simultaneously with the department.

8.6(3) *Method of service.* Petitions for declaratory orders, petitions for intervention, and every document relating to such petitions shall be served upon the department and each known party simultaneously with their filing. The party filing a document is responsible for service on all parties.

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

8.6(4) Filing—when made. Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the Director's Office, Department of Administrative Services, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319; delivered to an established courier service for immediate delivery to that office; or mailed by first-class mail or state interoffice mail to that office, so long as there is proof of mailing.

8.6(5) Proof of mailing. Proof of mailing includes either: a legible United States Postal Service postmark on the envelope, a certificate of service, a notarized affidavit, or a certification in substantially the following form:

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

(Date)

(Signature)

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—8.7(17A) Consideration. Upon request by petitioner, the department of administrative services shall schedule a brief and informal meeting between the original petitioner, all intervenors, and the department to discuss the questions raised. The department of administrative services may solicit comments from any person on the questions raised. Also, comments on the questions raised may be submitted to the department by any person.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—8.8(17A) Action on petition.

8.8(1) Within the time allowed by Iowa Code section 17A.9(5), after receipt of a petition for a declaratory order, the department director or designee shall take action on the petition as required by Iowa Code section 17A.9(5).

8.8(2) The date of issuance of an order or of a refusal to issue an order shall be the date of mailing of a decision or order, or date of delivery if service is by other means, unless another date is specified in the order.

11—8.9(17A) Refusal to issue order.

8.9(1) The department shall not issue a declaratory order where prohibited by Iowa Code section 17A.9(1), and may refuse to issue a declaratory order on some or all questions raised for the following reasons:

- a. The petition does not substantially comply with the required form.
- b. The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the department of administrative services to issue an order.
- c. The department of administrative services does not have jurisdiction over the questions presented in the petition.
- d. The questions presented by the petition are also presented in a current rule making, contested case, or other agency or judicial proceeding, that may definitively resolve them.
- e. The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter.
- f. The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order.
- g. There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances.

h. The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge an agency decision already made.

i. The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the question presented may fairly be presumed to be adverse to that of petitioner.

j. The petitioner requests the department of administrative services to determine whether a statute is unconstitutional on its face or whether any of the other conditions under Iowa Code section 17A.19 have been met.

k. The department will not issue declaratory orders on the following:

- (1) Actuarial assumptions used or proposed to be used by the department;
- (2) The impact of proposed legislation;
- (3) Issues which require the disclosure of confidential information; or
- (4) Items listed in 11—7.1(8A,17A).

8.9(2) A refusal to issue a declaratory order must indicate the specific grounds for the refusal and constitutes final agency action on the petition.

8.9(3) Refusal to issue a declaratory order pursuant to this provision does not preclude the filing of a new petition that seeks to eliminate the grounds for the refusal to issue an order.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—8.10(17A) Contents of declaratory order—effective date. In addition to the order itself, a declaratory order must contain the date of its issuance, the name of petitioner and all intervenors, the specific statutes, rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion.

A declaratory order is effective on the date of the issuance.

11—8.11(17A) Copies of orders. A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

11—8.12(17A) Effect of a declaratory order. A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. It is binding on the department of administrative services, the petitioner, and any intervenors and is applicable only in circumstances where the relevant facts and the law involved are indistinguishable from those on which the order was based. As to all other persons, a declaratory order serves only as precedent and is not binding on the department. The issuance of a declaratory order constitutes final agency action on the petition.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

These rules are intended to implement Iowa Code chapters 8A and 17A.

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CHAPTER 9 WAIVERS

11—9.1(17A,8A) Definitions.

“*Department*” or “*DAS*” means the department of administrative services authorized by Iowa Code chapter 8A.

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

“*Person*” means an individual, corporation, limited liability company, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, vendor, or any legal entity.

“*Waiver or variance*” means any action by the department that suspends in whole or in part the requirements or provisions of a rule as applied to an identified person on the basis of the particular circumstances of that person. For simplicity, the term “waiver” shall include both a “waiver” and a “variance.”

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—9.2(17A,8A) Scope. This chapter outlines generally applicable standards and a uniform process for the granting of individual waivers from rules adopted by the department in situations where no other more specifically applicable law provides for waivers. To the extent another more specific provision of law governs the issuance of a waiver from a particular rule, the more specific provision shall supersede this chapter with respect to any waiver from that rule.

11—9.3(17A,8A) Applicability.

9.3(1) *Department authority.* The department may grant a waiver from a rule only if the department has jurisdiction over the rule from which waiver is requested or has final decision-making authority over a contested case in which a waiver is requested and the requested waiver is consistent with applicable statutes, constitutional provisions, or other provisions of law. The department may not waive requirements created or duties imposed by statute. Any waiver must be consistent with statute.

9.3(2) *Interpretive rules.* This chapter shall not apply to rules that merely define the meaning of a statute or other provisions of law or precedent if the department does not possess delegated authority to bind the courts to any extent with its definition.

11—9.4(17A,8A) Granting a waiver. In response to a petition completed pursuant to rule 11—9.6(17A,8A), the director may, in the director’s sole discretion, issue an order waiving in whole or in part the requirements of a rule.

9.4(1) *Criteria for waiver or variance.* A waiver may be granted if the director finds based on clear and convincing evidence each of the following:

a. The application of the rule would pose an undue hardship on the person for whom the waiver is requested;

b. The waiver from the requirements of the rule in the specific case would not prejudice the substantial legal rights of any person;

c. The provisions of the rule subject to the petition for a waiver are not specifically mandated by statute or another provision of law; and

d. Substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver is requested.

In determining whether a waiver should be granted, the director shall consider the public interest, policies and legislative intent of the statute on which the rule is based. When the rule from which a waiver or variance is sought establishes administrative deadlines, the director shall balance the special individual circumstances of the petitioner with the overall goal of uniform treatment of all affected persons.

9.4(2) *Special waiver or variance of rules not precluded.* These rules shall not preclude the director from granting waivers or variances in other contexts or on the basis of other standards if a statute or other department rule authorizes the director to do so; the director deems it appropriate to do so; and the director is not prohibited by state or federal statute, federal regulations, this rule, or any other rule adopted under Iowa Code chapter 17A from issuing such waivers.

9.4(3) Procurement-related waiver or variance. The director may waive a rule or grant a variance due to noncompliance with a stated requirement in a procurement, sale, or auction if the request meets all of the following criteria:

a. The request is made prior to the issuance of a notice of intent to award a contract or the finalization of a sale.

b. The waiver or variance will tend to promote competition rather than inhibit or reduce competition.

c. The waiver or variance will not materially alter the substantive contents of the offer, a response to an invitation to bid or a response to a request for proposal.

d. The noncompliance with the stated requirement is correctable (if correction is necessary) without materially or substantially altering the substantive contents of the offer, a response to an invitation to bid or a response to a request for proposal.

e. No other person who submits an offer, a response to an invitation to bid or a response to a request for proposals is materially or substantially harmed by the waiver or variance. A person shall not be deemed to have been harmed if the waiver or variance merely increases competition.

f. Fundamental notions of good faith and fair dealing favor the issuance of a waiver or variance.

g. The waiver or variance will not result in unreasonable delay in the procurement, sale or auction and will not interfere with certainty or finality in the procurement, sale or auction.

If the stated terms of the procurement, sale or auction permit or authorize waiver or variance from the stated terms, the director may waive or vary the stated terms without regard to subrule 9.4(1).

9.4(4) Special waiver or variance not permitted. The compensation rates for publication in a newspaper for any notice, order or citation or other publication required or allowed by law as determined by the state printing administrator pursuant to Iowa Code section 618.11 shall not be waived or varied. The procedure established in this chapter does not apply to waiver or variance of contractual terms or conditions; contracts shall be waived or varied only upon their own terms. These rules do not apply to the Terrace Hill commission established in Iowa Code section 8A.326 or rules adopted by the commission unless these rules are adopted by the Terrace Hill commission.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—9.5(17A,8A) Filing of petition for waiver. Any person may file with the department a petition requesting a waiver, in whole or in part, of a rule of the department on the ground that the application of the rule to the particular circumstances of that person would qualify for a waiver.

A petition for a waiver must be submitted in writing to the Iowa Department of Administrative Services, Office of the Director, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319-0104, Attention: Legal Counsel. Requests for waiver may be delivered, mailed, sent by facsimile transmission or by other electronic means reasonably calculated to reach the intended recipient.

9.5(1) Appeals. If the petition relates to a pending appeal or contested case, a copy of the petition shall also be filed in the appeal proceeding or contested case using the caption of the appeal or contested case.

9.5(2) Other. If the petition does not relate to an appeal or contested case, the petition will be submitted to the department's legal counsel.

11—9.6(17A,8A) Content of petition. A petition for waiver or variance shall include the following information where applicable and known to the requester:

1. The name, address, and telephone number of the entity or person for whom a waiver is being requested, and the case number of any related pending appeal or contested case.

2. A description and citation of the specific rule (and the stated requirement in a procurement, auction or sale) from which a waiver is requested.

3. The specific waiver requested, including the precise scope and duration, and any alternative means or other condition or modification proposed to achieve the purposes of the rule.

4. The relevant facts that the petitioner believes would justify a waiver under each of the four criteria described in subrule 9.4(1) or the criteria in subrule 9.4(3) if the request relates to a procurement,

sale or auction. This statement shall include a signed statement from the petitioner attesting to the accuracy of the facts provided in the petition, and a statement of reasons that the petitioner believes will justify the waiver.

5. A history of any prior contacts between the department and the petitioner relating to the activity that is the subject of the requested waiver including, but not limited to, a list or description of prior notices, investigative reports, advice, negotiations, consultations or conferences, a description of contested case hearings relating to the activity within the past five years, and penalties relating to the proposed waiver.

6. Any information known to the requester regarding the department's treatment of similar cases.

7. The name, address, and telephone number of any public agency or political subdivision which also regulates the activity in question, or which might be affected by the granting of a waiver.

8. The name, address, and telephone number of any entity or person who would be adversely affected by the granting of a petition, if reasonably known to the petitioner.

9. The name, address, and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver.

10. Signed releases of information authorizing persons with knowledge regarding the request to furnish the department with information relevant to the waiver or variance.

11—9.7(17A,8A) Additional information. Prior to issuing an order granting or denying a waiver, the department may request additional information from the petitioner relative to the petition and surrounding circumstances. If the petition was not filed in conjunction with an appeal, the director may, on the director's own motion or at the petitioner's request, schedule a telephonic, ICN, or in-person meeting between the petitioner and the director.

11—9.8(17A,8A) Notice. The department shall acknowledge the receipt of a petition by written means reasonably calculated to reach the petitioner or designee. The department shall ensure that, within 30 days of the receipt of the petition, notice and a concise summary of the content of the petition have been provided to all persons to whom notice is required by any provision of law. In addition, the department may give notice to other persons.

To accomplish this notice provision, the department may require the petitioner to serve the notice on all persons to whom notice is required by any provision of law and provide a written statement to the department attesting that notice has been provided.

11—9.9(17A,8A) Hearing procedures. The provisions of Iowa Code sections 17A.10 to 17A.18A regarding contested case hearings shall apply in three situations: (1) to any petition for a waiver or variance of rule filed within a contested case; (2) when the director so provides by rule or order; or (3) when a statute so requires. Prior to issuing an order granting or denying a proposed waiver, the department shall determine whether or not the facts alleged in the proposed waiver are accurate and complete.

11—9.10(17A,8A) Ruling. An order granting or denying a waiver or variance shall be in writing and shall contain a reference to the particular person and rule or portion thereof to which the order pertains, a statement of the relevant facts and reasons upon which the action is based, and a description of the precise scope (including any conditions) and duration of the waiver if one is issued.

9.10(1) Director discretion. The final decision on whether the circumstances justify the granting of a waiver shall be made at the sole discretion of the director, upon consideration of all relevant factors. Each petition for waiver shall be evaluated by the director based on the unique, individual circumstances set out in the petition.

9.10(2) Burden of persuasion. If the petition for waiver is based on a request pursuant to subrule 9.4(1), the burden of persuasion rests with the petitioner to demonstrate by clear and convincing evidence that the director should exercise discretion to grant a waiver from a department rule.

9.10(3) Narrowly tailored exception. A waiver, if granted, shall provide the narrowest exception possible to the provisions of a rule.

9.10(4) *Administrative deadlines.* When the rule from which a waiver or variance is sought establishes administrative deadlines, the director shall balance the special individual circumstances of the petitioner with the overall goal of uniform treatment of all affected persons.

9.10(5) *Conditions.* The director may place any condition on the waiver that the director finds desirable to protect the public health, safety, and welfare or other such reasonable conditions as are appropriate to achieve the objectives of the particular rule in question through alternative means.

9.10(6) *Time period of waiver.* A waiver shall not be permanent unless the petitioner can show that a temporary waiver would be impracticable. If a temporary waiver is granted, there is no automatic right to renewal. At the sole discretion of the director, a waiver may be renewed if the director finds that grounds for a waiver continue to exist.

9.10(7) *Time for ruling.* The director shall grant or deny a petition for a waiver or variance as soon as practicable but, in any event, shall do so within 120 days of its receipt, unless the petitioner agrees to a later date or the department, specifying good cause, extends this time period with respect to a particular petition for an additional 30 days. However, if a petition is filed in an appeal, the director shall grant or deny the petition no later than the time at which the final decision in that appeal is issued.

9.10(8) *When deemed denied.* Failure of the director to grant or deny a petition within the required time period shall be deemed a denial of that petition by the director. However, the director shall remain responsible for issuing an order denying a waiver.

9.10(9) *Service of order.* Within seven days of its issuance, any order issued under this chapter shall be transmitted to the petitioner or the person to whom the order pertains, and to any other person entitled to such notice by any provision of law.

11—9.11(17A,8A) *Public availability.* All orders granting or denying a waiver petition shall be indexed, filed, and available for public inspection as provided in Iowa Code section 17A.3. Petitions for a waiver and orders granting or denying a waiver petition are public records under Iowa Code chapter 22. Some petitions or orders may contain information the department is authorized or required to keep confidential. The director may accordingly redact confidential information from petitions or orders prior to public inspection.

11—9.12(17A,8A) *Rules from which the department shall not grant waivers.* The department shall not grant waivers from the following rules:

1. Rules regarding the taxability of pension, tax-sheltered annuity, deferred compensation, or health and dependent care benefits under the Internal Revenue Code or the Iowa Code and rules adopted thereunder.
2. Rules governing separations, disciplinary actions and reductions in force under 11—Chapter 60 and grievances and appeals under 11—Chapter 61 (except as permitted by statute and applicable department rules).

11—9.13(17A,8A) *Summary reports.* Semiannually, the director shall prepare a summary report identifying the rules for which a waiver has been granted or denied, the number of times a waiver was granted or denied for each rule, a citation to the statutory provisions implemented by these rules, and a general summary of the reasons justifying the director's actions on waiver requests. If practicable, the report shall detail the extent to which the granting of a waiver has affected the general applicability of the rule itself. Copies of this report shall be available for public inspection and shall be provided semiannually to the administrative rules coordinator and the administrative rules review committee.

11—9.14(17A,8A) *Cancellation of a waiver.* A waiver issued by the director pursuant to this chapter may be withdrawn, canceled, or modified if, after appropriate notice and hearing, the director issues an order finding any of the following:

1. The petitioner or the person who was the subject of the waiver order withheld or misrepresented the material facts relevant to the propriety or desirability of the waiver;

2. The alternative means for ensuring that the public health, safety and welfare will be adequately protected after issuance of the waiver order have been demonstrated to be insufficient; or
3. The subject of the waiver order has failed to comply with all conditions contained in the order.

11—9.15(17A,8A) Violations. Violation of a condition in a waiver order shall be treated as a violation of the particular rule for which the waiver was granted. As a result, the recipient of a waiver under this chapter who violates a condition of the waiver may be subject to the same remedies or penalties as a person who violates the rule at issue.

11—9.16(17A,8A) Defense. After the director issues an order granting a waiver, the order is a defense within its terms and the specific facts indicated therein for the person to whom the order pertains in any proceeding in which the rule in question is sought to be invoked.

11—9.17(17A,8A) Judicial review. Judicial review of the department's decision to grant or deny a waiver petition may be taken in accordance with Iowa Code chapter 17A.

These rules are intended to implement Iowa Code chapter 8A and section 17A.9A.

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CHAPTER 41
AUDITING CLAIMS

[Prior to 12/17/86, see Comptroller, State[270] Ch 1]

[Prior to 5/12/04, see 701—Ch 201]

All vouchers and claims required by law to be audited by the department of administrative services, state accounting enterprise, should conform to the following rules.

11—41.1(8A) General provisions.

41.1(1) *Submission of claims and approval.* All claims shall be typewritten, or written in ink, and be itemized and certified by the claimant.

EXCEPTION: The claimant's certification is not needed when the original invoice is attached to the claim. The original invoice shall indicate in detail the items of service, expense, thing furnished, or contract upon which payment is sought.

Approval of the claim shall be certified thereon by the head of the state agency, or the deputy, or the chair of the board or commission or its executive officer, or by a person delegated by the head of the state agency to fulfill this responsibility. A list of authorized signators shall be provided to the department of administrative services, state accounting enterprise.

All travel claims submitted shall be the actual expense incurred (not exceeding maximum limitations) by the claimant, and shall not include expenses paid for other individuals, or for the purchase of miscellaneous items which are not needed in the performance of official duties while traveling. All travel vouchers shall contain the vendor/customer code of the employee or other individual identification (with prior written approval by the department of administrative services, state accounting enterprise).

All claims shall show in the space provided the Iowa Code reference for the appropriation or fund from which the claim is payable.

When an original invoice is submitted by a vendor, rather than the claimant signing the voucher, the vendor shall provide the state agency with an original invoice that the vendor would use in the normal conduct of its business. A state agency shall not impose additional or different requirements on submission of invoices than those contained in these rules unless the department of administrative services, state accounting enterprise, exempts the agency from these invoice requirements upon a finding that compliance would result in poor accounting or management practices.

41.1(2) *Interest on claims.* For any claim received for services, supplies, materials or a contract which is payable from the state treasury that remains unpaid after 60 days following the receipt of the claim or the satisfactory delivery, furnishing or performance of the services, supplies, materials or contract, whichever date is later, the state shall pay interest at the rate of 1 percent per month on the unpaid amount of the claim. Agencies may enter into written contracts for goods and services on payment terms of less than 60 days if the state may obtain a financial benefit or incentive which would not otherwise be available from the vendor. All agencies entering into written contracts for goods and services on payment terms of less than 60 days shall maintain written documentation demonstrating that the agency obtained a financial benefit or incentive which would not otherwise have been available from the vendor. This subrule does not apply to claims against the state under Iowa Code chapters 25 and 669 or the claims paid by federal funds. The interest shall be charged to the appropriation or fund to which the claim is certified.

41.1(3) *Availability of rules.* All state agencies are required to mail the number of copies of the proposed rule as requested to the state office of a trade or occupational association which has registered its name and address with the agency. The trade or occupational association shall reimburse the agency for the actual cost incurred in providing the copies of the proposed rule.

41.1(4) *Property claims and real estate claims.* Claims for personal property sold, the acquisition of real estate, or services rendered to the state must have the original invoices or other documentation attached whenever possible to do so.

41.1(5) *Form for travel claim.* All travel claims are to be on a travel voucher or on a form approved (in writing) by the department of administrative services, state accounting enterprise.

41.1(6) *Intradepartmental rules on claims.* All intradepartmental rules pertaining to the auditing of claims internally shall be subject to the review and approval (in writing) of the department of administrative services, state accounting enterprise.

This rule is intended to implement Iowa Code sections 8A.514 and 17A.4.
[ARC 3002C, IAB 3/29/17, effective 5/3/17; ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—41.2(8A) Official travel.

41.2(1) *Personal funds to be supplied.* All employees shall provide themselves with sufficient funds for all current expenses. See subrules 41.2(3) and 41.2(4) regarding travel advances.

41.2(2) *Reimbursable expenses and travel allowances.* The reimbursement allowed shall be limited to an allowance for subsistence and transportation, and other actual and necessary travel expenses incurred by a traveler in the performance of official duties subject to applicable limitations. All travel reimbursements shall be made on the basis of the usually traveled route.

41.2(3) *Travel advance.* State employees who are required to travel out of state may apply for a travel advance if the anticipated out-of-pocket expenses are in excess of \$200. An advance may not exceed 80 percent of the anticipated expenses. In addition, employees shall comply with the conditions set forth below:

a. The travel advance shall be deducted from the expense voucher submitted by the employee upon completion of the trip.

b. If for any reason an employee does not make the anticipated trip, the travel advance shall be immediately returned to the state.

c. The employee shall give the department of administrative services, state accounting enterprise, authority to recover funds owed the state (through payroll deduction) which have not been repaid within 30 days of completion of the trip.

d. The department of administrative services, state accounting enterprise, reserves the right to refuse advances when funds are currently owed the state or when there have been prior abuses.

41.2(4) *Permanent in-state travel advance.* State employees who are not covered by collective bargaining agreements negotiated under the provisions of Iowa Code chapter 20 may be eligible for a permanent in-state travel advance if they meet and agree to the following conditions:

a. Employees whose in-state travel expense reimbursements average between \$100 and \$150 per month for the preceding 12 months shall receive upon written request a permanent travel allowance of \$100.

b. Employees whose in-state travel expense reimbursements average over \$150 per month for the preceding 12 months shall receive upon written request a permanent travel allowance of \$150.

c. The department of administrative services, state accounting enterprise, shall have authority to deduct the permanent travel advance from the employee's last paychecks upon separation from state service.

d. The department of administrative services, state accounting enterprise, and employing agency reserve the right to review the employee's monthly travel expenses and should the employee fail to meet the above requirements, or become ineligible due to a change in duties or job assignment, the advance will be withdrawn (through payroll deduction) following proper notification.

41.2(5) *Official domicile defined.*

a. Office employee. The official domicile of an officer or employee assigned to an office is the city, town or metropolitan area (as established by the department of administrative services, state accounting enterprise) within which such office is located. Transportation costs between the employee's residence and office, and subsistence within the limits of an employee's official domicile are not reimbursable.

b. Field employees. The official domicile of field employees shall be designated by the administrative head of the state agency. Subsistence within the limits of an employee's official domicile shall not be allowed. No transportation costs will be allowed between the employee's place of residence and office.

c. Nonreimbursable travel. When additional expense is incurred by reason of an employee residing in a city or town other than the employee's official domicile, the additional expense is otherwise caused by an employee's choice of residence, and is not reimbursable.

11—41.3(8A) Temporary duty assignment.

41.3(1) *Subsistence while on temporary duty assignment.* When an employee is on temporary duty assignment, subsistence may be allowed for each day (including Saturdays, Sundays and holidays) from the time of departure from the employee's official domicile until the employee's return to the previous official domicile or a newly assigned domicile.

41.3(2) *Weekends.* When authorized by the administrative head of the agency or the designated representative, an employee who is on temporary duty status will be reimbursed for expenses involved while returning home for the weekend provided the amount, including transportation, does not exceed the amount that would have been allowable had the claimant remained at the temporary duty station.

11—41.4(8A) Authorization for travel.

41.4(1) *Approval by administrative head of the agency.* All official travel shall be authorized by the administrative head of the agency or the designated representative, prior to the travel whenever possible.

41.4(2) *Out of state.* Official travel out of the state for any executive branch employee must receive prior electronic authorization on the Travel Department Authorization form from the administrative head of the agency.

41.4(3) *Requests for out-of-state travel.* All requests for out-of-state travel shall be on a form approved by the administrative head of the agency and shall include information required by Iowa Code section 8A.512A.

41.4(4) *Most economical or advantageous mode of travel.* Reimbursement for transportation approved by the administrative head of the agency shall be for the most economical or advantageous mode and by the usually traveled route.

[ARC 2267C, IAB 11/25/15, effective 12/30/15]

11—41.5(8A) Mode of transportation.

41.5(1) *Airline travel accommodations.* When the administrative head of the agency determines that airline travel is the most economical or advantageous to the state, the use of airline travel may be authorized. The most economical mode of airline travel is considered to be coach or economy class, if available.

41.5(2) *Train travel.* In cases where train travel is utilized, the most economical mode shall be considered coach fare, if available.

41.5(3) *Purchase of tickets.*

a. All state agencies covered by the statewide travel agency contracts may purchase airline tickets through a travel agency under contract. Agencies shall develop internal policies so that agencies purchase or direct their employees to purchase tickets from the source determined by the agency to be the best value.

b. For all other tickets purchased, it shall be the employee's responsibility to purchase the ticket for whatever mode of transportation that is determined to be the most economical. Reimbursement will be made by attaching a receipt to the employee travel voucher. Refunds received on any unused portion of the ticket shall be shown and deducted from the original ticket.

41.5(4) *Use of privately owned vehicle.* Authorized use of a privately owned vehicle for travel on official state business will be subject to rule 11—103.4(8A).

a. In state. Where use of a privately owned vehicle is authorized by rule 11—103.4(8A), reimbursement shall be on a mileage basis at a rate established by the director pursuant to Iowa Code section 8A.363. Reimbursement for travel at the official domicile will be reimbursed at a rate (established by the director pursuant to Iowa Code section 8A.363) per mile if the purpose of the travel is official business. The per-mile reimbursement includes all costs incurred in connection with the operation of the vehicle.

b. Out of state. If the traveler desires to use a personally owned vehicle instead of common carrier and it is authorized by the administrative head of the agency, the cost of mileage (not to exceed airfare) to the destination's nearest air terminal, plus expenses incurred to final destination and subsistence allowance en route will be allowed. Out-of-state subsistence allowance will be allowed only for the number of meals and nights lodging which would have been necessary had the traveler used the available public transportation to destination instead of a private vehicle. Taxi or mileage expenses will be allowed at the destination if the expenses are incurred while the traveler is on official business.

If two or more travelers on official business travel in one privately owned vehicle instead of common carrier, the use of one vehicle may be authorized on a mileage basis not to exceed the statutory limit per mile.

41.5(5) Mileage while on temporary duty assignment. In general, mileage for use of privately owned vehicles may be allowed for travel within the area of temporary duty, if approved by the administrative head of the agency, provided a state-owned vehicle is not available. When a privately owned vehicle is authorized in the transaction of official business within the area or in the vicinity of the city to which the traveler is assigned or directed, the traveler shall show on the travel claim the number of miles of vicinity travel for each.

41.5(6) Assignment of more than one employee to a vehicle. In authorizing the use of privately owned or state-owned vehicles, the agency head shall, whenever possible, assign more than one employee to the use of one vehicle.

41.5(7) Verification of mileage. The travel shall be by the usually traveled route. Mileage shall be based on mileage published by the American Automobile Association, when available. Any variation from the published mileage should be documented in writing.

41.5(8) Use of buses, street cars, limousines and rental cars. When buses, street cars, limousines, or rental cars are used for official travel within the official station or city to which a traveler is directed, the traveler shall show the cost of the fares in the "miscellaneous" column of the travel voucher.

41.5(9) Abode and point of duty in interstate travel. Insofar as official interstate travel is concerned, the employee's hotel may be considered a point of official duty.

41.5(10) Taxicabs. Taxicab charges shall be allowed only from regular domicile or place of business to station or other terminal; from station or terminal at origin of destination of trip to hotel or domicile or place of business; or between bus, rail or plane stations or terminals or other points of official duty.

41.5(11) Home-travel from and to. Actual taxi or common carrier fares shall be allowed for transportation directly from home of traveler to railroad, bus or airport terminals at the beginning of official travel status and for transportation directly from railroad, bus or airport terminals to home of traveler at conclusion of official travel status. The maximum reimbursement will be the current cost of taxi fare from the capitol to the Des Moines airport.

41.5(12) Rental or charter of special conveyances. The rental or charter of aircraft, automobiles, boats, buses, or other special conveyances shall be held to a minimum but may be authorized in those cases when no public or ordinary means of transportation is available, or when such public or ordinary means of transportation cannot be used advantageously in the best interest of the state. Specific justification shall accompany the voucher in each instance where the use of special conveyance is authorized and shall include information such as the location where special conveyance commenced, and the points visited. The department of administrative services, state accounting enterprise, may require a comparison of costs between public or ordinary means of transportation compared to the cost of special conveyance.

[ARC 2267C, IAB 11/25/15, effective 12/30/15; ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—41.6(8A) Subsistence allowance.

41.6(1) The phrase "subsistence allowance." The phrase "subsistence allowance" used herein shall be construed to include all charges (including applicable taxes) for meals and lodging (single rate only). Charges for radios, television, and similar appliances are not reimbursable.

41.6(2) Subsistence allowances for in-state travel—monetary and time limitations. Officers and employees shall be allowed overnight lodging and meal expense when required to travel outside of the

city of their official domicile. The amounts shall not exceed the limits established in the department of administrative services, state accounting enterprise, procedure manual.

a. Rescinded, effective February 19, 1986.

b. Rescinded, effective February 19, 1986.

41.6(3) Subsistence allowances for out-of-state travel—monetary and time limitations.

a. Lodging and meal expenses are not limited outside the state but the incurred expenditures are to be reasonable. Receipts for lodging are to accompany the claim and show the dates, room number, occupants, and amount per night. Lodging will be limited to the night preceding and the night of the ending date of the convention or meeting. Elected officials are not required to furnish receipts.

b. Meals will be limited to lunch and dinner the day preceding and breakfast and lunch the day after the meeting.

11—41.7(8A) Miscellaneous expense.

41.7(1) Definition. Miscellaneous expenses are those deemed necessary in the conduct of official business of the state which are not included in the categories of subsistence, mileage, and state-owned vehicle operation. All miscellaneous expenses shall be claimed under the column heading “miscellaneous expense” on the travel claim and be supported by sufficient documentation.

41.7(2) Receipts. A receipt for, or explanation of, each and every transaction involving miscellaneous expenditures shall be provided.

41.7(3) Baggage. Charges for baggage in excess of the weight or of the size carried free by transportation companies shall be allowed if the baggage is used for official business. Charges for the storage of baggage may also be allowed if it is shown that such storage was on account of official business. Specific justification must be submitted with the claim voucher.

41.7(4) Telephone and telegraph messages. Expenses for official telephone and telegraph messages which must be paid for by the traveler shall be allowed. Toll and local calls and telegrams should be supported and attached to the travel claim showing date, city or town called or telegraphed, name of person or firm called or to where telegram was sent and amount of each call or telegram.

41.7(5) Stenographic or typewriting services. Charges for official stenographic or typewriting services shall be allowed on official travel.

41.7(6) Purchase of supplies. The purchase of stationery and all other similar supplies shall be allowed in emergencies warranting their use for handling of official business while on official travel, and shall be submitted and certified on a travel voucher (or other approved form) with the proper receipts attached.

41.7(7) Parking. Parking will be allowed for state and private cars at an airport during the employee’s flight.

41.7(8) Registration fees. The payment of registration fees which are required for participation in meetings shall be allowed. Registration fees shall be supported by the official receipt of the conference or convention subject to the following limitations:

a. Expenditures for payment of registration fees for the purpose of obtaining the privileges of membership or other personal benefits from an organization are not reimbursable. Memberships in organizations must be in the name of the state agency and have approval of the director of the department requesting the membership and of the director of the department of management and shall be published to the Iowa transparency Internet site established by Iowa Code section 8G.4.

b. Registration fees paid by the traveler will be claimed for reimbursement as a miscellaneous nonsubsistence expense and a receipt must be attached to the claim.

c. Reimbursement of registration fees, at the official domicile, may require prior written approval of the department of administrative services, state accounting enterprise.

[ARC 0636C, IAB 3/6/13, effective 4/10/13]

11—41.8(8A) State-owned vehicle. Any expense other than parking should not be claimed on the expense voucher but should be reimbursed through procedures established by fleet services.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

Rules 11—41.2(8A) to 11—41.8(8A) are intended to implement Iowa Code sections 8A.506 to 8A.519.

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CHAPTER 42
ACCOUNTING PROCEDURES OF PUBLIC IMPACT
[Prior to 5/12/04, see 701—Ch 202]

11—42.1(8A) Scope and application. The department of administrative services, state accounting enterprise, is responsible for the payment of money due based on contracts with vendors for goods and services entered into by all state agencies and governmental subdivisions. Consequently, the department has implemented rules and policies to ease the administration of the payment of all obligations owed to third parties. The policies and procedures governing the payment of these obligations are set forth in the Department of Administrative Services, State Accounting Enterprise, Accounting Policies and Procedures Manual. This manual may be accessed at das.iowa.gov, or copies of the appropriate provisions may be requested and obtained by mail from State Accounting Enterprise, Department of Administrative Services, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319.

This rule is intended to implement Iowa Code section 8A.502.

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CHAPTER 48
PREPAYMENT OF EXPENSES
[Prior to 5/12/04, see 701—Ch 210]

11—48.1(8A) Definitions. For purposes of this chapter, the following definitions apply:

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

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

This rule is intended to implement Iowa Code section 8A.514.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—48.2(8A) Prepayment of expenses. The following expenses may be prepaid without prior written approval from the department:

1. Contracts for software purchases, software maintenance, or other maintenance contracts which have been negotiated with a clause requiring prepayment.
2. Subscriptions for magazines and periodicals.
3. Publications.
4. Rental of building space, post office boxes, parking spaces, and booths (only the portion that must be prepaid to reserve a space). Documentation must be attached to the claim.
5. Maintenance contracts that have been negotiated with a clause requiring prepayment.
6. If there is documentation attached to the claim which indicates the registration must be paid prior to the function, or there is documentation attached which indicates there is a savings of at least current general fund earning rate of the state treasurer if the registration is paid in advance.

This rule is intended to implement Iowa Code section 8A.514.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—48.3(8A) Prepayment under special circumstances. Advance payment on contracts is allowable in certain instances. Reimbursement of expenses should be utilized whenever possible. The time elapsing between the receipt of the money and its disbursement should be minimized as much as is administratively feasible. In certain circumstances, the grantee may lack sufficient working capital to provide the service for which the grant was made. Contractors deemed by the department to have an employee/employer relationship with the state are not eligible for advance payments. Advance payments may be made under the following guidelines.

48.3(1) Advance payments may be made up to one month in advance of the anticipated expenditure. This is considered to be administratively feasible on a statewide basis. Requests for advance payments in excess of one month must have the prior approval from the department.

48.3(2) When it has been determined by the state agency that the grantee lacks sufficient working capital to provide the service of the grant, the grantee may be given a two-month “working capital advance” (i.e., an advance may be made for up to two months of projected expenses). After the initial two-month “working capital advance” has been made, the grantee should submit claims for the reimbursement on a monthly basis. This should allow the grantee enough start-up funds to commence the project, while also allowing the grantee to maintain a one-month advance after the initial start-up, which parallels subrule 48.3(1) above.

a. Documentation that indicates the grantee lacks sufficient working capital to commence the project must be attached to the initial claim.

b. Documentation supporting the projected costs must be attached to the initial claim.

This rule is intended to implement Iowa Code section 8A.514.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—48.4(8A) Prior approval for prepayment of expenses. Any expense not specifically mentioned in rule 11—48.2(8A) must have prior approval to be paid in advance of receiving the good or service. Prior approval will be allowed only under the following circumstances.

1. If prepayment is required in order for the state to receive the good or service.

2. If the department can document that the state will benefit through reduced rates equal to or greater than the current general fund earning rate of the state treasurer.

This rule is intended to implement Iowa Code section 8A.514.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

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CHAPTER 55
ELIGIBLE LISTS

[Prior to 11/5/86, Merit Employment Department[570]]

[Prior to 2/18/04, see 581—Ch 6]

11—55.1(8A) Establishment of eligible lists. The director shall establish and maintain various lists of eligible applicants for use in filling vacant positions. Eligible lists may be by job class or specific position. Eligible lists may be continuous or may be abolished after a vacancy is filled. The following are types of eligible lists:

55.1(1) Recall lists. These lists shall consist of the names of permanent employees who were separated by layoff; or who moved to another class or had their work hours reduced in lieu of layoff. Recall shall be in accordance with 11—subrule 60.3(6).

55.1(2) Promotional lists. Promotional lists shall consist of the names of permanent employees and those as designated in 11—paragraph 54.2(4) “a” who have applied for a job class and who have met the minimum qualifications and other promotional screening requirements for the class. The length of time of eligibility for promotion from these lists need not be the same as that for appointment from nonpromotional lists.

55.1(3) All-applicant lists. All-applicant lists shall consist of the names of all persons who have applied for positions, met the minimum qualifications for the class, and undergone, as necessary, the designated screening for the class. Persons in the certified disability program or any other formal waiver program established by the department shall be identified as such and placed on the all-applicant list.

11—55.2(8A) Removal of names from eligible lists. The director may remove names from an eligible list for a particular job class(es) for any of the following reasons in addition to those cited in 11—subrule 54.2(6):

1. Failure by the applicant to maintain a record of current address as evidenced by the return of a properly addressed letter or other similar evidence.
2. Failure by the applicant to respond to a written inquiry from the director or an appointing authority as to availability within five workdays following the date the inquiry was sent.
3. Receipt of a statement that the applicant no longer wants to be on the list for the class.
4. Declination of an appointment or promotion under previously agreed to conditions.
5. Appointment to a job class.
6. Abolition or expiration of an eligible list for a job class(es).
7. In the case of promotional lists, separation from state service.
8. Correction of erroneous placement on a list.
9. Violation of any of the provisions of Iowa Code chapter 8A or these rules. Applicants removed for this reason shall be notified in writing by the director within five workdays following removal. Appeal of removal for this reason shall be in accordance with 11—subrule 61.2(4).

10. Failure by the applicant to maintain contact as instructed by the department concerning current availability, mailing address and telephone number.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—55.3(8A) Statement of availability. It shall be the applicant’s responsibility to notify the director in writing of any change in address or other changes affecting availability for employment. The director may at any time verify the availability of applicants. The names of applicants shall be withheld from all eligible lists which do not meet the stated conditions and locations under which the applicants have indicated availability.

These rules are intended to implement Iowa Code sections 8A.401, 8A.402, 8A.411, 8A.413, 8A.417, 8A.418, 8A.453, 8A.455, 8A.456 and 8A.458.

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¹ Effective date of amendment to 6.6(2) and 6.6(3) delayed 70 days by the Administrative Rules Review Committee. Delay lifted by Committee on 2/8/83. See details following chapter analysis.

² See IAB Personnel Department

CHAPTER 56
FILLING VACANCIES

[Prior to 11/5/86, Merit Employment Department[570]]

[Prior to 2/18/04, see 581—Ch 7]

11—56.1(8A) Method of filling vacancies. Vacancies shall be filled through promotion, transfer, demotion, recall, reinstatement or original appointment. The method and order in which vacancies are filled shall be determined by the director, taking into consideration the provisions of collective bargaining agreements and these rules. Vacancies shall be announced before a list of applicants is issued to an appointing authority.

11—56.2(8A) List requests. An appointing authority shall submit a request form when filling a vacancy.

11—56.3(8A) Types of lists. The following types of lists may be issued.

56.3(1) Recall list. The director will provide the names of those persons who are eligible for recall on the date and time issued in accordance with the provisions of 11—subrule 60.3(6) or applicable collective bargaining agreements.

56.3(2) Promotional list. The director will provide the names of qualified applicants who are permanent employees and those designated in 11—subrule 54.2(4) who have indicated availability for the conditions and location specified in the vacancy announcement.

56.3(3) All-applicant list. The director will provide the names of all qualified applicants who have indicated availability for the conditions and location specified in the vacancy announcement.

11—56.4(8A) Selective lists. The director may provide lists of only those eligibles for a position who possess specific education, experience or other selective qualifications required to perform the duties of a position. The director may establish procedures for determining and approving selective qualifications, processing requests and issuing lists with selectives.

11—56.5(8A) Expiration of a list. The expiration of a list shall be 120 calendar days following the date of issue unless otherwise approved by the director. All appointments or promotions must be reported to the director before the expiration date of the list. Effective dates of appointments or promotions must be no later than 60 days after the expiration date of the list unless otherwise authorized by the director, except that appointments or promotions “pending graduation” or “pending license” shall be allowed to be effective up to nine months following the expiration date of the list.

[ARC 2267C, IAB 11/25/15, effective 12/30/15]

11—56.6(8A) Incomplete lists. If the number of names available on a nonpromotional list is less than six, the appointing authority will be granted provisional appointment authority.

[ARC 0401C, IAB 10/17/12, effective 11/21/12]

11—56.7(8A) Referral and appointment of “conditional” applicants. The names of applicants who are on the eligible list for a class “pending graduation” or “pending license” are considered to be “conditional.” If a “conditional” applicant is selected, the appointment shall not be effective until the applicant has met the minimum requirements for qualification. Appointments shall be made in accordance with 11—subrule 54.2(5) and rule 11—56.5(8A).

11—56.8(8A) Adjustment of errors. An error in the compilation or issuance of a list, if called to the attention of the director prior to the filling of the vacancy, shall be corrected and a new list issued. Except for a recall list, such correction shall not result in the removal of any eligible already certified nor invalidate any appointment already made.

These rules are intended to implement Iowa Code sections 8A.401, 8A.402, 8A.411, 8A.413, 8A.414, 8A.416 to 8A.418, 8A.453, 8A.456 and 8A.458.

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² See IAB Personnel Department

³ Effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held May 13, 1992; delay lifted by the Committee at its meeting held June 10, 1992.

CHAPTER 58
PROBATIONARY PERIOD

[Prior to 11/5/86, Merit Employment Department[570]]

[Prior to 2/18/04, see 581—Ch 9]

11—58.1(8A) Duration. All original full-time or part-time appointments to permanent positions shall require a six-month period of probationary status. Appointments to peace officer positions at the department of public safety require a 12-month probationary period following appointment. Employees with probationary status shall not be eligible for promotion, reinstatement following separation, or other rights to positions unless provided for in this chapter, nor have reduction in force, recall, or appeal rights.

A six-month period of probationary status may, at the discretion of the appointing authority and with notice to the employee and the director, be required upon reinstatement, and all rules regarding probationary status shall apply during that period.

The provisions of this chapter shall apply to all executive branch employees, except employees of the board of regents, unless collective bargaining agreements provide otherwise.

[ARC 0401C, IAB 10/17/12, effective 11/21/12]

11—58.2(8A) Disciplinary actions. In addition to less severe progressive discipline measures, the appointing authority may demote, suspend, reduce pay within the same pay grade, or discharge an employee during the period of probationary status without right of appeal. The appointing authority shall notify the employee in writing of the effective date of the action, and in the case of a suspension or reduction in pay, the duration of the action. In no case shall suspension extend beyond 30 calendar days, nor beyond the end of the probationary period. A copy of the notice shall be sent to the director by the appointing authority.

Disciplinary demotion during the period of probationary status to a position covered by merit system provisions shall require that the employee meet the minimum qualifications for the class. If demoted, the total required period of probationary status shall include the time spent in the higher class. The pay shall be set in accordance with 11—subrule 53.6(7).

11—58.3(8A) Voluntary demotion during the period of probationary status. Voluntary demotion during the period of probationary status to a position covered by merit system provisions shall require that the employee meet the minimum qualifications for the class. The total required period of probationary status shall include the time spent in the higher class. The pay shall be set in accordance with 11—subrule 53.6(7).

11—58.4(8A) Promotion during the period of probationary status. A probationary employee who is promoted during the period of probationary status to a position covered by merit system provisions shall be hired in accordance with 11—subrule 56.3(3). The total required probationary period shall include the probationary service in the class from which the employee is promoted. The rate of pay shall be set in accordance with 11—subrule 53.6(6).

[ARC 0401C, IAB 10/17/12, effective 11/21/12]

11—58.5(8A) Transfer during the period of probationary status. A probationary employee who is transferred during the period of probationary status by the appointing authority to a position covered by merit system provisions must meet the minimum qualifications required for the class. The total required period of probationary status shall include the probationary time spent in the class from which transferred. The rate of pay shall be set in accordance with 11—subrule 53.6(8).

11—58.6(8A) Reclassification during the period of probationary status. An employee who is reclassified during the period of probationary status need only meet the minimum qualifications for the class. The total required period of probationary status shall include the probationary time spent in the previous class. The rate of pay shall be in accordance with 11—subrule 53.6(9).

11—58.7(8A) Leave without pay during the period of probationary status. A probationary employee may be granted leave without pay at the appointing authority's discretion in accordance with these rules. When a probationary employee is granted leave without pay, the employee's probationary period shall not be extended by the amount of leave granted unless the leave is for education or training.

11—58.8(8A) Vacation and sick leave during the period of probationary status. Probationary employees shall accrue and may be granted vacation and sick leave in accordance with the provisions of these rules.

11—58.9(8A) Probationary period for promoted permanent employees. This rule shall only apply to promotion within an appointing authority's department and to positions covered by merit system provisions.

An employee may be required to serve a six-month probationary period in the class to which promoted before the promotion becomes permanent.

At any time during the promotional probationary period the appointing authority may return the employee to the formerly held class. Return under this probationary period rule shall not be considered a demotion and there shall be no right to an appeal. The former salary and pay increase eligibility date shall be restored with credit allowed for the time spent in the higher class.

These rules are intended to implement Iowa Code sections 8A.401, 8A.411, 8A.413, 8A.415 to 8A.418, 8A.453, 8A.456 and 8A.458.

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See details following chapter analysis.

CHAPTER 59
PROMOTION, TRANSFER, TEMPORARY ASSIGNMENT, REASSIGNMENT
AND VOLUNTARY DEMOTION

[Prior to 11/5/86, Merit Employment Department[570]]

[Prior to 2/18/04, see 581—Ch 10]

11—59.1(8A) Promotion. An appointing authority may promote an employee with permanent status if the employee meets the minimum qualifications and other promotional screening requirements for the position. The employee must be on the list of eligibles for the position and available under the conditions stated on the list request. Vacancies must be filled in accordance with 11—Chapter 56.

[ARC 0401C, IAB 10/17/12, effective 11/21/12; ARC 3215C, IAB 7/19/17, effective 7/1/17]

11—59.2(8A) Reassignment. An appointing authority may reassign an employee. Reassignments may be intra-agency or interagency. Interagency reassignments require the approval of both the sending and the receiving appointing authorities.

An employee who refuses a reassignment may be discharged in accordance with rule 11—60.2(8A), except as provided in this rule.

If the reassignment of an employee would result in the loss of merit system coverage, an appointing authority may not reassign that employee without the employee's written consent regarding the change in merit system coverage. A copy of the consent letter shall be forwarded by the appointing authority to the director. If the employee does not consent to the change in coverage, a reduction in force may be initiated in accordance with these rules or the applicable collective bargaining agreement.

[ARC 0401C, IAB 10/17/12, effective 11/21/12]

11—59.3(8A) Temporary assignments.

59.3(1) An appointing authority may assign a permanent employee to special duty when that employee is temporarily needed in another position. This assignment shall be without prejudice to the employee's rights in or to the regularly assigned position. Unless there is a statutory requirement to the contrary, the employee need not be qualified for the class to which temporarily assigned.

59.3(2) An appointing authority may temporarily assign a permanent employee duties that are extraordinary for the employee's class. These duties may be of a level higher than, lower than, or similar to the duties regularly assigned to the employee's class, and may be in addition to or in place of some or all of the employee's regularly assigned duties.

59.3(3) Requests shall be submitted to the director in writing for assignments to special duty or extraordinary duty that exceed three complete pay periods and shall explain the need and the period of time requested. Temporary assignments shall not initially be approved for a period longer than one year. Extensions may be requested. Requests shall be submitted on forms prescribed by the director.

59.3(4) An appointing authority may make temporary assignments without additional pay for up to three consecutive pay periods in a fiscal year. Approval of temporary assignments without additional pay beyond three consecutive pay periods may be granted by the director.

59.3(5) An appointing authority shall provide restricted duty work assignments, without change to an employee's class and regular pay rate, for those employees who have a medical release to return to restricted duty following a job-related illness or injury. The original period of restricted duty shall be the hourly equivalent of 20 workdays (which shall be on a pro-rata basis for part-time employees), or until the employee is medically released for full duty, whichever is less. Extensions to the original period may be requested by the appointing authority for approval by the director. Exceptions to this subrule must be approved by the director.

11—59.4(8A) Voluntary demotion. An appointing authority may grant an employee's written request for a demotion to a lower class. If the voluntary demotion involves movement from a position covered by merit system provisions to one that is not, the request must clearly indicate the employee's knowledge of the change in merit system coverage. If the employee objects to the change in coverage, the demotion shall not take effect. Also, no demotion shall be made from one position covered by merit system

provisions to another, or from a position not covered by merit system provisions to one that is, until the employee is approved by the director as being qualified. A copy of the voluntary demotion request shall be sent by the appointing authority to the director at the time of the demotion.

Voluntary demotion may be either intra-agency or interagency, and shall not be subject to appeal under these rules. Vacancies must be filled in accordance with 11—Chapter 56.
[ARC 3215C, IAB 7/19/17, effective 7/1/17]

11—59.5(8A) Transfer. Transfers are restricted to the movement of an employee to a vacant position of the same or different job class in the same pay grade. Transfers may be interagency or intra-agency. To be eligible to transfer, the employee must meet any minimum qualifications and selective requirements for the position. Vacancies must be filled in accordance with 11—Chapter 56.

An employee may request a voluntary transfer. The decision to grant or deny a request for voluntary transfer is made by the receiving appointing authority.

An appointing authority may involuntarily transfer an employee. To do so, any applicable collective bargaining agreement provisions regarding transfer must first be exhausted. Involuntary interagency transfers require the approval of both the sending and the receiving appointing authorities.

If the transfer of an employee would result in the loss of merit system coverage, the transfer shall not take place without the affected employee's written consent to the change in merit system coverage. A copy of the consent letter shall be forwarded by the appointing authority to the director. If the employee does not consent to the change in coverage, a reduction in force may be initiated in accordance with these rules or the applicable collective bargaining agreement.

[ARC 3215C, IAB 7/19/17, effective 7/1/17]

These rules are intended to implement Iowa Code sections 8A.401, 8A.402, 8A.411, 8A.413, 8A.414, 8A.417, 8A.418, 8A.439, 8A.453, 8A.456 and 8A.458.

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² See IAB Personnel Department

CHAPTER 61
GRIEVANCES AND APPEALS
[Prior to IAB 3/14/84, subject appeared in Chs 12 and 15]
[Prior to 11/5/86, Merit Employment Department[570]]
[Prior to 1986, see Executive Council[420]Ch 10]
[Prior to 1/21/04, see 581—Ch 12]

11—61.1(8A) Grievances. The grievance procedure is an informal process. It is not a contested case. All employees shall have the right to file grievances. The right to file a grievance and the grievance procedure provided for in these rules shall be made known and available to employees throughout the agency by the appointing authority through well-publicized means. Employees covered by a collective bargaining agreement may use this grievance procedure for issues that are not covered by their respective collective bargaining agreements.

Grievances shall state the issues involved, the relief sought, the date the incident or violation took place and any rules involved and shall be filed on forms prescribed by the director. Grievances involving suspension, reduction in pay within the same pay grade, disciplinary demotion, or discharge may be filed as appeals in accordance with subrule 61.2(6) and commence with Step 3 of the grievance procedure described in subrule 61.1(1).

61.1(1) *Grievance procedure.*

a. Step 1. The grievant shall initiate the grievance by submitting it in writing to the immediate supervisor, or to a supervisor designated by the appointing authority, within 14 calendar days following the day the grievant first became aware of, or should have through the exercise of reasonable diligence become aware of, the grievance issue. The immediate supervisor shall, within 14 calendar days after the day the grievance is received, attempt to resolve the grievance within the bounds of these rules and give a decision in writing to the grievant with a copy to the director.

b. Step 2. If the grievant is not satisfied with the decision obtained at the first step, the grievant may, within 7 calendar days after the day the written decision at the first step is received or should have been received, file the grievance in writing with the appointing authority. The appointing authority shall, within 14 calendar days after the day the grievance is received, attempt to resolve the grievance within the bounds of these rules by affirming, modifying, or reversing the decision made at the first step, or otherwise grant appropriate relief. The decision shall be given to the grievant in writing with a copy to the director.

c. Step 3. If the grievant is not satisfied with the decision obtained at the second step, the grievant may, within 7 calendar days after the day the written decision at the second step was received, or should have been received, file the grievance in writing with the director. The director shall, within 30 calendar days after the day the grievance is received, attempt to resolve the grievance and send a decision in writing to the grievant with a copy to the appointing authority. The director may affirm, modify, or reverse the decision made at the second step or otherwise grant appropriate relief. If the relief sought by the grievant is not granted, the director's response shall inform the grievant of the appeal rights in subrule 61.2(5).

d. If the grievant is not satisfied with the decision obtained from the third step, the grievant may file an appeal in accordance with subrule 61.2(5).

61.1(2) *Exceptions to time limits.*

a. If the grievant fails to proceed to the next available step in the grievance procedure within the prescribed time limits, the grievant shall have waived any right to proceed further in the grievance procedure and the grievance shall be considered settled.

b. If any management representative fails to comply with the prescribed time limits at any step in the grievance procedure, the grievant may proceed to the next available step.

c. The maximum time periods at any of the three steps in the grievance procedure may be extended when mutually agreed to in writing by both parties.

61.1(3) *Group grievances.* When the appointing authority or the director determines that two or more grievances or grievants address the same or similar issues, they shall be processed and decided as a group grievance.

61.1(4) Grievance meetings.

a. When it is determined by a designated management representative or the director that a meeting with the grievant will be held, all reasonable attempts will be made to hold the meeting during the grievant's regularly scheduled hours of work.

b. The grievant may be assisted at a grievance meeting by an employee with the same bargaining status as the grievant. This peer employee may be of the grievant's choosing except where that would constitute a conflict of interest or unreasonably impact the operational efficiency of an appointing authority as determined by the director.

c. The grievant, an employee who is the grievant's peer, and employees authorized to attend the grievance meeting by the appointing authority or the director shall be in paid status for that time spent at and traveling to and from the grievance meeting during their regularly scheduled hours of work. In addition, employees shall, if eligible for overtime compensation, be in paid status for that time spent at and traveling to and from the grievance meeting outside of their regularly scheduled hours of work. In the case of a group grievance, only one of the grievants shall be in paid status. A grievant's peer shall not process or prepare for a grievance during work time except for meal and rest periods.

d. The appointing authority shall not authorize mileage, or the use of a state vehicle for employees to attend or participate in a grievance meeting, except for those employees who are required to attend or participate in the meeting by the appointing authority or the director.

61.1(5) Bypassing steps for discrimination grievances. A grievance step may be bypassed by the grievant when the grievance alleges discrimination and the respondent at the step is the person against whom the grievance has been filed.

[ARC 0401C, IAB 10/17/12, effective 11/21/12; ARC 2000C, IAB 5/27/15, effective 7/1/15; ARC 3215C, IAB 7/19/17, effective 7/1/17]

11—61.2(8A) Appeals.**61.2(1) Appeal of position classification decisions.**

a. Appeal of a position classification decision shall be in accordance with rule 11—52.5(8A) and the contested case provisions of Iowa Code chapter 17A.

b. The appellant (including all appellants in the case of a group hearing), an employee who is the appellant's representative, and employees directed by the appointing authority to attend the classification appeal hearing by the appointing authority or the director shall be in paid status for the time spent at and traveling to and from the hearing during their regularly scheduled hours of work. In addition, only employees directed by management to attend the hearing shall, if eligible for overtime compensation, be in paid status for the time spent at and traveling to and from the hearing outside of their regularly scheduled hours of work.

c. The appointing authority shall not authorize mileage or the use of a state vehicle for employees to attend or participate in a classification appeal hearing, except for those employees who are directed to attend the hearing by the appointing authority or the director.

61.2(2) Reserved.

61.2(3) Appeal of examination rating. Following examination, an applicant may file a written appeal to the employment appeal board in the department of inspections and appeals for a review of the rating received on the examination for the sole purpose of assuring that uniform rating procedures were applied consistently and fairly. Right of appeal shall expire unless filed with the board within 30 calendar days following the notice of the examination results.

A rating on an examination may be corrected if it is found by the employment appeal board that a substantial error has been made by the department. The correction of a rating shall not, however, affect any certifications or appointments already made.

61.2(4) Appeal of disqualification, restriction, or removal from eligible lists. An applicant who has been disqualified or whose name has been restricted or removed from an eligible list in accordance with rule 11—54.2(8A) or 11—55.2(8A), or who has been restricted from certification in accordance with rule 11—56.7(8A) may file a written appeal to the employment appeal board in the department of inspections and appeals for a review of that action. The written appeal must be filed with the board within 30

calendar days following the notice of disqualification, removal from the eligible list, or restriction from certification. The burden of proof to establish eligibility shall rest with the appellant.

When an appeal is generated as the result of an action initiated by the department, the department shall be responsible for representation. When an appeal is generated as the result of an action initiated by an appointing authority through the department, the appointing authority shall pay the costs of the appeal assessed to the department and shall participate in representation as requested by the department.

If the applicant's name is restored to an eligible list, that decision shall not affect any certifications or appointments already made.

61.2(5) *Appeal of grievance decisions.* An employee who has alleged a violation of Iowa Code sections 8A.401 to 8A.458 or the rules adopted to implement Iowa Code sections 8A.401 to 8A.458 may, within 30 calendar days after the date the director's response at the third step of the grievance procedure was issued or should have been issued, file an appeal with the public employment relations board. A nontemporary employee covered by merit system provisions who is suspended, reduced in pay within the same pay grade, disciplinarily demoted, or discharged, except during the employee's period of probationary status, may, if not satisfied with the decision of the director, request an appeal hearing before the public employment relations board within 30 calendar days after the date the director's decision was issued or should have been issued. However, when the grievance concerns allegations of discrimination within the meaning of Iowa Code chapter 216, the Iowa civil rights commission procedures shall be the exclusive remedy for appeal and shall, in such instances, constitute final agency action. In all other instances, decisions by the public employment relations board constitute final agency action.

61.2(6) *Appeal of disciplinary actions.* Any nontemporary employee covered by merit system provisions who is suspended, reduced in pay within the same pay grade, disciplinarily demoted, or discharged, except during the employee's period of probationary status, may bypass steps one and two of the grievance procedure provided for in rule 11—61.1(8A) and may file an appeal in writing to the director for a review of the action within 7 calendar days after the effective date of the action. The appeal shall be on the forms prescribed by the director. The director shall affirm, modify or reverse the action and shall give a written decision to the employee within 30 calendar days after the receipt of the appeal. The time may be extended by mutual agreement of the parties. If not satisfied with the decision of the director, the employee may request an appeal hearing before the public employment relations board as provided in subrule 61.2(5).

61.2(7) *Appeal of reduction in force.* An employee who is to be or has been laid off or who has changed classes in lieu of layoff, and who alleges that the reduction in force was used to circumvent the rights of appeal provided for in subrule 61.2(6) or subrule 61.2(1), paragraph "a" or "d," may file an appeal with the director within 30 calendar days following receipt of the notice of reduction in force to the employee from the appointing authority.

61.2(8) *Remedies.* All remedies provided in rule 11—61.2(8A) must be exhausted pursuant to Iowa Code section 17A.19, subsection 1, prior to petition for judicial review.

[ARC 0401C, IAB 10/17/12, effective 11/21/12; ARC 2000C, IAB 5/27/15, effective 7/1/15; ARC 3215C, IAB 7/19/17, effective 7/1/17]

11—61.3(8A) *Informal settlement.* The director or an appellant may request that an informal conference be held to determine if a dispute can be resolved in a manner agreeable to all parties prior to a contested case hearing. If the director and the appellant agree to negotiate a settlement, the various points of the proposed settlement shall be included in a written statement of facts. Negotiations for a settlement shall be completed at least five workdays prior to the date of the contested case hearing, unless additional time is agreed to by the director, the appellant and the public employment relations board, the department of inspections and appeals, or the classification appeal committee, as applicable. The settlement shall not be binding until approved in accordance with the procedures set forth in 2017 Iowa Acts, House File 291, section 51.

[ARC 3215C, IAB 7/19/17, effective 7/1/17]

These rules are intended to implement Iowa Code section 8A.413.

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¹ History relating also to “Grievances and Complaints”, Ch 15, prior to IAB 3/14/84.

² Effective date of amendments to 12.4(19A) delayed 70 days by Administrative Rules Review Committee. Delay lifted by Committee on 2/8/83. See details following chapter analysis.

³ See IAB Personnel Department

CHAPTER 62
PERFORMANCE REVIEW
[Prior to 11/5/86, Merit Employment Department[570]]
[Prior to 3/17/04, see 581—Ch 13]

11—62.1(8A) System established. The director shall establish, administer and maintain a uniform system of performance planning and evaluation to be applied to all employees in the executive branch of state government, excluding board of regents employees, and shall prescribe forms and procedures for its use. Such forms and procedures shall be in accordance with the accountable government Act pursuant to Iowa Code section 8E.207, subsection 2. Appointing authorities shall determine and assign the job duties to be performed by employees.

11—62.2(8A) Minimum requirements.

62.2(1) Performance plan. The individual employee performance plan shall be based on the responsibilities, strategies or goals assigned during the rating period and shall include the standards or expectations, including action steps, performance criteria, and timetables, required for performance to be considered as meeting job expectations. The individual employee performance plan shall be given to and discussed with the employee at the start of the rating period. Significant changes in responsibilities, standards or expectations that occur during the rating period shall be included in the individual employee performance plan, and a revised copy shall be given to and discussed with the employee.

62.2(2) Performance evaluation. A performance evaluation shall be prepared for each employee at least every 12 months. Additional evaluations may be prepared at the discretion of the supervisor. Ratings on the evaluation form are to be accompanied by descriptive comments supporting the ratings. The evaluation may also include job-related comments concerning achievements or areas of strength, areas for improvement, and training/development plans. The supervisor or team shall discuss the evaluation with the employee, and the employee shall be given the opportunity to attach written comments. Periods of service during FMLA, workers' compensation, military, or educational leave shall be considered as meeting job expectations.

Exit performance reviews shall be completed by the former supervisor on or before the last day before the movement of an employee to employment in another section, bureau, division or agency of state government. This review shall be for the period between the previous review up to the movement to the other position. A copy shall be forwarded to the new supervisor of the employee.

[ARC 3215C, IAB 7/19/17, effective 7/1/17]

11—62.3(8A) Copies of records. The employee shall receive a copy of each individual employee performance plan and evaluation. The originals shall be retained by the employee's agency in accordance with the policies of the department. The performance evaluation and attachments are confidential records within the meaning of Iowa Code section 22.7, subsection 11.

These rules are intended to implement Iowa Code sections 8A.413 and 8E.207.

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CHAPTER 64 BENEFITS

[Prior to 8/15/86; See Deferred Compensation Program, 270—Ch 4]

[Prior to 1/7/04, see 581—Ch 15]

11—64.1(8A) Health benefits. The director is authorized by the executive council of Iowa to administer health benefit programs for employees of the state of Iowa who are covered under Iowa Code chapter 509A. The executive council of Iowa shall determine the amount of the state's contribution toward each individual employee's premium cost and shall authorize the remaining premium cost to be deducted from the employee's pay. The state's contribution for each contract-covered employee shall be as provided for in applicable collective bargaining agreements negotiated in accordance with Iowa Code chapter 20. [ARC 8265B, IAB 11/4/09, effective 12/9/09; ARC 3215C, IAB 7/19/17, effective 7/1/17]

11—64.2(8A) Dental insurance. The director is authorized by the executive council of Iowa to administer dental insurance programs for employees of the state of Iowa who are covered under Iowa Code chapter 509A.

[ARC 8265B, IAB 11/4/09, effective 12/9/09]

11—64.3(8A) Life insurance. The director is authorized by the executive council of Iowa to administer life insurance programs for employees of the state of Iowa who are covered under Iowa Code chapter 509A, except for employees of the board of regents.

[ARC 8265B, IAB 11/4/09, effective 12/9/09]

11—64.4(8A) Long-term disability insurance. The director is authorized by the executive council of Iowa to administer long-term disability insurance programs for employees of the state of Iowa who are covered under Iowa Code chapter 509A, except for employees of the board of regents.

Employees who receive loss of time benefits under the state workers' compensation program shall have those benefits, except for benefits designated as medical costs pursuant to Iowa Code section 85.27 and that portion of benefits paid as attorneys' fees approved pursuant to Iowa Code section 86.39, deducted from any state long-term disability benefits received where the workers' compensation injury or illness was a substantial contributing factor to the award of long-term disability benefits. Disability benefit payments will be further reduced by primary and family social security payments as determined at the time social security disability payments commence, railroad retirement disability income, and any other state-sponsored sickness or disability benefits payable.

[ARC 8265B, IAB 11/4/09, effective 12/9/09]

11—64.5(8A) Health benefit appeals. A member who disagrees with a group health benefit company's decision on the application of group contract benefits may:

1. File a written appeal with the respective company as defined in the group contract, or
2. File a written appeal with the commissioner of insurance at the department of commerce.

11—64.6(8A) Deferred compensation.

64.6(1) Definitions. The following definitions shall apply when used in this rule:

"Account" means any fixed annuity contract, variable annuity contract, life insurance contract, documents evidencing mutual funds, variable or guaranteed investments, or combination thereof provided for in the plan.

"Beneficiary" means the person or estate entitled to receive benefits under the plan following the death of the participant.

"Director" means the director of the Iowa department of administrative services.

"Employee" means a nontemporary (permanent full-time or permanent part-time) employee of the employer, including full-time elected officials and members of the general assembly, except employees of the board of regents. For the purposes of enrollment, elected officials-elect and members-elect of the general assembly shall be considered employees. Persons in a joint employee relationship with the employer shall not be considered employees eligible to participate in the plan.

“*Employer*” means the state of Iowa and any other governmental employer that participates in the plan. Effective July 1, 2003, “employer” shall also include any governmental entity located within the state of Iowa that enters into an agreement to allow its employees to participate in the plan.

“*Fiduciary*” means a person or company that manages money or property for another and that must exercise the standard of care imposed by law or contract. For the purpose of these rules, “fiduciary” means the trustee, the plan administrator, investment providers, and the persons they designate to carry out or help carry out their duties or responsibilities as fiduciaries under the plan.

“*Governing body*” means the executive council of the state of Iowa.

“*Group*” means one or more employees.

“*Investment provider*” means a company authorized under this rule to issue an account or administer the records of such an account or accounts under the deferred compensation plan authorized by Iowa Code sections 8A.402 and 509A.12.

“*Normal retirement age*” means 65 years of age, unless an employee declares a different age pursuant to the plan’s catch-up provision. The age cannot be earlier than a year in which the employee is eligible to receive retirement benefits without an age reduction penalty from the employer-sponsored retirement plan.

“*Participating employee*” or “*participant*” means any employee or former employee of the employer who is currently deferring or who has previously deferred compensation under the plan and who retains the right to benefits under the plan.

“*Plan*” means the state of Iowa employee contribution plan for deferred compensation as authorized by Internal Revenue Code Section 457 and Iowa Code sections 8A.434 and 509A.12.

“*Plan administrator*” means the designee of the director who is authorized to administer the plan.

“*Plan year*” means a calendar year.

“*Retirement investors’ club*” means the voluntary retirement savings program for employees designed to increase personal long-term savings. The program contains three plans, the 457 employee contributions plan, the 401(a) employer contribution plan, and the 403(b) tax-sheltered annuity plan.

“*Trust*” means the Iowa state employee deferred compensation trust fund created in the state treasury and under the control of the department.

“*Trustee*” means the director of the Iowa department of administrative services.

64.6(2) Plan administration.

a. Director’s authorization. The director is authorized by the governing body to administer a deferred compensation program for eligible employees and to enter into contracts and service agreements with deferred compensation investment providers for the benefit of eligible employees and on behalf of the state of Iowa and other eligible employers. This rule shall govern all investment options and participant activity for the funds placed in the program.

b. Plan modification. The trustee may at any time amend, modify, or terminate the plan without the consent of the participant (or any beneficiary thereof). The plan administrator shall provide to participating employees and investment providers sufficient notice of all amendments to the plan. No amendment shall deprive participants of any of the benefits to which they are entitled under the plan with respect to deferred amounts credited to their accounts before the effective date of the amendment. If the plan is curtailed or terminated, or the acceptance of additional deferred amounts is suspended permanently, the plan administrator shall nonetheless be responsible for the supervision of the payment of benefits resulting from amounts deferred before the amendment, modification, or termination. Payment of benefits will be deferred until the participant would otherwise have been entitled to a distribution pursuant to the provisions of the plan.

c. Location of account documentation. The investment providers shall send the original annuity policies, contracts or account forms to the plan administrator. Failure to do so may result in termination of an investment provider’s contract or service agreement. The plan administrator shall keep all such original documents. Participating employees may review their own documentation during normal work hours at the department, but may not under any circumstances remove the documentation from the premises.

d. Not an employment contract. Participation in this plan by an employee shall not be construed to give a contract of employment to the participant or to alter or amend an existing employment contract of the participant, nor shall participation in this plan be construed as affording to the participant any representation or guarantee regarding the participant's continued employment.

e. Tax relief not guaranteed. The employer, trustee, and the investment providers do not represent or guarantee that any particular federal or state of Iowa income, payroll, personal property or other tax consequences will result because of the participant's participation in the plan. The participant is obligated to consult with the participant's own tax representative regarding all questions of federal or state of Iowa income, payroll, personal property or other tax consequences arising from participation in the plan.

f. Investment agents. The investment providers shall, subject to the trustee's consent, have the power to appoint agents to act for the investment providers in the administration of accounts according to the terms, conditions, and provisions of their contracts or service agreements with the plan. Investment providers are responsible for the conduct of their agents, including their adherence to the plan document and administrative rules. The plan administrator may require an investment provider to remove the authority of any agent to provide services to the plan or plan participants when cause has been shown that the agent has violated these rules or state or federal law or regulation related to the governance of the plan or agent conduct.

g. Plan expenses. Expenses incurred by the plan administrator while administering the plan, including fees and expenses approved by the plan trustee for investment advisory, custodial, record-keeping, and other plan administration and communication services, and any other reasonable and necessary expenses or charges allocable to the plan that have been incurred for the exclusive benefit of plan participants and that have been approved by the plan trustee may be charged to the short-term interest that has accrued in the deferred compensation trust fund created by Iowa Code section 8A.434 prior to the allocation of funds to a participant's chosen investment provider. Such expenses may also be funded from fees assessed to eligible employers who choose to offer the plan to their employees.

h. Time periods. As necessary or desirable to facilitate the proper administration of the plan and consistent with the requirements of Section 457 of the Internal Revenue Code (IRC), the plan administrator may modify the time periods during which a participating employee or beneficiary is required to make any election under the plan, and the time periods for processing these elections by the plan administrator, including the making or amending of a deferral agreement, the making or amending of investment provider selections, the election of distribution commencement dates or distribution methods.

i. Supplementary information and procedures. Any explanatory brochures, pamphlets, or notices distributed by the plan shall be distributed for information purposes only and shall not override any provision of the plan or give any person any claim or right not provided for under the plan. In the event any form or other document used in administering the plan, including but not limited to enrollment forms and marketing materials, conflicts with the terms of the plan, the terms of the plan shall prevail.

j. Binding plan. The plan, and any properly adopted amendments, shall be binding on the parties and their respective heirs, administrators, trustees, successors and assignees and on all beneficiaries of the participant.

64.6(3) Rights of participating employees.

a. Exclusive benefit. The trustee shall hold the assets and income of the plan for the exclusive benefit of the participating employee or the participating employee's beneficiary.

b. Creditors. The accounts of a participating employee under the plan shall not be subject to creditors of the participating employee or the participant's beneficiary and shall be exempt from execution, attachment, prior assignment, or any other judicial relief, or order for the benefit of creditors or other third persons.

c. Designation of beneficiary. Upon enrollment, a participating employee must designate a beneficiary or beneficiaries. An employee who has an open account with an investment provider that is no longer able to open new accounts may change the employee's designated beneficiary or beneficiaries at any time thereafter by providing the plan administrator with written notice of the change on the form prescribed by the plan administrator. An employee who has an open account with an investment

provider that is able to open new accounts may change the employee's designated beneficiary or beneficiaries at any time thereafter by completing the investment provider's beneficiary change form.

d. Assignment. Neither a participating employee, nor the participating employee's beneficiary, nor any other designee shall have the right to commute, sell, assign, transfer, borrow, alienate, use as collateral or otherwise convey the right to receive any payments.

64.6(4) Trust provisions.

a. Investment options. The trustee shall adopt various investment options for the investment of deferred amounts by participating employees or their beneficiaries and shall monitor and evaluate the appropriateness of the investment options offered by the plan.

b. Designation of fiduciaries. The trustee, the plan administrator, and the persons they designate to carry out or help carry out their duties or responsibilities are fiduciaries under the plan. Each fiduciary has only those duties or responsibilities specifically assigned to fiduciaries under the plan, contractual relationship, trust, or as delegated to fiduciaries by another fiduciary. Each fiduciary may assume that any direction, information, or action of another fiduciary is proper and need not inquire into the propriety of any such action, direction, or information. No fiduciary will be responsible for the malfeasance, misfeasance, or nonfeasance of any other fiduciary, except where the fiduciary participated in such conduct, or knew or should have known of such conduct in the discharge of the fiduciary's duties under the plan and did not take reasonable steps to compel the cofiduciary to redress the wrong.

c. Fiduciary standards.

(1) All fiduciaries shall discharge their duties with respect to the plan and trust solely in the interest of the participating employees and their beneficiaries and in accordance with Iowa Code section 633.123. Such duties shall be discharged for the exclusive purpose of providing benefits to the participating employees and beneficiaries and, if determined applicable, defraying expenses of the plan.

(2) The investment providers shall discharge their duties with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims and as defined by applicable Iowa law.

d. Trustee powers and duties. The trustee may exercise all rights or privileges granted by the provisions of the plan and trust and may agree to any alteration, modification or amendment of the plan. The trustee may take any action respecting the plan or the benefits provided under the plan that the trustee deems necessary or advisable. Persons dealing with the trustee shall not be required to inquire into the authority of the trustee with regard to any dealing in connection with the plan. The trustee may employ persons, including attorneys, auditors, investment advisors or agents, even if they are associated with the trustee, to advise or assist, and may act without independent investigation upon their recommendations. Instead of acting personally, the trustee may employ one or more agents to perform any act of administration, whether or not discretionary.

e. Trust exemption. This trust is intended to be exempt from taxation under IRC Section 501(a) and is intended to comply with IRC Section 457(g). The trustee shall be empowered to submit or designate appropriate agents to submit the plan and trust to the IRS for a determination of the eligibility of the plan under IRC Section 457, and the exempt status of the trust under IRC Section 501(a), if the trustee concludes that such a determination is desirable.

f. Held in trust. Notwithstanding any contrary provision of the plan, in accordance with IRC Section 457(g), all amounts of compensation deferred pursuant to the plan, all property and rights purchased with such amounts, and all income attributable to such amounts, property, or rights shall be held in trust for the exclusive benefit of participants and beneficiaries under the plan. Any trust under the plan shall be established pursuant to a written agreement that constitutes a valid trust under the law of the state of Iowa. All plan assets shall be held under one or more of the following methods:

(1) Compensation deferred under the plan shall be transferred to a trust established under the plan within a period that is not longer than is reasonable for the proper administration of the accounts of participants. To comply with this requirement, compensation deferred under the plan shall be transferred to a trust established under the plan not later than 15 business days after the end of the month in which the compensation would otherwise have been paid to the employee.

(2) Notwithstanding any contrary provision of the plan, including any annuity contract issued under the plan, in accordance with IRC Section 457(g), compensation deferred pursuant to the plan, all property and rights purchased with such amounts, and all income attributable to such amounts, property, or rights shall be held in one or more annuity contracts, as defined in IRC Section 401(g), issued by an insurance company qualified to do business in the state where the contract was issued, for the exclusive benefit of participants and beneficiaries under the plan or held in a custodial account as described in subparagraph (3) below. For this purpose, the term “annuity contract” does not include a life, health or accident, property, casualty, or liability insurance contract. Amounts of compensation deferred under the plan shall be transferred to an annuity contract described in IRC Section 401(f) within a period that is not longer than is reasonable for the proper administration of the accounts of participants. To comply with this requirement, amounts of compensation deferred under the plan shall be transferred to a contract described in IRC Section 401(f) not later than 15 business days after the end of the month in which the compensation would otherwise have been paid to the employee.

(3) Notwithstanding any contrary provision of the plan, in accordance with IRC Section 457(g), compensation deferred pursuant to the plan, all property and rights purchased with such amounts, and all income attributable to such amounts, property, or rights shall be held in one or more custodial accounts for the exclusive benefit of participants and beneficiaries under the plan or held in an annuity contract as described in subparagraph (2) above. For purposes of this subparagraph, the custodian of any custodial account created pursuant to the plan must be a bank, as described in IRC Section 408(n), or a person who meets the nonbank trustee requirements of Treasury Regulations Section 1.408-2(e)(2) to (6) relating to the use of nonbank trustees.

Amounts of compensation deferred under the plan shall be transferred to a custodial account described in IRC Section 401(f) within a period that is not longer than is reasonable for the proper administration of the accounts of participants. To comply with this requirement, amounts of compensation deferred under the plan shall be transferred to a custodial account described in IRC Section 401(f) not later than 15 business days after the end of the month in which the compensation would otherwise have been paid to the employee.

64.6(5) Absolute safeguards of the employer, trustee, their employees, and agents.

a. Questions of fact. The trustee and the plan administrator are authorized to resolve any questions of fact necessary to decide the participating employee’s rights under the plan. An appeal of a decision of the plan administrator shall be made to the trustee, or the trustee’s designee, who shall render a final decision on behalf of the plan.

b. Plan construction. The trustee and the plan administrator are authorized to construe the plan and to resolve any ambiguity in the plan and to apply reasonable and fair procedures for the administration of the plan. An appeal of a decision of the plan administrator shall be made to the trustee, or the trustee’s designee, within 30 days of the plan administrator’s decision. The trustee, or the trustee’s designee, shall render a final decision on behalf of the plan.

c. No liability for loss. The participating employee specifically agrees that the employer, the plan, the trustee, the plan administrator, or any other employee or agent of the employer shall not be liable for any loss sustained by the participating employee or the participating employee’s beneficiary for the nonperformance of duties, negligence, or any other misconduct of the above-named persons except that this paragraph shall not excuse malicious or wanton misconduct.

d. Payments suspended. The trustee, plan administrator, investment providers, their employees and agents, if in doubt concerning the correctness of their actions in making a payment of a benefit, may suspend the payment until satisfied as to the correctness of the payment or the identity of the person to receive the payment, or until the filing of an administrative appeal under Iowa Code chapter 17A, and thereafter in any state court of competent jurisdiction, a suit in such form as they consider appropriate for a legal determination of the benefits to be paid and the persons to receive them.

e. Court costs. The employer, the plan, the trustee, the plan administrator, their employees and agents are hereby held harmless from all court costs and all claims for the attorneys’ fees arising from

any action brought by the participating employee, or any beneficiary thereof, under the plan or to enforce their rights under the plan, including any amendments of the plan.

64.6(6) Eligibility. Except employees of the board of regents, any nontemporary executive, judicial or legislative branch employee, or employee of a governmental employer that enters into an agreement to join the plan, who is regularly scheduled for 20 or more hours of work per week or who has a fixed annual salary is eligible to defer compensation under this rule. An elected official-elect and elected members-elect of the general assembly are also eligible provided that deductions meet the requirements set forth in the plan. Final determination on eligibility shall rest with the plan administrator.

64.6(7) Communications.

a. Forms. All enrollments, elections, designations, applications and other communications by or from an employee, participant, beneficiary, or legal representative of any such person regarding that person's rights under the plan shall be made in the form and manner established by the plan administrator and shall be deemed to have been made and delivered only upon actual receipt by the person designated to receive such communication. The employer or the plan shall not be required to give effect to any such communication that is not made on the prescribed form and in the prescribed manner and that does not contain all information called for on the prescribed form.

b. Notices mailed. All notices, statements, reports, and other communications from the plan to any employee, participant, beneficiary, or legal representative of any such person shall be deemed to have been duly given when delivered to, or when mailed by first-class mail to, such person at that person's last mailing address appearing on the plan records.

64.6(8) Disposition of funds while employed.

a. Unforeseeable emergency. A participating employee may request that the plan administrator allow the withdrawal of some or all of the funds held in the participating employee's account based on an unforeseeable emergency. Forms must be completed and returned to the plan administrator for review in order to consider a withdrawal request. The plan administrator shall determine whether the participating employee's request meets the definition of an unforeseeable emergency as provided for in federal regulations. In addition to being extraordinary and unforeseeable, an unforeseeable emergency must not be reimbursable:

- (1) By insurance or otherwise;
- (2) By liquidation of the participating employee's assets, to the extent the liquidation of such assets would not itself cause severe financial hardship; or
- (3) By cessation of deferrals under the plan.

Upon the plan administrator's approval of an unforeseeable emergency distribution, the participating employee will be required to stop current deferrals for a period of no less than six months.

A participating employee who disagrees with the initial denial of a request to withdraw funds on the basis of an unforeseeable emergency may request that the trustee or the trustee's designee reconsider the request by submitting additional written evidence of qualification or reasons why the request for withdrawal of funds from the plan should be approved. All such requests must be in writing and be received by the trustee, or the trustee's designee, within 30 calendar days of the date of the initial denial. Requests received after 30 days will be rejected as untimely, and the initial denial shall become final agency action.

b. Voluntary in-service distribution. A participant who is an active employee of an eligible employer shall receive a distribution of the total amount payable to the participant under the plan if the following requirements are met:

- (1) The total amount payable to the participant under the plan does not exceed \$5,000 (or the dollar limit under IRC Section 411(a)(11), if greater);
- (2) The participant has not previously received an in-service distribution of the total amount payable to the participant under the plan;
- (3) No amount has been deferred under the plan with respect to the participant during the two-year period ending on the date of the in-service distribution; and
- (4) The participant elects to receive the distribution.

The plan administrator may also elect to distribute the accumulated account value of a participant's account without consent, if the above criteria are met.

This provision is available only once in the lifetime of the participating employee. If funds are distributed under this provision, the participating employee is not eligible under the plan to utilize this provision at any other time in the future.

c. Transfers under domestic relations orders.

(1) To the extent required under a final judgment, decree, or order (including approval of a property settlement agreement) made pursuant to a state domestic relations law, any portion of a participating employee's account may be paid or set aside for payment to a spouse, former spouse, or child of the participating employee. The plan will determine whether the judgment, decree, or order is valid and binding on the plan and whether it is issued by a court or agency with jurisdiction over the plan. The judgment, decree or order must specify which of the participating employee's accounts are to be paid or set aside, the valuation date of the accounts and, to the extent possible, the exact value of the accounts. Where necessary to carry out the terms of such an order, a separate account shall be established with respect to the spouse, former spouse, or child who shall be entitled to choose investment providers in the same manner as the participating employee. Unless otherwise subsequently suspended or altered by federal law, all applicable taxes shall be withheld and paid from this lump sum distribution. The provisions of this subparagraph shall not be construed to authorize any amount to be distributed under the plan at a time or in a form that is not permitted under IRC Section 457.

(2) A right to receive benefits under the plan shall be reduced to the extent that any portion of a participating employee's account has been paid or set aside for payment to a spouse, former spouse, or child pursuant to these rules or to the extent that the employer or the plan is otherwise subject to a binding judgment, decree, or order for the attachment, garnishment, or execution of any portion of any account or of any distributions therefrom. The participating employee shall be deemed to have released the employer and the plan from any claim with respect to such amounts in any case in which:

1. The department, the retirement investors' club, or the plan has been served with legal process or otherwise joined in a proceeding relating to such amounts,

2. The participating employee has been notified of the pendency of such proceeding in the manner prescribed by the law of the jurisdiction in which the proceeding is pending for service of process or by mail from the employer or a plan representative to the participating employee's last-known mailing address, and

3. The participating employee fails to obtain an order of the court in the proceeding relieving the employer and the plan from the obligation to comply with the judgment, decree, or order.

(3) The department, the retirement investors' club or the plan shall not be obligated to incur any cost to defend against or set aside any judgment, decree, or order relating to the division, attachment, garnishment, or execution of the participating employee's account or of any distribution therefrom.

64.6(9) *Investment providers.*

a. Participation. The investment providers under the plan are authorized to offer new accounts and investment products to employees only if awarded a contract or service agreement through a competitive bid process. A list of active investment providers shall be provided, upon request, to any employee or other interested party. Inactive investment providers shall participate to the extent necessary to fully discharge their duties under the applicable federal and state laws and regulations, the plan, their service agreements or contracts with the employer, and their investment accounts or contracts with participating employees.

b. Investment products. Investment products shall be limited to those that have been approved by the plan administrator. No new accounts shall be available to employees for life insurance under the plan.

c. Reports and consolidated statements. The investment providers will provide various reports to the plan administrator as well as consolidated statements, newsletters, and performance reports to participants as specified in the service agreements or contracts with investment providers.

d. Dividends and interest. The only dividend or interest options available on policies or funds are those where the dividend or interest remains within the account to increase the value of the account.

e. Minimum contract requirements. In addition to meeting selection requirements, an investment provider must meet and maintain the requirements set forth in its contract or service agreement with the state of Iowa.

f. Removal from participation. Failure to comply with the provisions of these rules, the investment provider contract or service agreement with the employer, or the terms and conditions of the investment provider account with the participating employee may result in termination of an investment provider contract or service agreement, and all rights therein shall be exercised by the employer.

64.6(10) Marketing and education.

a. Orientation and information meetings. Employers may hold orientation and information meetings for the benefit of their employees during normal work hours using materials developed and approved by the plan administrator. Active investment providers may make authorized presentations upon approval of individual agency or department authorities during nonwork hours. There shall be no solicitation of employees by investment providers at an employee's workplace during the employee's working hours, except as authorized in writing by the plan administrator.

b. General requirements for solicitation.

(1) An active investment provider may solicit business from participants and employees through representatives, the mail, or direct presentations.

(2) Active investment providers and representatives may solicit business at an employer's work site only with the prior permission of the agency director or other appropriate authority.

(3) Investment providers or representatives may not conduct any activity with respect to a registered investment option unless the appropriate license has been obtained.

(4) An investment provider or representative may not make a representation about an investment option that is contrary to any attribute of the option or that is misleading with respect to the option.

(5) An investment provider or representative may not state, represent, or imply that its investment options are endorsed or recommended by the plan administrator, the employing agency, the state of Iowa, or an employee of the foregoing.

(6) An investment provider or representative may not state, represent, or imply that its investment option is the only option available under the plan.

c. Disclosure.

(1) Enrollment. When soliciting business for an investment product, an active investment provider or representative shall provide each participating employee or eligible employee with a copy of the approved disclosure for that option. If a variable annuity product has several alternative investment choices, the participant must receive disclosures concerning all investment choices. An active investment provider shall notify the plan administrator in writing if the investment provider will be marketing its investment options through representatives. The notification must contain a complete identification of the representatives who will be marketing the options. Every representative and agent who enrolls eligible employees in the plan and is authorized by the investment provider to sign plan forms must be included on this notification.

(2) Disbursement methods and account values. When discussing distribution methods for an investment option, investment providers or representatives shall disclose to each participating employee or eligible employee all potential distribution methods and the potential income derived from each method for that option.

d. Approval of a disclosure form.

(1) An investment provider shall complete and submit to the plan administrator a disclosure form for each approved investment product. If a variable annuity product has several investment choices, the plan administrator must receive all disclosures related to those investment choices. An investment provider shall complete a disclosure form on each investment product that has participating employee funds (including those no longer offered).

(2) If changes occur during the plan year, any changes must be submitted to the plan administrator for approval prior to their implementation. Disclosure forms will be updated quarterly. Even if no changes occur, an investment provider shall resubmit its disclosure form to the plan administrator for approval every year.

(3) If an investment provider or representative materially misstates a required disclosure or fails to provide disclosure, the plan administrator may sanction the investment provider or bind the investment provider to the disclosure as stated on the form.

e. Confidentiality. The plan administrator may provide to all active investment providers any information that can be made available under the department's rules. Notwithstanding any rule of the department to the contrary, the plan administrator shall make available to all active investment providers the names and home addresses of all state employees. The plan administrator may assess reasonable costs to the active investment providers to defray the expense of producing any requested information. All information obtained under the plan shall be confidential and used exclusively for purposes relating to the plan and as expressly contemplated by the service agreement or contract entered into by the investment provider.

f. Number of investment providers. Only investment providers that are selected through a competitive bid process, that are subsequently awarded a contract or service agreement, and that are authorized to do business in the state of Iowa may sell annuities, mutual funds or other approved products under the plan, and then only if the investment providers agree to the terms, conditions, and provisions of the contract or service agreement.

64.6(11) Investment option removal/replacement. The plan administrator may determine that an investment option offered under the plan is no longer acceptable for inclusion in the plan. If the plan administrator decides to remove an investment option from the plan as the result of the option's failure to meet the established evaluation criteria and according to the recommendations of consultants or advisors, the option shall be removed or phased out of the plan. Employees newly enrolling in the plan shall be informed in writing that investment options that do not meet the evaluation criteria are not open to new enrollments.

a. Notice to participant. Any participating employees already deferring to the investment option being phased out shall be informed in writing that they need to redirect future deferrals from this option to an alternative investment option offered under the plan by notifying the investment provider, unless otherwise directed, of their new investment choice.

b. Automatic transfer. If any participating employee has failed to move a remaining account balance from the investment option being phased out, the plan administrator shall instruct an investment provider to automatically move that participating employee's account balance into another designated alternative investment option offered under the plan.

c. Reexamination. At any time during this process, the plan administrator may reexamine the performance of the investment option being phased out and the recommendations of consultants and advisors to determine if continued inclusion of the investment option in the plan is justified.

64.6(12) Demutualization of investment providers.

a. Ballots. An investment provider that is a mutual company and that provides any annuity product or life insurance product held under the plan shall provide the plan administrator with a ballot(s) for official vote registration. The ballot(s) shall be completed and returned to the company according to the specified deadline in the instructions. The ballot(s) shall include the owner's name, policy numbers of affected contracts, name of annuitant or insured, number of shares anticipated, and the control number for the group of shares.

b. Policyholder booklet. The company shall provide the plan administrator with a policyholder booklet, as well as instructions and guide information, prior to or in conjunction with the delivery of the ballot(s). Notices of progress, time frames and meetings will also be provided to the plan administrator as such information becomes available.

c. Method of compensation. Compensation will be provided in cash according to the terms of the demutualization plan. In the event that stocks are issued in lieu of cash, the company shall provide a listing which includes participants' names, social security numbers, policy numbers, and number of shares pro rata.

d. Liquidation of stock. An arrangement will be entered into between the plan administrator and a stockbroker as soon as administratively possible in order to liquidate the stock for cash. The broker

shall retain commission fees according to the arrangement entered into from the value obtained at the time of sale. The employer will not realize a tax liability nor will the participating employees.

e. Deposit of proceeds. The proceeds of the sale of the stock, less the broker commission, and any dividends issued prior to the sale of the stock, shall be made payable to the plan. Cash shall be deposited into the plan's trust fund until payment instructions are received from the participant or the participant's beneficiary.

[ARC 8265B, IAB 11/4/09, effective 12/9/09; ARC 1568C, IAB 8/6/14, effective 9/10/14; ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—64.7(8A) Dependent care. The director administers the dependent care flexible spending account plan for employees of the state of Iowa. The plan is permitted under IRC Section 125. The plan is also a dependent care assistance plan under IRC Section 129. Administration of the plan shall comply with all applicable federal regulations, the Plan Document, and the Summary Plan Description. For purposes of this rule, the plan year is a calendar year.

64.7(1) Employee eligibility. All nontemporary employees who work at least 1040 hours per calendar year are eligible to participate in the dependent care flexible spending plan. Temporary employees are not eligible to participate in this plan.

64.7(2) Enrollment. An open enrollment period, as designated by the director, shall be held for employees who wish to participate in the plan. New employees may enroll within 30 calendar days following their date of hire. Employees also may enroll or change their existing dependent care deduction amounts during the plan year provided that they have a qualifying change in family status as defined in the Plan Document and the Summary Plan Description. To continue participation, employees shall reenroll each year during the open enrollment period.

64.7(3) Termination of participation in the plan. An employee may terminate participation in the plan provided that the employee has a qualifying change in status as defined in the Summary Plan Description. Employees who terminate state employment and are rehired within 30 days must resume their participation in the plan. Employees who terminate state employment and are rehired more than 30 days after termination may reenroll in the plan.

11—64.8(8A) Premium conversion plan (pretax program). The director administers the premium conversion plan for employees of the state of Iowa. The plan is permitted under IRC Section 125. Pursuant to IRC Section 105, the plan is also an insured health care plan to the extent that participants use salary reduction to pay for health or dental insurance premiums. In accordance with IRC Section 79, the plan is also a group term life insurance plan to the extent that salary reduction is used for life insurance premiums. Administration of the plan shall comply with all federal regulations and the Plan Document. For purposes of this rule, the plan year is January 1 to December 31 of each year.

64.8(1) Employee eligibility. All nontemporary employees who work at least 1040 hours per calendar year are eligible to participate in the pretax conversion plan. Temporary employees are not eligible to participate in the plan.

64.8(2) Enrollment. An enrollment and change period, as designated by the director, shall be held for employees who wish to make changes in their current pretax status. New employees will automatically be enrolled in the plan after satisfying any waiting period requirements for group insurance unless an election form is submitted. Employees also may change their existing pretax status during the plan year if they have a qualifying change in status as defined in the Plan Document.

64.8(3) Termination of participation in the plan. An employee may terminate participation in the plan during an open enrollment period. Otherwise, an employee may terminate participation if the employee has a qualifying change in status as defined in the Plan Document.

[ARC 8265B, IAB 11/4/09, effective 12/9/09]

11—64.9(8A) Interviewing and moving expense reimbursement.

64.9(1) Interviewing expenses. If reimbursement is approved by the appointing authority, a person who interviews for state employment shall be reimbursed for expenses incurred in order to interview.

Reimbursement shall be at the same rate at which an employee is reimbursed for expenses incurred during the performance of state business.

64.9(2) *Moving expenses for reassigned employees.* A state employee who is reassigned at the direction of the appointing authority shall be reimbursed for moving and related expenses in accordance with the policies of the department of administrative services or the applicable collective bargaining agreement. Eligibility for reimbursement shall occur when all of the following conditions exist:

- a. The employee is reassigned at the direction of the appointing authority;
- b. The reassignment requires a permanent change in duty station beyond 25 miles;
- c. The employee must change the employee's place of personal residence beyond 25 miles unless the department of administrative services has given prior written approval; and
- d. The reassignment is for the primary benefit of the state.

64.9(3) *Moving expenses for newly hired or promoted employees.* If reimbursement is approved by the appointing authority, a person newly hired or promoted may be reimbursed for moving and related expenses. Reimbursement shall be at the same rates used for the reimbursement of a current employee who has been reassigned. Reimbursement shall not occur until the employee is on the payroll.

64.9(4) *Temporary living expenses.* An employee may be reimbursed for up to 90 days of temporary living expenses. Such reimbursement shall be included as part of the total amount reimbursable under the relocation policy.

64.9(5) *Repayment.* As a condition of receiving reimbursement for moving expenses, the recipient must sign an agreement to continue employment with the appointing authority for a period following the date of receipt of reimbursement that is deemed by the appointing authority to be commensurate with the amount of reimbursement received. In the event that the recipient leaves the department of the appointing authority for any reason, the recipient will repay to the appointing authority a proportionate fraction of the amount received for each month remaining in the period provided for in the agreement. If the recipient continues employment with the state, then the repayment will be subject to a repayment schedule approved by the director. If the recipient leaves state government, then the repayment will be recouped out of the final paycheck. Recoupment must be coordinated with the accounting enterprise of the department of administrative services to ensure proper tax reporting.

11—64.10(8A) Education financial assistance. Education financial assistance may be granted for the purpose of assisting employees in developing skills that will improve their ability to perform job responsibilities. Assistance may be in the form of direct payment to the organization or institution or by reimbursement to the employee as provided for in subrule 64.10(4).

64.10(1) *Employee eligibility.* Any nontemporary employee may be considered for education financial assistance.

64.10(2) *Workshop, seminar, or conference attendance.* The appointing authority may approve education financial assistance for an employee attending a workshop, seminar, or conference conducted by a professional, educational, or governmental organization or institution when attendance by the employee would not require a reduction in job responsibilities.

a. Assistance for meeting continuing education requirements may be approved when the assistance is applied toward maintaining a professional registration, certification, or license and the workshop, seminar, or conference is related to the duties and responsibilities of the employee's position.

b. Payment of registration fees and other costs, such as lodging, meals, and travel, shall be in accordance with the policies and procedures of the department of administrative services.

c. If attendance is outside the state of Iowa, travel must be authorized by the head of the employee's department pursuant to Iowa Code section 8A.512A(2) "a."

64.10(3) *Educational institution coursework.* Education financial assistance to an employee taking academic courses at an educational institution, with or without educational leave, shall require the preapproval of the appointing authority and the director. Requests for reimbursement shall be on forms prescribed by the director.

a. An employee may take academic courses at any accredited educational institution (university, college, area community college) within the state. Attendance at an out-of-state institution may be

approved provided that there are geographical or educational considerations which make attendance within the state impractical.

b. Reimbursement requests shall be made to the director before the employee takes the courses. If the director does not approve the request, the employee shall not be reimbursed.

c. Reimbursement may be approved for courses taken to meet continuing education requirements when necessary to maintain a professional registration, certification, or license when the courses relate to the duties and responsibilities of the employee's position.

d. An employee receiving other financial assistance, such as scholarship aid or Veterans Administration assistance, shall be eligible to receive education financial assistance only to the extent that the total of all methods of reimbursement does not exceed 100 percent of the payment of expenses.

e. In order for the employee to be reimbursed, the employee's department shall submit to the department of administrative services the employee's original paid receipt from the educational institution, the approved education financial assistance form, and proof of the employee's successful completion of the courses as follows:

(1) Undergraduate courses shall require at least a "C-" grade.

(2) Graduate courses shall require at least a "B-" grade.

(3) Successful completion of vocational or correspondence courses or continuing education courses shall require an official certificate, diploma or notice.

64.10(4) *Repayment.* As a condition of applying for reimbursement for education expenses, the recipient must sign an agreement to continue employment with the appointing authority. The agreement must be signed prior to approval and will stipulate the period of time deemed by the appointing authority to be commensurate with the amount of reimbursement received. The period of time commences upon successful completion of the course. In the event that the recipient leaves the department of the appointing authority for any reason, the recipient will repay to the appointing authority an appropriate fraction of the amount received for each month remaining in the period provided for in the agreement. If the recipient continues employment with the state, then the repayment will be subject to a repayment schedule approved by the director. If the recipient leaves state government, then the repayment will be recouped out of the final paycheck. Recoupment must be coordinated with the accounting enterprise of the department of administrative services to ensure proper tax reporting.

64.10(5) *Annual report.* The appointing authority shall report to the director and legislative council, not later than October 1 of each year, the direct and indirect costs to the department for education financial assistance granted to employees during the preceding fiscal year in a manner prescribed by the director. [ARC 8265B, IAB 11/4/09, effective 12/9/09; ARC 2267C, IAB 11/25/15, effective 12/30/15; ARC 3041C, IAB 4/26/17, effective 5/31/17]

11—64.11(8A) Particular contracts governing. Where provisions of collective bargaining agreements differ from the provisions of this chapter, the provisions of the collective bargaining agreement shall prevail for employees covered by the collective bargaining agreements.

11—64.12(8A) Tax-sheltered annuities (TSAs).

64.12(1) *Administration.* The director is authorized by 2003 Iowa Code Supplement section 8A.402 to administer a tax-sheltered annuity program for eligible employees.

64.12(2) *Definitions.* The following definitions shall apply when used in this rule:

"Company" means any life insurance company or mutual fund provider that issues a policy under the tax-sheltered annuity plan authorized under Iowa Code section 8A.438.

"Employee" means an employee of the state of Iowa, including employees of the board of regents administrative staff on the centralized payroll system, or an employee of a participating employer.

"Employer" means the state of Iowa, a public school district in the state of Iowa, an area education agency in the state of Iowa, or a community college in the state of Iowa.

"Participating employee" means an employee participating in the plan.

"Participating employer" means an employer that has elected to join the state's tax-sheltered annuity plan.

"Plan" means the tax-sheltered annuity plan authorized in Iowa Code section 8A.438.

“*Plan administrator*” means the designee of the director who is authorized to administer the tax-sheltered annuity plan.

“*Plan year*” means a calendar year.

“*Policy*” means any retirement annuity, variable annuity, family of mutual funds or combination thereof provided by IRC Section 403(b) and Iowa Code section 8A.438.

“*Salary reduction form*” means the tax-sheltered annuity form signed by the participating employee to begin or change payroll deductions.

64.12(3) Eligibility.

a. Initial eligibility. Any employee who works for the department of education, the board of regents administrative office, or a participating employer is eligible to participate in this plan. Participating employers may establish different eligibility requirements, as long as the requirements conform to IRC Section 403(b) and the applicable federal regulations. Final determination on eligibility shall rest with the plan administrator.

b. Eligibility after terminating reduction of compensation. Any employee who terminates the reduction of compensation may choose to reenroll in the plan in accordance with paragraphs 64.12(4)“a” and “b” and 64.12(6)“a.”

64.12(4) Enrollment and termination.

a. Enrollment. State employees may enroll in the plan at any time. Participating employers may establish different enrollment periods, as long as the periods conform to IRC Section 403(b) and the applicable federal regulations. The salary reduction form must be submitted to the employing agency’s personnel assistant or payroll office for approval.

b. Forms submission. State personnel assistants shall provide the plan administrator with the salary reduction form in a timely manner.

c. Termination of salary reductions. A participating employee may terminate salary reductions by providing to the employing agency’s personnel assistant or payroll office written notification on a form required by the plan administrator.

d. Availability of forms. It is the responsibility of each employee interested in participating in the plan to obtain the necessary forms from the investment provider.

64.12(5) Tax status.

a. FICA and IPERS. The amount of compensation reduced under the salary reduction form shall be included in the gross wages subject to FICA and IPERS until the maximum taxable wages established by law have been reached.

b. Federal and state income taxes. The amount of earned compensation reduced under the form is exempt from federal and state income taxes until such time as the funds are paid or made available as provided in IRC Section 403(b).

64.12(6) Reductions from earnings.

a. Salary reduction amount changes. Participating employees may increase or decrease their salary reduction amount by providing to their personnel assistant or payroll office written notice on a form required by the plan administrator. Salary reduction amounts may be changed to permit a one-time lump sum contribution from the last paycheck due to termination of employment.

b. Maximum salary reduction limits. Employees’ salary reductions may not exceed the maximum limit set forth in federal law.

c. Minimum salary reduction amount. Participating employers may establish a minimum amount as long as the minimum conforms to IRC Section 403(b) and the applicable federal regulations.

64.12(7) Companies.

a. Time of payment. Participating employers shall transmit amounts within 15 business days after the end of the calendar month.

b. Cooperation with third-party administrator. Companies are required to cooperate with the plan’s third-party administrator, including the provision of daily account information as well as any other data or information required for administration of the plan.

c. Annual status report. Each company shall provide to the participating employee at the employee’s home address an annual status report stating the value of each participant’s policy. This

practice shall be continued even after the participating employee terminates or stops contributions to the plan. These annual reports are required as long as a value exists in the contract or any activity occurs during the year.

d. Crediting of accounts. Companies must minimize crediting errors and provide timely and reasonable credit resolution.

e. Solicitation. There shall be no solicitation of employees by companies at the employees' workplace during employees' work hours, except as authorized by the plan administrator or participating employer.

f. Dividends. The only dividend options available on cash value policies are those where the dividend remains with the company to increase the value of the policy.

g. Removal from participation. Failure to comply with the provisions of these rules will result in permanent removal as a participating company and may require that the monthly ongoing deferrals to existing contracts be discontinued, as determined by the director.

64.12(8) Disposition of funds.

a. Distribution eligibility. An employee is eligible for a distribution of funds based upon any of the following circumstances: severance of employment; reaching age 59½; becoming disabled; qualifying for a financial hardship; or becoming eligible for a reservist distribution. Distribution will be made in accordance with applicable IRS regulations.

b. Financial hardship. A participating employee may request to withdraw some or all of the salary reduction contributions to the policy, but not the income earned thereon, based on a financial hardship and in accordance with 401(k) regulations. New contributions to the plan will not be allowed after the receipt of a distribution based on financial hardship until such time as allowed by law.

c. Federal and state withholding taxes. It is the company's responsibility, when making payments to an employee, to withhold the required federal and state income tax, to timely remit the tax to the proper government agency, and to file all necessary reports as required by federal and state regulations, including IRS Form 1099-R.

d. Federal penalties. Under IRC Section 72(t), an additional tax of 10 percent of the amount includable in gross income applies to early withdrawal for qualified plans as defined in IRC Section 4974(c). An IRC Section 403(b) contract is a qualified plan for these purposes.

64.12(9) General.

a. Orientation and information meetings. Employers may hold orientation and information meetings for the benefit of their employees using materials developed or approved by the plan administrator, but there shall be no solicitation of employees by companies allowed at such meetings without employer approval.

b. Company changes.

(1) If a participating employee wishes to redirect contributions to another company, the employee shall submit a form to the personnel assistant or payroll office in accordance with paragraph 64.12(6) "a."

(2) The funds accumulated under the old policy may be transferred in total to the new policy or to another existing policy, if allowed under the participating employer's plan elections, in accordance with the plan's policies and applicable IRC Section 403(b) provisions.

c. Deferred compensation or tax-sheltered annuity participation—maximum contribution. State employees who, under the laws of the state of Iowa, are eligible for both deferred compensation and tax-sheltered annuities shall be allowed to contribute to one plan or the other, but not to both at the same time.

d. Direct transfer/rollover.

(1) Effective January 1, 2002, a former employee may request a direct transfer/rollover to an eligible retirement plan as defined in IRC Section 402(c)(8)(B). Eligible rollover amounts that are received by a former employee are subject to mandatory federal and state withholding as required by law.

(2) An employee may request a trustee-to-trustee transfer of funds to a defined benefit governmental plan for the purchase of permissive service credit.

64.12(10) Forfeiture. IRC Section 403(b)(1)(C) provides that an employee's interest in an IRC Section 403(b) contract is nonforfeitable, except for failure to pay future premiums.

64.12(11) Nontransferability. The employee's interest in the contract is nontransferable within the meaning of IRC Section 401(g). The contract may not be sold, assigned, discounted, or pledged as collateral for a loan or as security for the performance of an obligation or for any other purpose.
[ARC 8265B, IAB 11/4/09, effective 12/9/09]

11—64.13(8A) Health flexible spending account. The director administers the health flexible spending account plan for employees of the state of Iowa. The program is permitted under IRC Section 125. Administration of the plan shall comply with all applicable federal regulations and the Plan Document. To the extent that the provisions of the Plan Document or administrative rule conflict with IRC Section 125, the provisions of IRC Section 125 shall govern. For purposes of this rule, the plan year is a calendar year.

64.13(1) Employee eligibility. All nontemporary employees who work at least 1040 hours per calendar year are eligible to participate in the health flexible spending account plan. Temporary employees are not eligible to participate in this plan.

64.13(2) Enrollment. An open enrollment period, as designated by the director, shall be held for employees who wish to participate in the plan. New employees may enroll within 30 calendar days following their date of hire. Employees also may enroll or change their existing health flexible spending account salary reduction amounts during the plan year, provided they have a qualifying change in status as defined in the Plan Document, and as permitted under IRC Section 125. To continue participation, employees shall reenroll each year during the open enrollment period.

64.13(3) Modification or termination of participation in the plan. An employee may modify or terminate participation in the plan, provided the employee has a qualifying change in status as defined in the Plan Document, and as permitted under IRC Section 125. Employees who have terminated state employment and are rehired within 30 days must resume their participation in the plan. Employees who terminate state employment and are rehired more than 30 days after termination may reenroll in the plan.

64.13(4) Continuation of coverage. The health flexible spending account plan shall provide the opportunity to continue coverage as required by applicable state and federal laws.

64.13(5) Eligible health care expenses. The types of expenses eligible for reimbursement shall be consistent with medical expenses as defined under IRC Section 213.

64.13(6) Acceptable proof of eligible expense. Only those expenses for which appropriate documentation is submitted shall be eligible for reimbursement. Such documentation shall include the date upon which the expense was incurred; sufficient evidence that the expense is an eligible health care expense; evidence that the expense has been incurred and will not be reimbursed under an otherwise qualified health plan authorized by IRC Sections 105 and 106; and the amount of such expense.

64.13(7) Appeal process. In the event that a participant disagrees with a determination as to reimbursement from the health flexible spending account plan, a formal appeals mechanism is hereby provided. The participant may submit a formal appeal in writing to the director (or designee). Such appeal must be accompanied by a previous written request for favorable consideration to the designated administrator of the plan, along with evidence as to an unfavorable determination in response to this request. Upon receipt of a qualified appeal, the director (or designee) shall provide a written determination within 30 days of receipt. Such determination shall be final and binding. This appeal process is not a contested case proceeding as defined by Iowa Code chapter 17A.

64.13(8) Third-party administrator. The director may contract with a third-party administrator to perform such actions as are reasonably necessary to administer the health flexible spending account plan.
[ARC 3215C, IAB 7/19/17, effective 7/1/17]

11—64.14(8A) Deferred compensation match plan. The director is authorized by the governing body to administer a deferred compensation match plan for employees of the state of Iowa and employees of other eligible participating governmental employers. The plan shall be qualified under IRC Section

401(a) and Iowa Code section 509A.12. The assets and income of the plan shall be held in trust for the exclusive benefit of the participating employee or the participating employee's beneficiary. The trustee shall be the director of the department of administrative services. The director shall adopt various investment options for the investment of plan funds by participating employees or their beneficiaries and shall monitor and evaluate the appropriateness of the investment options offered by the plan.

The plan shall match eligible participant contributions to the deferred compensation plan with contributions by the employer. Eligibility of participants and the rate of employer matching contributions shall be subject to determination by the trustee and the governing body. The only voluntary contributions by participants that the plan shall accept are eligible rollover contributions.

11—64.15(8A) Insurance benefit eligibility.

64.15(1) Full-time and part-time employees with probationary or permanent status who work 20 or more hours a week are eligible for health and dental insurance coverage. For employees working 20 to 29 hours per week, the state's share of the premium is one-half the amount paid for full-time employees (30 to 40 hours per week). Temporary employees are not eligible for health or dental insurance.

64.15(2) Full-time employees with probationary or permanent status who work 30 or more hours a week are eligible for life and long-term disability insurance coverage. Temporary employees are not eligible for life and long-term disability insurance.

11—64.16(8A) Sick leave insurance program. The director is authorized to establish a sick leave insurance program (program) for employees. The program shall allow eligible employees to convert a portion of their sick leave balance at retirement into a sick leave bank with which the state will pay the state's share of retiree health insurance. Employees of the department of natural resources or department of public safety who are classified as peace officers and are not covered by a collective bargaining agreement shall receive benefits at retirement consistent with the provisions of the negotiated collective bargaining agreement with the State Police Officers Council. The benefits for sick leave banks earned by all department of public safety peace officer employees shall be administered by the department of public safety.

64.16(1) To be eligible to participate in the program, the employee must be employed on or after July 1, 2006, and must retire under a retirement system in the state maintained in whole or in part by public contributions or payment prior to reaching Medicare eligibility.

a. Participation in the program ceases when any one of the following occurs:

- (1) The employee's sick leave balance is exhausted;
- (2) The employee reaches Medicare eligibility;
- (3) The employee terminates participation in the state's group insurance program;
- (4) The employee returns to permanent employment with the state;
- (5) The employee fails to pay any required amount; or
- (6) The employee dies.

b. A deceased employee's sick leave bank is not transferable to another person, including a spouse.

64.16(2) Upon a participating employee's termination of employment, the employee's sick leave hours are multiplied by the employee's regular hourly wage. The employee receives up to \$2,000 of this amount on the employee's final paycheck. The remainder is multiplied by a conversion factor, and that amount is placed into the employee's sick leave bank. The conversion factors are as follows: If an employee has up to 750 hours, the rate is 60 percent; if an employee has over 750 hours and up to 1,500 hours, the rate is 80 percent; and if the employee has more than 1,500 hours, the rate is 100 percent. The employee's sick leave balance before payment of up to \$2,000 is used to determine the number of hours an employee has for conversion purposes. The amounts placed into the employee's sick leave bank have no cash value, other than for purposes of paying the state's share of retiree health insurance premiums under this program. The value of sick leave hours for peace officer employees of the department of natural resources and the department of public safety shall be calculated in the same manner as for those employees covered by the collective bargaining agreement with the State Police Officers Council.

64.16(3) Rescinded IAB 5/27/15, effective 7/1/15.

64.16(4) To participate in the program, an employee must complete a sick leave insurance program enrollment form upon retirement. Upon commencement of participation in the program, the employee may choose to continue the employee's current health insurance plan selection or may choose any other state group health plan whose total cost is the same or lower than the total cost of the current plan selection. Except for employees eligible for benefits negotiated consistent with the collective bargaining agreement negotiated with the State Police Officers Council, employees may not apply the sick leave balance to a private insurance plan.

[ARC 2000C, IAB 5/27/15, effective 7/1/15; ARC 3215C, IAB 7/19/17, effective 7/1/17]

These rules are intended to implement Iowa Code sections 8A.402, 8A.433 to 8A.438, and 8A.454 and Iowa Code chapter 509A.

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CHAPTER 65
POLITICAL ACTIVITY

[Prior to 11/5/86, Merit Employment Department [570]]

[Prior to 2/18/04, see 581—Ch 16]

11—65.1(8A) Political activity of employees. All employees have the right to express their opinions as individuals on political issues and candidates. Such expressions may be either verbal or demonstrative in the form of pictures, buttons, stickers, badges, pins, or posters. Employees' rights to express their opinions on political matters in this form or manner shall not be restrained while on duty unless:

65.1(1) It is a violation of the law; or

65.1(2) The display of such items would cause or constitute a real and present safety risk or would substantially and materially interfere with the efficient performance of official duties; or

65.1(3) The employee has substantial contact with the public and the level of trust and confidence associated with the employee's position is perceived to be such that political expressions in any form, while on duty, might influence the public.

11—65.2(8A) Restrictions on political activity of employees. All employees are prohibited from:

65.2(1) Using the influence of their positions, public property, or supplies to secure contributions or to influence an election for any political party or any person seeking political office.

65.2(2) Soliciting or receiving anything of value in excess of the limits in Iowa Code section 68B.5 as a political contribution or subterfuge for a contribution from any other person for any political party or any person seeking political office during scheduled working hours, while on duty, when using state equipment, or on state property.

65.2(3) Promising or using influence to secure public employment or other benefits financed from public funds as a reward for political activity.

65.2(4) Discriminating in favor of or against any employee or applicant on account of their political contributions or permitted political activities.

Employees of the alcoholic beverages division of the department of commerce, in addition to the foregoing subrules, are subject to the prohibitions set forth in Iowa Code section 123.13. All employees are further subject to the provisions of Iowa Code chapter 721.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—65.3(8A) Application of Hatch Act. In addition to the restrictions set forth in rules 11—65.1(8A) and 11—65.2(8A), employees occupying state positions wholly funded by federal "grant-in-aid" or other specific federal funding are subject to the provisions of the federal Hatch Act. Where compliance with the political restrictions of the Hatch Act is required for the receipt of federal funds, the appointing authority shall identify those state positions so covered. The employees under those further political activity restrictions shall be made aware of the additional restrictions by posting or other written notification from the appointing authority.

Persons found by proper authority to have violated the provisions of the federal Hatch Act are subject to summary discharge.

[ARC 2000C, IAB 5/27/15, effective 7/1/15]

These rules are intended to implement Iowa Code sections 8A.413, 8A.416 and 8A.418.

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CHAPTER 66
 CONDUCT OF EMPLOYEES
 [Prior to 11/5/86, Merit Employment Department [570]]
 [Prior to 2/18/04, see 581—Ch 18]

11—66.1(8A) General. Employees shall fulfill to the best of their ability the duties and responsibilities of the position to which appointed. In carrying out their official job duties, employees shall work for the appointing authority's efficient and effective delivery of services. Employees shall perform assigned responsibilities in such a manner as neither to endanger their impartiality nor to give occasion for distrust or question of their impartiality.

11—66.2(68B) Selling of goods or services. Rescinded IAB 11/10/04, effective 10/20/04. See rules 351—6.10(68B) to 351—6.12(68B) and 11—1.7(68B).

11—66.3(68B) Outside employment or activity. Rescinded IAB 3/11/09, effective 4/15/09.

11—66.4(8A) Performance of duty. Employees shall, during scheduled hours of work, devote their full time, attention and efforts to assigned duties and responsibilities subject to the Iowa Code and the Iowa Administrative Code. Continued employment is dependent upon the satisfactory performance of assigned duties and responsibilities, i.e., “meets job expectations,” as well as appropriate conduct as provided for in these rules and the work rules of their agency of employment. This rule shall not be interpreted to prevent the separation or reduction of employees because of the lack of funds or work, reorganization done in accordance with these rules, or the provisions of the Iowa Code or a collective bargaining agreement.

11—66.5(8A) Prohibitions relating to certain actions by state employees.

66.5(1) Employees shall not be prohibited from disclosing any information to members or employees of the general assembly, or to any other public official or law enforcement agency if the employee believes the information is evidence of the violation of a law, rule, mismanagement, a gross abuse of funds, an abuse of authority, or a substantial and specific danger to public health or safety. An employee need not inform the appointing authority about such disclosure unless the employee presented the information as the official position of the appointing authority.

a. This subrule does not apply to the disclosure of information prohibited by statute.

b. Agencies are prohibited from any reprisals in the form of a disciplinary action or failure to appoint or promote an employee who discloses information, fails to inform the appointing authority of the disclosure of information, or who declines to contribute to a charity or organization. Reprisals for disclosing information shall be subject to civil action.

66.5(2) Employees may contact the office of ombudsman to report violations of this rule.
 [ARC 4053C, IAB 10/10/18, effective 11/14/18]

These rules are intended to implement Iowa Code sections 8A.413 and 68B.4.

[Filed 9/17/70]

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CHAPTER 71
COMBINED CHARITABLE CAMPAIGN

[See also 681—12.7, 13.7, 14.2, 15.8, 16.9]

[Prior to 1/7/04, see 581—Ch 25]

11—71.1(8A) Policy. These rules define and structure the state’s charitable organization campaign program. The intent of the campaign is to provide an opportunity for state employees to contribute to eligible charitable agencies through the state’s payroll deduction process, to ensure accountability of participants with regard to the funds contributed, and to minimize workplace disruption and administrative costs by allowing solicitation at the work site only once per year. Nothing about this program shall be construed as support or endorsement by the state of Iowa for any individual charitable agency or federation of agencies.

11—71.2(8A) Definitions.

“*Campaign administrator*” means the individual appointed by the director to administer the combined charitable campaign program.

“*Charitable agency*” means an agency or federation of agencies that is eligible to receive contributions which may be deducted on the contributor’s Iowa individual tax return in accordance with U.S. Internal Revenue Code Sections 501(a) and 501(c)3, and which otherwise meets the criteria provided for in rule 11—71.6(8A).

“*One gift campaign*” means the annual fundraising solicitation for charitable agencies which meet the eligibility requirements established in these rules.

“*State employees*” means any employees subject to a state payroll system, except for employees of the board of regents for whom rules shall be promulgated by the board of regents.

11—71.3(8A) Basic premises.

71.3(1) Solicitation period. The solicitation period shall fall within the period of September 1 through September 30, although that period may be extended with the approval of the director.

71.3(2) Workplace solicitation. Individual charitable agencies or federations of agencies may not ever solicit state employees at their workplace. Workplace solicitation of employees will occur only during the solicitation period, only in accordance with the procedures contained in this chapter, and only with the approval of the campaign administrator.

71.3(3) Employee solicitations. Employee solicitation is to be conducted using only methods that encourage voluntary giving. Actions that do not allow for and encourage free choice or that even create the appearance that employees may not have a totally free choice to give or not give are absolutely prohibited. This should in no way be interpreted as restricting the need for an effective, well-organized education program for employees. All employees will be given the necessary information to make an informed, free-will decision. Group meetings for this purpose are permitted. Employees may choose to attend or not attend such meetings.

Employees shall be free to publicize their gifts or keep them confidential. Individual employee contribution records are confidential records in the meaning of Iowa Code section 22.7(11).

71.3(4) Pledge authorization forms. The campaign administrator shall approve the pledge authorization form. Pledge authorization forms shall conform to the provisions of rule 11—43.13(70A).

71.3(5) Terminations. Employees wishing to terminate their deductions shall be required to give 30 days’ advance notice in writing to the appointing authority of the department in which they work, as required by rule 11—43.12(70A).

11—71.4(8A) Administration. The director shall select a campaign administrator to organize and manage the program. The state accounting enterprise shall serve as the campaign’s fiscal agent. It shall be the sole responsibility of the campaign administrator to determine, using the criteria set forth in these rules, which charitable agencies or federations of agencies shall be eligible to participate in the campaign.

71.4(1) *Request to participate.* Charitable agencies and federations of charitable agencies wishing to participate in the one gift campaign program shall forward the completed application packet developed by the campaign administrator to the campaign administrator prior to the date publicized in January of each year by the campaign administrator. Applications received prior to the publicized date and subsequently approved shall be eligible for inclusion in the list of approved charities published prior to each annual solicitation period. Applications received after the publicized date may be accepted with the approval of the campaign administrator.

71.4(2) *Notification of agencies.* The campaign administrator shall, within 30 calendar days following the closing date for applications, send letters of denial or acceptance on behalf of the director, and include reasons for denial when applicable.

71.4(3) *Request for reconsideration.* A charitable agency that has been denied participation will be allowed ten calendar days following the date of the notice of denial to file a written request for reconsideration with the director. The director shall notify agencies of the final decision within ten calendar days following the date the request was received. The director's decision shall constitute final agency action.

71.4(4) *Distribution of campaign moneys.*

a. An approved pledge authorization form shall be used. Pledge authorization forms shall be developed by the campaign administrator and fiscal agent as provided for in rule 11—43.6(70A). State employees shall be allowed to specifically designate their gifts to agencies or federations of agencies described in the campaign materials, and the pledge authorization form shall be designed to accommodate such designations.

b. Gifts not specifically designated shall be distributed to participating agencies or federations of agencies based on the same percentage ratio as the designated dollars are distributed. This fact shall be prominently displayed in the campaign materials.

c. The one gift campaign shall charge the actual administrative costs of managing the campaign to each participating charitable agency based on the percentage of total campaign moneys received by that agency. Such charges shall not include the salaries of state employees involved in the ongoing administration of the program.

d. Any shrinkage (moneys pledged but not contributed) shall reduce the moneys distributed to charitable agencies in the same ratio as the designated moneys.

e. Moneys collected will be sent to the charitable agencies monthly by the department of revenue.

f. Moneys collected that cannot be distributed to a charitable agency because the agency has ceased to do business or the agency has been disqualified from participation in the campaign shall be distributed to participating agencies or federations of agencies based on the same percentage ratio as the designated dollars are distributed. This fact shall be prominently displayed on the campaign materials.

11—71.5 Reserved.

11—71.6(8A) Eligibility of charitable agencies.

71.6(1) *Criteria to be included in campaign.* Any charitable agency or federation of agencies may participate in the campaign provided it meets the following criteria:

a. Be a charitable agency as defined in rule 11—71.2(8A).

b. Make available to the general public and the campaign administrator an annual financial report which is prepared by an independent certified public accountant, and provide for an annual external audit by an independent certified public accountant. The campaign administrator may, in lieu of the annual external audit, accept Internal Revenue Service Form 990.

c. Receive its funds from either a communitywide solicitation or a statewide solicitation.

d. Be a nonprofit, tax-exempt charitable organization within the meaning of Section 501(c)3 of the United States Internal Revenue Code and any relevant state laws.

e. Have an active and responsible governing board that meets at least semiannually whose members have no conflict of interest and who, except for a paid staff director, serve without compensation.

- f. Be providing or supporting services that are readily accessible to residents of the state of Iowa.
- g. Have a direct and substantial local presence in the state of Iowa. A telephone number alone shall not constitute a local presence.
- h. Operate without discrimination in employment, in accordance with Iowa Code chapter 216, and in the delivery of services and the distribution of funds.
- i. Make a report available on an annual basis to the general public detailing the local activities of the agency.
- j. Have a detailed annual budget approved by its governing board in a form consistent with generally accepted accounting principles and procedures wherein the organization's administrative (management and general) and fund-raising expenses do not exceed 25 percent of its total expenses as reflected in the organization's audited financial statements.

71.6(2) Federations (umbrella organizations). Applications submitted on behalf of federations shall list all participating constituent agencies and shall include a certification that all participating constituent agencies meet these eligibility criteria, and that they agree to comply with the rules set forth in this chapter. No charitable agency may participate both individually and as a member of a federation.

71.6(3) Criteria for ongoing participation. Once approved for participation, annual reapplication is not necessary. The campaign administrator may at any time, however, review a charitable agency's continuing eligibility and may require additional information which demonstrates that the criteria for participation are still being met. The campaign administrator will send notice on behalf of the director to any charitable agency which may be disqualified from further participation in the campaign stating the reason(s) for disqualification. Reasons for disqualification include, but shall not be limited to:

- a. Failure to comply with the rules contained in this chapter.
- b. Filing an application to participate in the campaign which contains false or misleading information.
- c. Failure to provide eligibility information requested by the campaign administrator.

71.6(4) Reconsideration of decertification. Any disqualified agency may request reconsideration of the director's decision using the procedures for reconsideration in subrule 71.4(3).

71.6(5) Contributions to decertified agencies. Any charitable agency decertified under the provisions of subrule 71.6(3) shall have any further payment of contributions terminated. Future collections of pledges to the decertified agency shall be distributed in the same ratio as other undesignated gifts.

These rules are intended to implement Iowa Code section 8A.432.

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TITLE V
GENERAL SERVICES
CHAPTER 100
CAPITOL COMPLEX OPERATIONS
[Prior to 9/17/03, see 401—Chapter 3]

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

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

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

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

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

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

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

“Modular office components” means parts of a modular office system.

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

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

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

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

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

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

“Standard modular office systems” means modular office systems that meet standards set by the department of administrative services, expressed by function and connectivity, for use by state agencies. These standards are for the purpose of facilitating reuse of modular office system components.

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

[ARC 3179C, IAB 7/5/17, effective 7/1/17; ARC 3287C, IAB 8/30/17, effective 10/4/17; ARC 3676C, IAB 3/14/18, effective 4/18/18]

11—100.2(8A) Security.

100.2(1) *Dangerous weapons.* No member of the public shall carry a dangerous weapon in state buildings on the capitol complex except as otherwise provided in subrule 100.2(2). This provision applies to any member of the public whether or not the individual possesses a valid Iowa permit to carry weapons. This provision does not apply to:

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

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

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

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

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

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

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

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

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

b. Requiring any member of the public who is inside a state building on the capitol complex outside normal business hours, other than when the building or portion of the building is open to the public during a scheduled event, to provide identification and to state the nature of the person's business in the building. A member of the public who is in a state building on the capitol complex outside normal

business hours, other than during a scheduled event, and who does not have authorization to be on the premises may be required to exit the building and be escorted from the building.

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

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

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

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

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

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

[ARC 3179C, IAB 7/5/17, effective 7/1/17; ARC 3287C, IAB 8/30/17, effective 10/4/17]

11—100.3(142B) Smoking.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This rule is intended to implement Iowa Code section 8A.322.
[ARC 4053C, IAB 10/10/18, effective 11/14/18]

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

11—100.5(8A) Solicitation.

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

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

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

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

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

This rule is intended to implement Iowa Code sections 8A.322 and 303.9 and chapter 216D.
[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—100.6(8A) Office space management.

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

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

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

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

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

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

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

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

- a.* A description of the intended space modification result;
- b.* The tasks required to achieve the intended result, such as creating construction specifications, identifying wiring needs, selection of a space planner and a moving service, and identifying related purchases;
- c.* The party responsible for accomplishing each task; and
- d.* The scheduled time line for tasks included in the design, installation (construction and move) and completion of the project.

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

100.6(6) Purchase of standard modular office systems and components. If Iowa Prison Industries (IPI) manufactures office furniture and standard modular office systems and related components, an agency shall purchase them from IPI or obtain a written waiver in accordance with Iowa Code section 904.808, except as otherwise permitted in paragraphs "a" and "b."

a. Purchase from a targeted small business. An agency may purchase standard modular office systems and related components and other furniture items from a targeted small business (TSB) without

further competition when the purchase will not exceed \$10,000, as provided in Iowa Code section 8A.311(10)“a.”

b. Procurement of standard modular office systems and components and other furniture items manufactured in Iowa. An agency may conduct a competitive procurement for standard modular office systems and related components and other furniture items that IPI manufactures if the competitive procurement requires that the products must be manufactured in Iowa. In such procurements, IPI shall be allowed to submit a bid to provide the products. If a bidder other than IPI is the lowest bidder, the agency shall obtain written verification from the bidder that the bidder’s product is manufactured in Iowa before making the award.

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

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

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

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

[ARC 3676C, IAB 3/14/18, effective 4/18/18]

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

[Filed emergency 1/11/02—published 2/6/02, effective 1/14/02]

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[Filed ARC 4053C (Notice ARC 3937C, IAB 8/15/18), IAB 10/10/18, effective 11/14/18]

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

CHAPTER 101

PARKING

[Prior to 5/26/04, see 401—Ch 4]

11—101.1(8A) Purpose.

101.1(1) The purpose of these rules is to provide citizens with the most convenient access to Iowa state offices on the capitol complex, to provide state employees a parking space within a reasonable distance of their offices, to remove the hazards inherent in unregulated parking, to define prohibited parking, and to set forth fines and the means of enforcement.

101.1(2) Parking spaces or lots will be assigned to three classes of drivers: (1) visitors and employees with disabilities, (2) other visitors, and (3) other employees.

101.1(3) Capitol complex parking area designations may be found on the department's website at das.iowa.gov.

[Editorial change: IAC Supplement 9/16/15]

11—101.2(8A) Definitions. The following definitions shall apply to this chapter.

“Access coordinator” means an employee, designated within each agency, with the assigned duties of disseminating information on capitol complex parking and building access and requesting and distributing employee parking permits and access cards from the department of administrative services, the department of public safety, and the house of representatives or the senate, as appropriate, for employee parking lot assignment and building access.

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

“Capitol complex parking area” means a parking lot or parking structure for employees or visitors that is within the boundaries of the capitol complex and that is under the control of the executive branch of state government.

“Combined lot” or *“overflow lot”* means a parking area designated by the department of administrative services for both employees and visitors.

“Controlled lot” means a parking area for which access or usage is designated by any of the following: parking gates, vehicle decals, signs, symbols, or markings.

“Council member” means a member of a state board, committee, commission, or council who is not a full-time state employee and who is present on the capitol complex only on an occasional basis in the member's official capacity.

“Delinquent” means a parking fine that has not been paid within 30 days of issuance. If the owner or operator of the vehicle contests the parking citation by filing a written request for hearing within 10 days of the issuance of the citation, the fine will be suspended pending the outcome of the contested case. If the appeal decision upholds the citation, an unpaid fine shall become delinquent 10 days after issuance of the final decision or 31 days after issuance of the ticket, whichever is later.

“Department” means the department of administrative services.

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

“Employee” means any person employed full-time or part-time by the state of Iowa, including legislators, judges, and temporary workers. “Employee” includes a contractor and the contractor's employees who regularly work on the capitol complex. “Employee” shall also mean a council member who is at the capitol complex in the member's official capacity.

“Habitual violator” means any owner or operator of a vehicle who has received six or more separate and distinct parking citations in the past 12 months regardless of whether payment for the citations is made in a timely manner.

“Legislative parking area” means a parking lot within the boundaries of the capitol complex that is under the control of the legislative branch of state government.

“Operator” means any person who is in actual physical control of a vehicle.

“Overnight parking” means parking on the capitol complex between 11 p.m. and 6 a.m.

“Overtime parking” means parking in a space or parking area longer than the posted time limit.

“Owner” means a person who is named on the legal title of a vehicle as the owner or, in the case of a vehicle without a title certificate, the person who is lawfully seized of the vehicle.

“Parking permit” means a device such as but not limited to a decal, placard or tag distributed by the department of administrative services or the legislative branch and used to identify the vehicle of a state employee or council member in capitol complex and legislative parking areas.

“Peace officer” means a person defined as a peace officer in Iowa Code section 801.4, who is assigned to the Iowa state patrol district 16 on either a permanent or temporary basis.

“Persons with disabilities parking permit” means a permit as defined in Iowa Code section 321L.2 that bears the international symbol of accessibility and that is issued by the department of transportation or by the corresponding agency of another state that allows the holder to park in a persons with disabilities parking space.

“Persons with disabilities parking sign” means a sign that bears the international symbol of accessibility and that meets the requirements of Iowa Code section 321L.6.

“Persons with disabilities parking space” means a parking space, including the access aisle, that is designated for use only by motor vehicles displaying a persons with disabilities parking permit and that meets the requirements of Iowa Code sections 321L.5 and 321L.6 and 661—Chapter 18.

“Person with a disability,” as defined in Iowa Code section 321L.1, means a person who has a disability that limits or impairs the person’s ability to walk.

“Reserved parking” means a parking area designated by a “reserved” parking sign or other assignment indicator pursuant to subrule 101.3(2), and assigned by the director to a specific agency, vehicle or individual.

“Vehicle” means every device in, upon, or by which any person or property is or may be transported or drawn upon a highway. “Vehicle” does not include any device moved by human power.

“Visitor” means a member of the public at the capitol complex who is not included in the definition of employee.

11—101.3(8A) Parking space assignments.

101.3(1) Each parking space on the capitol complex will be assigned, on an individual or lot basis, by the director, except legislative parking areas which shall be assigned by the chief clerk of the house of representatives or the secretary of the senate or by the legislative council. Parking assignments may be dependent upon factors including, but not limited to, office location, type of vehicle (such as an oversized vehicle or a motorcycle), or the need to park after normal working hours.

101.3(2) The assignment of parking spaces will be indicated and designated by traffic control devices including but not limited to signs, instructions, lines or symbols painted on curbs or on parking surfaces, or by curbs, barricades, blocks, and lights.

101.3(3) A parking permit must be displayed by all vehicles parked by employees on the capitol complex.

11—101.4(8A) Parking for persons with disabilities.

101.4(1) Spaces designated for persons with disabilities in visitor parking areas, unless specifically posted for employee parking, shall be used only by visitors with disabilities or by persons transporting visitors with disabilities. Such visitors are required to display a persons with disabilities parking permit in or on their vehicle pursuant to Iowa Code section 321L.4.

101.4(2) Spaces designated for employees with disabilities shall be used only by employees with disabilities, or persons who are transporting employees with disabilities, who display a persons with disabilities parking permit in or on their vehicle pursuant to Iowa Code section 321L.4 and who display a capitol complex parking decal.

11—101.5(8A) Visitor parking. Visitors to the capitol complex shall park in areas designated for visitor parking, in combined lots, or on the street where parking is not prohibited. A visitor shall not park in a parking area posted for employee parking except as provided in subrule 101.9(4).

11—101.6(8A) Deliveries. Most buildings on the capitol complex have delivery entrances with limited space for parking while a person loads or unloads a vehicle. Drivers of delivery vehicles and others needing to load or unload their vehicles near the building shall use these entrances. Each of the restrictions and regulations contained in these rules, all traffic control devices, and state laws shall apply to delivery vehicles.

11—101.7(8A) Employee parking. Employees shall park only in assigned capitol complex employee parking areas or combined lots, and not in areas designated solely for visitors or otherwise reserved or restricted except as provided in subrule 101.9(4). An employee who is a council member shall be assigned a parking permit that, when displayed, will allow the council member to park in either an employee or a visitor parking area.

101.7(1) Access card issuance. The director or Iowa state patrol district 16 will issue to each employee an access card, if needed, for access to the employee's assigned lot. An access card shall be assigned to an employee by name for access granted to that employee. Generic or spare access cards shall not be issued.

101.7(2) Parking permit issuance. All employees who park any vehicle, other than a state vehicle, on the capitol complex shall register the vehicle through their access coordinator and obtain a parking permit and a space or lot assignment. The parking permit will be coded and shall be used only in the assigned space or lot(s).

a. All employees, except legislative employees, who park any vehicle, other than a state vehicle, on the capitol complex shall register the vehicle with the department of administrative services through their access coordinator.

b. Legislative employees must register with the chief clerk of the house of representatives or the secretary of the senate for a parking permit and a parking space or lot assignment, unless such registration and assignment are delegated by the legislative branch to another entity.

c. The department may establish a process for issuing nonadhesive capitol complex parking permits to an access coordinator for temporary use by employees from the coordinator's agency who normally do not work on the capitol complex and to council members associated with the coordinator's agency. Access coordinators shall record the number from the temporary permit and forward this information to the department as requested. The access coordinator shall collect the temporary permit from the driver when the driver no longer needs a parking permit.

101.7(3) Failure to obtain a parking permit. An employee who fails to register a vehicle pursuant to subrule 101.7(2) or fails to obtain a parking permit and a space or lot assignment shall not park in capitol complex parking areas.

101.7(4) Display of permits.

a. Parking decals with adhesive backing must be permanently affixed to the lower corner of the vehicle's windshield on the driver's side within 48 hours of issuance. The use of tape or adhesive other than that found on the decal to affix the parking decal is prohibited.

b. Dash placards shall be placed on the vehicle's dashboard so they are visible through the windshield on the driver's side.

c. Hangtags shall be hung from the vehicle's rearview mirror.

101.7(5) Replacement of parking permits.

a. *Lost parking permit.* An employee or a council member shall replace a lost parking permit by contacting the access coordinator and making application to the department of administrative services or the chief clerk of the house of representatives or the secretary of the senate, as appropriate.

b. *Damaged parking permit.* An employee or a council member shall replace a parking permit that becomes damaged or unidentifiable or a decal that is affixed to a vehicle being reassigned to a parking

area that requires a different parking permit by contacting the access coordinator and making application to the department, or legislative branch, as appropriate.

101.7(6) *Removal of parking permits.* A parking permit used in or affixed to a vehicle that is no longer being driven to the capitol complex by the employee or council member to whom the parking permit was issued shall be removed from the vehicle. When the individual to whom the parking permit was issued is no longer an employee, the parking permit shall be removed from the vehicle and returned to the individual's access coordinator.

101.7(7) *Replacement access cards.*

a. Replacement fee. If an access card is lost or stolen, it shall be replaced upon approval of an application submitted through the access coordinator and payment of the fee prescribed by the director. The replacement fee shall be based on the costs of replacing the card.

b. No replacement fee. The first card issued to an individual and any card replacing one that failed and is returned to the Iowa state patrol district 16 shall be issued free of charge.

101.7(8) *Access coordinator responsibilities.* An agency access coordinator shall:

a. Assist employees from the coordinator's agency with completing and filing an application for an access card or parking permit.

b. Ensure that employees of the coordinator's agency are familiar with the rules of this chapter and the procedures for obtaining a parking permit and access card.

c. Assist with distribution of parking permits to employees of the coordinator's agency.

11—101.8(8A) Temporary parking.

101.8(1) A request to park temporarily for the purpose of loading or unloading a vehicle in an area where parking is prohibited shall be directed to the Iowa state patrol district 16 at (515)281-5608. The requester shall provide the driver's name, license plate number of the vehicle and where it is parked.

101.8(2) An individual who is a visitor on the capitol complex and who drives a vehicle with a parking decal assigned to a specific employee lot may park in a visitor's space provided permission is granted by the Iowa state patrol district 16. The driver shall immediately telephone the Iowa state patrol district 16 at (515)281-5608 and give the driver's name, license plate number of the vehicle and where it is parked. The driver will receive instructions on obtaining permission.

101.8(3) An employee who drives a vehicle that has not been registered pursuant to subrule 101.7(2) or is without a parking decal pursuant to subrule 101.7(4) must obtain permission from Iowa state patrol district 16 to temporarily park on the capitol complex. The driver shall immediately telephone Iowa state patrol district 16 at (515)281-5608 and give the driver's name, license plate number of the vehicle and where it is parked. The driver will receive instructions on obtaining permission.

101.8(4) Temporary parking permission granted under subrule 101.8(1), 101.8(2), or 101.8(3) shall not constitute a waiver of the rules in this chapter.

11—101.9(8A) Prohibited parking. Failure to locate a space where parking is permitted in a designated capitol complex parking area does not entitle the operator to park in a manner prohibited by this chapter or state law.

101.9(1) Vehicles shall not be parked in a manner that violates any of the rules in this chapter or state law.

101.9(2) Vehicles shall not be parked in a manner that causes:

- a.* More than one space to be occupied by a single vehicle.
- b.* A street, parking lot lane or traffic lane within a capitol complex parking lot to be blocked.
- c.* A building entrance to be blocked or obstructed.
- d.* Access to fire hydrants, emergency equipment or vehicles to be blocked or obstructed.
- e.* Obstruction of the egress of another vehicle.
- f.* Pedestrian walkways or sidewalks to be obstructed or blocked.
- g.* Occupation of an area where vehicle parking is prohibited.
- h.* Overtime parking.

101.9(3) A vehicle shall not be parked in a space designated for use by visitors with disabilities unless the driver is a visitor with disabilities or is transporting a visitor with disabilities. A vehicle shall not be parked in a space designated for use by employees with disabilities unless the driver is an employee with disabilities or is transporting an employee with disabilities.

101.9(4) A vehicle shall not be parked in a space or lot unless that space or lot is designated for use by or assigned to the driver. However, general employee or visitor spaces or lots that are not otherwise designated (by sign or symbol that indicates a restricted or continuous reserved status, such as legislator, emergency or delivery vehicle, or persons with disabilities) may be used between 6 p.m. and 6 a.m. and during weekends and state government holidays, except as otherwise specified by this rule.

101.9(5) Vehicles shall not be parked on curbs, on grass or in any area not intended for vehicle parking.

101.9(6) Delivery vehicles shall not be parked in a manner or for a period of time that does not comply with the restrictions established for those vehicles by the director or with a traffic control device.

101.9(7) A vehicle with a delinquent parking ticket shall not be allowed to be parked on the capitol complex.

101.9(8) Vehicles of habitual violators shall not be allowed to be parked on the capitol complex.

101.9(9) If any vehicle is found stopped, standing or parked in any manner in violation of the provisions of these rules and the identity of the operator cannot be determined, the owner or operator or corporation in whose name the vehicle is registered shall be held responsible for the violation.

101.9(10) Vehicles shall not be parked on the capitol complex overnight in parking areas not specifically designated for overnight parking when there are conditions of snow or ice or when the department closes an area for maintenance.

11—101.10(8A) Waiver. As the purpose of these rules is to facilitate the system of parking, to encourage compliance and to reduce conflict, any rule contained herein, unless otherwise provided by law, may be suspended or waived by the director to aid law enforcement, to prevent undue hardship in any particular instance or to prevent unnecessary conflict or injustice. All suspensions and waivers shall be in writing. The director may change space and lot designations, excluding those in legislative parking areas, temporarily or permanently, to maintain appropriate availability of parking on the capitol complex. Waiver of these rules shall be requested in accordance with 11—Chapter 9.

11—101.11(8A) Enforcement.

101.11(1) Peace officers assigned to the Iowa state patrol district 16 shall be primarily responsible for the enforcement of these rules.

101.11(2) The Iowa state patrol peace officers may in their discretion enforce these rules by:

- a. Issuing oral or written orders or directions to an owner or operator.
- b. Issuing a citation.
- c. Removing a vehicle or causing a vehicle to be removed in accordance with subrule 101.11(6).

101.11(3) The director may rescind the privilege to park on the capitol complex for any vehicle for which there is a delinquent parking ticket.

101.11(4) The director may rescind the privilege to park on the capitol complex for any vehicle of a habitual violator.

101.11(5) Removal of vehicles.

a. A vehicle may be removed for nonpayment of all parking fines whether or not the vehicle is illegally parked at that time, when there are delinquent parking fines for the vehicle or registration plates.

b. A peace officer shall have the right to remove from the capitol complex the vehicle of a habitual violator.

101.11(6) If a peace officer determines that a vehicle is to be removed, the peace officer shall have the vehicle removed by the use of state equipment or by a private towing firm or contractor.

101.11(7) The director may contract with an individual or firm to provide services for removing (towing) vehicles found in violation of these rules or state law and to store such vehicles until claimed by the owner or disposed of as abandoned vehicles.

101.11(8) A peace officer, upon impounding a vehicle, shall give notice in person, by telephone or by ordinary mail to the owner of the vehicle. The notice shall state the specific violation or other reason for which the vehicle was impounded, its location and the fee for the removal, storage and notice. The towing firm or individual shall release the vehicle to the owner upon notification by the department of administrative services that the owner or operator has paid all outstanding citations and after the service fee has been paid to the towing firm or individual. The amount of this fee will be determined by the agreement between the director and the individual or firm.

101.11(9) If an owner or operator returns to the vehicle prior to its removal, but after the towing contractor has been summoned, the peace officer may require that the vehicle remain on the capitol complex until the towing contractor arrives. Upon the towing contractor's arrival, the vehicle may be allowed to be moved after the operator pays the towing contractor the cost of the service call and after the department of administrative services notifies the peace officer that all delinquent parking fines have been paid. The towing firm or individual shall issue a receipt for payment of the cost of the service call to the owner or operator.

101.11(10) An operator who enters a parking lot in a manner not consistent with usual parking lot access procedures shall be subject to a parking citation and possible charges for damages. Access to parking lots inconsistent with usual access procedures includes, but is not limited to: closely following another vehicle into a parking lot in a manner that prevents the gate from closing between vehicles; opening a gate for unauthorized persons with another operator's access card; driving over the curb or around the gate; driving through a gate that is not fully raised; or lifting a parking gate without authorization.

101.11(11) In addition to any enforcement action taken under this rule, charges may be filed under other criminal statutes if appropriate.

11—101.12(8A) Fines.

101.12(1) A fine of \$10 is hereby established for the violation of any of these rules, except those pertaining to persons with disabilities parking.

101.12(2) The parking fine shall be increased by \$10 for all outstanding delinquent violations if the fine is not or has not been paid within 30 days of the date upon which the violation occurred.

101.12(3) Improper use of a persons with disabilities parking space is subject to a fine pursuant to Iowa Code section 321L.4(2).

101.12(4) A violator may be notified of a violation by being served with a parking violation ticket which:

a. May be served personally to the operator or placed upon the vehicle that is parked in violation of a rule.

b. Advises the operator of the rule violated.

c. Instructs the operator that the operator is required for each violation to pay \$10 to the department of administrative services within 10 days by submitting the ticket or the ticket number and payment in cash or a check or money order payable to the Department of Administrative Services, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319.

d. Warns the operator that:

(1) The director may rescind the parking privilege of any owner or operator who has a delinquent parking ticket.

(2) The director may rescind the parking privilege of any owner or operator who meets the definition of "habitual violator."

When the parking privilege is rescinded, the vehicle shall not be allowed to be parked in any capitol complex parking area until all fines are paid or the owner or operator no longer meets the definition of "habitual violator." Peace officers may tow any vehicle parked on the capitol complex for which parking privileges have been rescinded.

e. Warns the violator that failure to pay the fine may result in the director's proceeding against the violator in an Iowa district court.

f. Advises the operator of how to obtain a hearing on the charges.

g. Warns that the fine for each separate violation shall be increased by \$10 if the parking ticket is not paid within 30 days of the date upon which the violation occurred.
[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—101.13(8A) Appeals. Appeals regarding enforcement of parking rules shall be pursuant to 11—Chapter 7, Contested Cases.

If the owner or operator wishes to contest a parking citation, the fees paid because of the removal or attempted removal of the vehicle, or any other action arising from these rules, the owner or operator shall notify the director in writing within ten days of the action. Upon such notification, the owner or operator will be provided with written instructions that describe the procedure the director will use to conduct a hearing to consider the owner's or operator's evidence and arguments.

These rules are intended to implement Iowa Code sections 8A.322 and 8A.323.

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CHAPTER 102
STATE PRINTING
[Prior to 8/18/04, see 401—Ch 5]

11—102.1(8A) Purpose. The purpose of this chapter is to provide for the operation of printing services by the department, the use of office copiers by state agencies, and the establishment of the publication rates of certain legal notices.

11—102.2(8A) Definitions.

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

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

“Department” means the department of administrative services.

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

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

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

11—102.3(8A) Location. The state printing office is located at the capitol complex in Des Moines, Iowa. Correspondence shall be addressed to State Printing, Department of Administrative Services, Hoover State Office Building, Des Moines, Iowa 50319.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—102.4(8A) State printing. The state printing operation maintains a centralized printing facility in the Hoover State Office Building with satellite offices in other locations not necessarily at the capitol complex.

State printing provides short-run turnaround printing services. When a request is made for state printing and the quantity of a printing order is such that it can be handled economically by state printing, state printing will produce it. Other work will be contracted out by state printing. State printing equipment is available at all times to serve the best interests of the state and provide high-quality, cost-effective printing services to state agencies, state officials, and other branches of state government.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—102.5(8A) Printing equipment.

102.5(1) Use of printing equipment. A state agency may consult with the department regarding the agency’s purchase of printing equipment, including office copiers, for direction on how to best meet the needs of the agency.

102.5(2) Private use of printing equipment. No state-owned printing equipment may be used to produce printing for private purposes. Items produced on state printing equipment shall be items for state agencies. However, state employees, persons doing business with the state of Iowa, and those requesting copies of public records may purchase copies produced on office copiers. The selling price

of these copies will be the actual cost of the copy including any search or supervisory costs involved, pursuant to 11—subrule 4.3(7).

11—102.6(8A,49) Publication of ballot and notice. A sample ballot as prescribed in Iowa Code section 49.53 may be published in a reduced size. When a ballot is reduced, the candidates' names on the ballot must not be smaller than six-point type.

This rule is intended to implement Iowa Code section 49.53.

11—102.7(8A,49) Cost of publication—sample ballot. The charges for the publication of a sample ballot shall not be more than the usual or customary display advertising rate that the newspaper charges its regular advertisers. In a city in which no newspaper is published and with a population of 2000 or less, a maximum cost has been established. The maximum cost for a quarter-page sample ballot must not exceed \$250 and maximum cost for a half-page sample ballot must not exceed \$350.

This rule is intended to implement Iowa Code section 49.54.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—102.8(8A,618) Fees paid to newspapers. The fees paid to newspapers for official publications, notices, orders, citations or other publications required or allowed by law shall not exceed the rate set June 1 of each year by the director. The director shall calculate a new rate for the following fiscal year as prescribed in Iowa Code section 618.11 and shall publish this rate as a notice in the Iowa Administrative Bulletin prior to the first day of the following calendar month. The new rate shall be effective on the first day of the calendar month following its publication. The calculation and publication of the rate by the director shall be exempt from the provisions of Iowa Code chapters 17A and 25B.

This rule is intended to implement Iowa Code section 618.11.

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CHAPTER 103
STATE EMPLOYEE DRIVING GUIDELINES
[Prior to 9/17/03, see 401—Chapter 11]

11—103.1(8A) Purpose. The purpose of this chapter is to provide for the assignment of state motor vehicles and for the administration of a self-insurance program for motor vehicles owned by the state.

11—103.2(8A) Definitions.

“At-fault accident” means an accident in which the state driver is determined to be 50 percent or more responsible for the accident.

“Cargo payload” means the net cargo weight transported. The weight of the driver, passengers, and fuel shall not be considered in determining cargo payload.

“Cargo volume” means the space calculated in cubic feet behind the vehicle driver and passenger seating area. In station wagons, the cargo volume is measured to the front seating area with the second seat laid flat behind the driver.

“Defensive driving course” means an eight-hour course with instruction provided by the Iowa state patrol.

“Driver improvement course” means an eight-hour course with instruction provided by a local area college.

“Gross vehicle weight rating (GVWR)” means the weight specified by the manufacturer as the loaded weight of a single vehicle.

“Habitual violation” means that the person has been convicted of three or more moving violations committed within a 12-month period.

“Passengers” means the total number of vehicle occupants transported on a trip, including the driver.

“Pool car” means a vehicle assigned to the state of Iowa, department of administrative services, fleet services.

“Preventable accident,” for purposes of this chapter, means an accident that could have been prevented or in which damage could have been minimized by proper evasive action.

“Primary use” means the utilized application exceeds 50 percent of the miles driven annually for United States Environmental Protection Agency (EPA)-designated light-duty trucks and vans and exceeds 75 percent of the miles driven annually for EPA-designated passenger sedans and wagons.

“Private vehicle” means any vehicle not registered to the state of Iowa.

“Special work vehicle” means but is not limited to fire trucks, ambulances, motor homes, buses, medium- and heavy-duty trucks (25,999 lbs. GVWR and larger), heavy construction equipment, and other highway maintenance vehicles, and any other classes of vehicles of limited application approved by the state vehicle dispatcher.

“State driver” means any person who drives a vehicle to conduct official state business other than a law enforcement officer employed by the department of public safety.

“State vehicle” means any vehicle registered to the state of Iowa, department of administrative services.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—103.3(8A) Applicability.

103.3(1) Agencies subject to vehicle assignment standards. Pursuant to Iowa Code Supplement section 8A.362, the agencies listed below shall assign all vehicles within their possession, control, or use in accordance with the standards set forth in rule 11—103.4(8A). The following agencies are subject to the vehicle assignment standards in rule 11—103.4(8A):

- a. State vehicle dispatcher;
- b. State department of transportation;
- c. Institutions under the control of the state board of regents;
- d. The department for the blind; and
- e. Any other state agency exempted from obtaining vehicles for use through the state vehicle dispatcher.

103.3(2) Exceptions to vehicle assignment standards. This rule shall not apply to special work vehicles, law enforcement vehicles and vehicles propelled by alternate fuels.

103.3(3) Exceptions to driving guidelines for the vehicle self-insurance program. The driving guidelines for the vehicle self-insurance program do not apply to the department of transportation or to institutions under the authority of the board of regents. Nor do they supersede any applicable federal law or regulation or state law. Persons who have been granted an ADA exception through the department of administrative services are also exempted from these guidelines.

11—103.4(8A) Vehicle assignment guidelines.

103.4(1) In order to maximize the average passenger miles per gallon of motor vehicle fuel consumed, vehicles shall be assigned on the following basis:

- a. EPA-rated compact sedans shall carry one or two passengers and their personal effects.
- b. EPA-rated compact wagons shall carry one or two passengers, their personal effects, and cargo for which a compact sedan cannot be used.
- c. EPA-rated midsize sedans shall carry three or more passengers and their personal effects.
- d. EPA-rated midsize wagons shall carry one or more passengers, their personal effects, and cargo that will not conform to the use of a midsize sedan.
- e. EPA-rated full-size sedans shall carry four or more passengers and their personal effects.
- f. Cargo vans shall be appropriate in size and GVWR for their primary use with regard to payload and cargo volume.
- g. Mini passenger vans shall carry three or more passengers, their personal effects, and cargo that does not conform to the use of a midsize wagon or full-size sedan.
- h. Eight-passenger vans shall carry five or more passengers and their personal effects.
- i. Twelve-passenger vans shall carry seven or more passengers and their personal effects.
- j. Fifteen-passenger vans shall carry nine or more passengers and their personal effects.
- k. Pickups and sport utility vehicles shall be appropriate in size, GVWR, and drivetrain (two-wheel drive or four-wheel drive) for their primary use with regard to trailering, payload, cargo volume, and on/off road requirements.

103.4(2) Vehicles that are made available for temporary assignment, such as departmental pool vehicles, shall be assigned in accordance with this rule. If an appropriately classified vehicle is unavailable, a larger available classification may be substituted. Other substitutions may be authorized in consideration of passenger physical characteristics or disabilities or any other distinguishing circumstances and conditions as determined by the state vehicle dispatcher, the director of the department of transportation, or the executive director of the board of regents for the vehicles under their respective authorities.

103.4(3) Vehicles permanently issued to agencies or drivers shall be assigned in accordance with this rule based on the primary use of the vehicle.

103.4(4) The director may delegate authority to officials of the state, and agency heads, for the use of private vehicles on state business.

103.4(5) If a state vehicle has been assigned to a state officer or employee, the officer or employee shall not collect mileage for the use of a privately owned motor vehicle unless the state motor vehicle assigned is not usable.

11—103.5(8A) Type of accident. The determination as to whether an accident is without fault, at fault, or preventable shall be made by the risk manager of the department of administrative services. In making this determination, the risk manager will consider all relevant information including information provided by the state driver and others involved in the accident, information provided by witnesses to the accident and information contained in any investigating officer's reports.

11—103.6(8A) Valid driver's license required. A state driver shall not drive a state or private vehicle on state business if the state driver does not currently possess a valid driver's license with the appropriate classifications, restrictions and endorsements.

11—103.7(8A) Required reporting. A state driver must report any potential liability, collision or comprehensive loss which occurs while conducting state business to the risk manager of the department of administrative services. The failure to report may result in payment of any loss from the funds of the state driver's employing agency rather than from the state self-insurance fund. All documentation, such as proof of required class completion and insurance coverage, must be provided to the department risk manager.

11—103.8(8A) Mandatory training. Each state driver who is assigned a state vehicle or who drives a state or private vehicle on state business at least 5,000 miles per year shall attend a defensive driving or driver improvement course every three years. Each state driver who drives a pool car shall also participate in vehicle safety classes as offered and required by the division of fleet and mail.

11—103.9(8A) Required adherence to motor vehicle laws. Each state driver is required to abide by all applicable motor vehicle laws of the state of Iowa or any other state in which the state driver may be traveling with the exception of drivers covered by Iowa Code section 321.231.

11—103.10(8A) Responsibility for payment of traffic violations. Each state driver is required to pay all fines arising from any violation of motor vehicle laws of the state of Iowa or any other state in which the state driver may be traveling.

11—103.11(8A) Access to driving records. The fleet and mail division has the authority to monitor the Iowa department of transportation driving record of employees who drive a state vehicle or a private vehicle to conduct state business.

11—103.12(8A) Corrective actions.

103.12(1) If a state driver is involved in any one of the following occurrences, the state driver will receive written counseling concerning the state driver's responsibilities and will be required to attend the next available defensive driving course. The defensive driving course must be attended after one of the following occurrences:

a. The state driver is involved in one at-fault or preventable accident while operating a state vehicle.

b. The state driver receives three moving traffic violations in a three-year period while operating a state vehicle or a private vehicle.

103.12(2) If a state driver is involved in any one of the following occurrences, the state driver will be suspended from driving a state vehicle for a period not to exceed one year and will be required to attend a driver improvement course. The driver shall attend the next available driver improvement course after one of the following occurrences. While the state driver is suspended from driving a state vehicle, the state driver will be allowed to receive mileage reimbursement from the state of Iowa for driving a private vehicle for state business. In addition, a state driver involved in one of the following occurrences shall provide proof of insurance which meets the minimum standards required by the state of Iowa, department of transportation, and proof of completion of the driver improvement course.

a. The state driver is involved in three at-fault or preventable accidents in a five-year period while operating a state vehicle.

b. The state driver is involved in five moving traffic violations within a three-year period while operating a state vehicle or a private vehicle.

c. The state driver is convicted of a first offense driving while intoxicated charge while operating a private vehicle on private business.

d. Transporting alcoholic beverages in the passenger compartment of a motor vehicle.

e. Habitual violation of traffic laws.

103.12(3) If a state driver is involved in any one of the following occurrences, the state driver will be suspended from driving a state vehicle for a period exceeding one year up to a permanent suspension or from driving a private vehicle on state business and will be required to attend and successfully complete, at the person's own expense, a driver improvement course. The driver shall attend the next

available driver improvement course after one of the following occurrences. In addition, a state driver involved in one of the following occurrences shall provide proof of insurance which meets the minimum standards required by the state of Iowa, department of transportation, and proof of completion of the driver improvement course.

a. The state driver is involved in four at-fault or preventable accidents during a five-year period while operating a state vehicle.

b. The state driver receives six or more moving traffic violations while operating a state or private vehicle within a three-year period.

c. A state driver is convicted of more than one operating while intoxicated offense within a five-year period while operating a private vehicle on private business.

d. The state driver fails to notify the fleet and mail division of an operating while intoxicated conviction received while operating a state vehicle or a private vehicle.

103.12(4) If a state driver fails to attend or does not successfully complete the driver improvement course, the state driver will be suspended from driving a state or private vehicle for state business until such time as a driver improvement course has been successfully completed.

103.12(5) If a state driver is involved in any one of the following occurrences, the state driver will be suspended from driving a state vehicle or a private vehicle on state business for a period up to one year.

a. Driving a state vehicle or a private vehicle on state business with a suspended driver's license.

b. Driving a private vehicle for state business without the minimum insurance required by law.

103.12(6) If convicted of a first offense driving while intoxicated while driving a private vehicle on private business, the state driver is required to provide proof of satisfactory completion of a course for drinking drivers as defined in Iowa Code section 321J.22 and completion of substance abuse evaluation and treatment services in addition to the corrective actions imposed by 103.12(2).

103.12(7) If a state driver is convicted of operating a state vehicle while intoxicated, or operating a private vehicle on state business while intoxicated, the state driver will be permanently suspended from driving a state vehicle or a private vehicle on state business. This suspension may not be reconsidered.

11—103.13(8A) Reconsideration of suspension. If a state driver is suspended from driving a state vehicle, the driver may request a reconsideration of the suspension. A written request for reconsideration must be submitted to the suspended driver's immediate supervisor. The immediate supervisor must provide a written report, supporting or denying the employee's request, to the director of the department of administrative services. The director shall act on this request and, within 60 days from receipt of the supervisor's request for reconsideration, notify the state driver's supervisor of the action taken.

11—103.14(8A) Probationary drivers. If driving privileges are reinstated following a request for reconsideration, the reinstated state driver will be placed in a probationary state vehicle driving status for a period of three months. If a state driver in probationary status has a preventable or at-fault accident while operating a state or private vehicle on state business or receives a moving traffic violation while operating a state or private vehicle on state business, the probationary status will be revoked and the state driver's original suspension period will be reinstated. Following revocation of probationary status, the state driver may not request further reconsideration of the suspension. A driver in probationary status is eligible to receive mileage reimbursement from the state.

11—103.15(8A) Temporary restricted license. State drivers may operate a state vehicle or a private vehicle on state business while holding a temporary restricted license issued pursuant to Iowa Code section 321.215 or 321J.20 that allows driving for work. In addition, a state driver operating under a temporary restricted license shall provide proof of financial responsibility which meets the minimum standards required by the state of Iowa, department of transportation, pursuant to Iowa Code section 321A.1.

11—103.16(8A) Vehicle fueling.

103.16(1) All fuel used in state-owned automobiles shall be purchased at cost from the various state installations or garages such as but not limited to those of the state department of transportation, state board of regents, department of human services, department of corrections, or state motor pools throughout the state, unless the state-owned sources for the purchase of fuel are not reasonably accessible.

103.16(2) All drivers of state vehicles shall fuel their assigned vehicles with self-service gasohol, a mixture of 10 percent ethanol and 90 percent gasoline (E10), unless under emergency circumstances. If the vehicle is capable of running on a blend of 85 percent ethanol and 15 percent gasoline, subrule 103.16(3) applies.

103.16(3) Agencies shall ensure that their flexible fuel vehicles that are capable of operating on 85 percent ethanol (E85) use E85 fuel whenever an E85 fueling facility is available to the driver when fuel is needed. E85 fuel may be procured at a retail establishment if a state fueling facility is not readily available. If an E85 facility is not readily available, the driver shall not completely fill the tank with fuel when a lesser quantity will be adequate to complete the trip to an E85 fueling site.

103.16(4) Agencies shall ensure that their diesel vehicles operate on biodiesel blends whenever the blends are available. It is also recommended that biodiesel blends be used within six months of purchase to ensure that the quality of the fuel is maintained.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

These rules are intended to implement Iowa Code sections 8A.104, 8A.361 to 8A.366, 80.9 and 801.4.

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CHAPTER 119
UNIFORM TERMS AND CONDITIONS FOR SERVICE CONTRACTS

[Prior to 9/17/03, see 401—Chapter 13]

[Prior to 8/21/13, see 11—Chapter 107]

11—119.1(8,8A) Authority and scope. In accordance with Iowa Code section 8.47, this chapter is adopted to provide uniform terms and conditions for departments and establishments to use in service contracts and to provide a mechanism for departments and establishments to seek approval to use in their service contracts special terms and conditions that are not included in this chapter. The terms and conditions generally require departments and establishments to include performance criteria when executing service contracts. Iowa Code section 8.47, which is part of the accountable government Act relating to service contracts, and these rules utilize the definition of “department and establishment” that is found in Iowa Code chapter 8.

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

11—119.2(8,8A) Applicability. This chapter shall apply to all departments and establishments purchasing services unless otherwise provided by law.

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

11—119.3(8,8A) Definitions. For the purposes of this chapter, the following definitions shall apply:

“*Department and establishment*” and “*department*” or “*establishment*” means any executive department, commission, board, institution, bureau, office, or other agency of the state government, including the state department of transportation, except for funds which are required to match federal aid allotted to the state by the federal government for highway special purposes, and except the courts, by whatever name called, other than the legislature, that uses, expends or receives any state funds.

“*Efficiency measures*” means unit cost or level of productivity associated with a given service, product or activity.

“*Input measures*” means the amount of resources invested, used or spent for services, products or activities.

“*Outcome measures*” means the mathematical expression of the effect on customers, clients, the environment, or infrastructure that reflects the purpose of the service, product or activity produced or provided.

“*Output measures*” means the number of services, products or activities produced or provided.

“*Performance measures*” means measures that assess a service, product or activity. Performance measures include quality, input, output, efficiency, and outcome measures.

“*Quality measures*” means the mathematical expression of how well the service, product or activity was delivered, based on characteristics determined to be important to the customers.

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

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

2. Services provided by a vendor to accomplish routine functions. These services contribute to the day-to-day operations of state government. By way of example and not by limitation, these services may include the following: ambulance service; charter service; boiler testing; bookkeeping

service; building alarm systems service and repair; commercial laundry service; communications systems installation, servicing and repair; court reporting and transcription services; engraving service; equipment or machine installation, preventive maintenance, inspection, calibration and repair; heating, ventilation and air conditioning (HVAC) system maintenance service; janitorial service; painting; pest and weed control service; grounds maintenance, mowing, parking lot sweeping and snow removal service; towing service; translation services; and travel service.

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

“*Service provider*” means a vendor that enters into a service contract with a department or establishment.

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

11—119.4(8,8A) Uniform terms and conditions for service contracts. All service contracts entered into by a department or establishment shall include, at a minimum, the following terms:

119.4(1) Payment clause. The contract shall include a clause or clauses describing the amount or basis for paying consideration to the party based on the party’s performance under the service contract. The payment clause(s) should be designed to work in harmony with any monitoring clauses and any postcontract review procedures. All payment clauses shall be consistent with Iowa Code section 8A.514. The payment clause(s) should also be designed to work in harmony with the outputs, outcomes or any combination thereof desired by a department or establishment. The payment clause should be appropriate to the nature of the contract as determined by the department or establishment. Acceptable kinds of payment clauses include the following. However, these descriptions are not intended to be an exhaustive or prescriptive list; they are provided as examples.

a. A payment clause in which the department or establishment describes the limit of the total fee to be paid, and the fee is divided between a base fee and an at-risk fee. The base fee is the amount of fee the service provider will earn for minimal performance in the completion of the contract. The at-risk portion of the fee is the incremental fee the service provider will earn as the service provider meets the performance criteria identified in the contract. The amount of the fee in both instances may be stated in terms of a percentage, an amount, or some other term. Incentives and disincentives may be used to affect the payment of the base fee and the at-risk portion of the fee. The amount of the incentive or disincentive may be stated in terms of a percentage, an amount, or some other term. The payment of the fee shall be based upon the outcomes or outputs achieved or the performance criteria satisfied.

b. A payment clause based on meeting minimum requirements for performance criteria, outcomes, or outputs with incentives and disincentives to achieve other desired outcomes, outputs or performance criteria. The incentives may be stated in terms of a percentage, a fixed amount, or some other term. Up to 100 percent of the incentive may be placed at risk in order to meet or exceed performance criteria or achieve desired outcomes or outputs. Disincentives may be employed to achieve performance criteria or outcomes. Disincentives may be stated in terms of a percentage, a fixed amount, or some other term. Disincentives may include payments to the department or establishment for performance failures up to 100 percent of the fee the service provider expects to earn from performance of the contract.

c. A payment clause based on a straight contingency fee with the entire fee at risk depending on outcomes achieved or outputs obtained or performance criteria satisfied.

d. A payment clause based on a base fee and an amount retained by a department or establishment to ensure performance criteria described in the contract are satisfied or outcomes are achieved or outputs are obtained. If the vendor meets the performance criteria or outcomes or outputs, then a department or establishment may pay some or all of the portions of the fee retained as an incentive or disincentive and as provided for in the contract.

e. A payment clause based on a base fee and a contingency fee depending on the outcomes achieved, outputs obtained, or performance criteria satisfied. The base fee may be stated in terms of an hourly fee, a fixed-price fee, or a not-to-exceed fee. The contingency fee may be stated in terms of a percentage of a recovery.

f. Any other payment clause determined by the department or establishment to be suitable and appropriate for the service contract that bases the amount or basis for paying consideration to the service provider based on the service provider's performance under the service contract.

119.4(2) *Monitoring clause.* The contract shall include a clause or clauses describing the methods to effectively oversee the party's compliance with the service contract by the department or establishment receiving the services during performance, including the delivery of invoices itemizing work performed under the service contract prior to payment. Monitoring should be appropriate to the nature of the contract as determined by the department or establishment. Acceptable methods of monitoring may include the following. However, these descriptions are not intended to be an exhaustive or prescriptive list; they are provided as examples.

a. One hundred percent inspection.

b. Random sampling.

c. Periodic inspection.

d. Customer input.

e. Invoices itemizing work performed.

f. A monitoring plan determined by the department or establishment to be appropriate for purposes of the service contract and that includes methods to effectively oversee the service provider's compliance with the service contract by the department or establishment.

119.4(3) *Review clause.* The contract shall include a clause or clauses describing the methods to effectively review performance of a service contract, including but not limited to performance measurements developed pursuant to Iowa Code chapter 8E. Performance measurement should be appropriate to the nature of the contract as determined by the department or establishment. The measures below are not intended as an exhaustive or prescriptive list; they are provided as examples. The review clause for performance may include:

a. Outcome measures.

b. Output measures.

c. Efficiency measures.

d. Quality measures.

e. A review plan determined by the department or establishment to be appropriate for the purposes of the service contract and that includes methods to effectively review performance of a service contract.

119.4(4) *Other terms.* The contract shall include:

a. Where appropriate, a nonappropriation clause;

b. A clause describing the duration of the contract;

c. Clauses requiring the service provider to comply with all applicable laws;

d. Where appropriate, an insurance clause;

e. A clause, exhibit, or other document that describes the scope of services to be performed;

f. A termination clause;

g. A default clause, where appropriate;

h. An independent contractor clause;

i. Where appropriate, a clause prohibiting inappropriate conflicts of interest on behalf of the service provider;

j. Other clauses as deemed appropriate by the department or establishment entering into a service contract.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2267C, IAB 11/25/15, effective 12/30/15]

11—119.5(8,8A) *Special terms and conditions.* Rule 11—119.4(8,8A) does not apply to service contracts containing special terms and conditions adopted by a department or establishment for use in its service contracts with the approval of the department of management, in cooperation with the office

of the attorney general and the department of administrative services as provided for in 2003 Iowa Code Supplement section 8.47(2).

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

11—119.6(8,8A) Exclusions and limitations.

119.6(1) These rules do not apply to contracts for both goods and services when the predominant factor, thrust and purpose of the contract as reasonably stated is for the purchase of goods with service incidentally involved. However, in no event shall departments and establishments designate contracts as contracts for goods to avoid the application of these rules.

119.6(2) These rules do not apply to service contracts utilizing funds that are required to match federal aid allotted to the state by the federal government for highway special purposes.

119.6(3) These rules do not apply to service contracts entered into as the result of an emergency procurement in accordance with 11—118.8(8A), unless the emergency procurement results in the extension of an existing contract that contains performance criteria.

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

11—119.7(8,8A) Effective date. This chapter shall apply to service contracts with a starting date on or after October 1, 2002.

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

These rules are intended to implement Iowa Code sections 8.47 and 8A.104.

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

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

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

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[Filed ARC 2267C (Notice ARC 2145C, IAB 9/16/15), IAB 11/25/15, effective 12/30/15]

[Filed ARC 4053C (Notice ARC 3937C, IAB 8/15/18), IAB 10/10/18, effective 11/14/18]

BANKING DIVISION[187]

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

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CHAPTER 1
DESCRIPTION OF ORGANIZATION
[Prior to 4/22/87, see Banking Department[140] Ch 1]

187—1.1(17A,524) Definitions. The definitions of terms listed in Iowa Code section 17A.2 shall apply for these terms as they are used throughout this chapter. In addition, as used in this chapter:

“*Division*” means the division of banking.

“*Superintendent*” means the superintendent of banking.

187—1.2(17A,524) Scope and application. This chapter describes the office of the superintendent and the established place at which, the employees from whom and the methods whereby the public may obtain information, make submittals on requests or obtain decisions.

187—1.3(17A,524) Division of banking. The division of banking is a subdivision of the department of commerce and consists of the superintendent and those employees who discharge the duties and responsibilities imposed upon the superintendent by the laws of this state. The superintendent has general control, supervision and regulatory authority over all entities which the division is given authority to regulate pursuant to the Code of Iowa. The division consists of three separate bureaus: the bank bureau, the finance bureau, and the professional licensing and regulation bureau. The bank bureau has primary responsibility relating to the supervision, regulation, and chartering of state banks. The finance bureau has primary responsibilities relating to the supervision, regulation, and licensing of appraisal management companies, closing agents, debt management businesses, delayed deposit services businesses, industrial loan companies, money services businesses, mortgage bankers, mortgage brokers, mortgage loan originators, real estate appraisers, and regulated loan companies. The professional licensing and regulation bureau has primary responsibilities relating to the regulation and licensing of specified professions by providing administrative support to and coordinating the activities of the following licensing boards: the Iowa accountancy examining board, the architectural examining board, the engineering and land surveying examining board, the interior design examining board, the landscape architectural examining board, and the real estate commission.

1.3(1) Organization—superintendent. The superintendent is the administrator of the division. The superintendent is appointed by the governor, by and with the approval of the senate, for a term of four years. The superintendent’s office is located at 200 East Grand Avenue, Suite 300, Des Moines, Iowa 50309-1827. The superintendent is assisted by the following officials who are responsible to the superintendent:

a. Bank bureau chief. The bank bureau chief performs such duties as the superintendent prescribes, including general supervision of all bank examining personnel, administration and supervision of regulatory examinations, and administration and supervision of all matters relating to the exercise of banking powers authorized by the laws of this state.

b. Bank analysts. Bank analysts perform such duties as the superintendent prescribes, including advanced technical analysis and review of examination and financial reports of banks and bank holding companies; assessing, measuring, and monitoring the risk conditions in state banks and bank holding companies; assisting the superintendent and banking council in the analysis of applications submitted to the division for approval; and the review and analysis of bank examination reports.

c. Finance bureau chief. The finance bureau chief performs duties prescribed by the superintendent, including general supervision over all matters relating to the licensing and supervision of appraisal management companies, closing agents, debt management businesses, delayed deposit services businesses, industrial loan companies, money services businesses, mortgage bankers, mortgage brokers, mortgage loan originators, real estate appraisers, and regulated loan companies.

d. Chief operating officer. The chief operating officer performs duties prescribed by the superintendent, including management of the administrative functions, information technology needs, and fiscal affairs of the division of banking. The chief operating officer is also responsible for

administration of personnel policies, work rules, payrolls, and employee benefits for all employees of the division.

e. Examiners. Each examiner performs duties prescribed by the superintendent in a manner consistent with the laws of this state and may be predominantly trained in an area within the jurisdiction of the superintendent. Bank examinations are performed by examining personnel situated in examination regions throughout the state. Each region is headed by a regional manager who is assisted by a staff of examiners.

f. Professional licensing and regulation bureau chief. The professional licensing and regulation bureau chief performs such duties as the superintendent prescribes, including budgetary and personnel matters related to the licensing and regulation of several professions, by providing administrative support to and coordinating the activities of the following licensing boards: the Iowa accountancy examining board created pursuant to Iowa Code chapter 542, the engineering and land surveying board created pursuant to Iowa Code chapter 542B, the real estate commission created pursuant to Iowa Code chapter 543B, the architectural examining board created pursuant to Iowa Code chapter 544A, the landscape architectural examining board created pursuant to Iowa Code chapter 544B, and the interior design examining board created pursuant to Iowa Code chapter 544C.

1.3(2) Field organization. Rescinded IAB 10/9/96, effective 11/13/96.

This rule is intended to implement Iowa Code sections 17A.3 and 524.208.
[ARC 4054C, IAB 10/10/18, effective 11/14/18]

187—1.4(17A,524) Forms and instructions. Rescinded IAB 3/2/05, effective 4/6/05.

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[Filed 4/1/87, Notice 2/25/87—published 4/22/87, effective 5/28/87]

[Filed 9/17/96, Notice 7/17/96—published 10/9/96, effective 11/13/96]

[Filed 11/8/00, Notice 10/4/00—published 11/29/00, effective 1/3/01]

[Filed 2/10/05, Notice 1/5/05—published 3/2/05, effective 4/6/05]

[Filed ARC 4054C (Notice ARC 3947C, IAB 8/15/18), IAB 10/10/18, effective 11/14/18]

CHAPTER 2
APPLICATION PROCEDURES
[Prior to 4/22/87, see Banking Department[140] Ch 2]

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

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

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

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

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

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

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

This rule is intended to implement Iowa Code section 524.303.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.3(6) Cash out merger. Rescinded IAB 10/10/18, effective 11/14/18.

This rule is intended to implement Iowa Code sections 524.1401 to 524.1405.
[ARC 4055C, IAB 10/10/18, effective 11/14/18]

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

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

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

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

a. Whether the convenience and needs of the public and existing customers of the applicant bank will be served by the proposed office.

b. Whether the population density and other economic characteristics of the area primarily to be served by the proposed office afford reasonable promise of adequate support for the office.

c. Whether the capital structure of the applicant bank is adequate in relation to the costs and anticipated increased business, if any, occasioned by the proposed office.

d. The history of operation and management of the applicant bank.

e. Such other factors as the superintendent may determine are relevant.

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

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

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

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

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

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

This rule is intended to implement Iowa Code section 524.312.
[ARC 4055C, IAB 10/10/18, effective 11/14/18]

187—2.6(17A,524) Change of control.

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

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

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

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

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

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

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

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

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

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

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

This rule is intended to implement Iowa Code section 524.544.

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

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

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

2.7(3) Reverse stock split. Rescinded IAB 10/10/18, effective 11/14/18.

2.7(4) Decision. Rescinded IAB 10/10/18, effective 11/14/18.

This rule is intended to implement Iowa Code sections 524.314, 524.1505, 524.1508, and 524.1509.
[ARC 4055C, IAB 10/10/18, effective 11/14/18]

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

187—2.9(17A) Licensing of a debt management company. Rescinded ARC 4055C, IAB 10/10/18, effective 11/14/18.

187—2.10 Reserved.

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

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

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

2.12(2) Public file. The public file in each case shall consist of the application with supporting data and supplementary information with the exception of material deemed by the superintendent to be confidential. In addition, the public file shall contain all data and information submitted by interested persons in favor of or in opposition to such application, excluding any material deemed by the superintendent to be confidential. The superintendent or the superintendent's designee shall not deem information confidential for purposes of the two immediately preceding sentences unless the person submitting the information requests that such information be deemed confidential. All factual information contained in any internal investigation report made by a bank examiner shall also be made a part of the public file, unless deemed confidential by the superintendent. The person submitting the application may not request that the entire application be deemed confidential.

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

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

2.12(3) Place of hearing. Hearings granted by the superintendent shall be heard in the office of the superintendent. The superintendent, in any matter, reserves the right to conduct hearings at any location deemed to be appropriate.

2.12(4) Date of hearing. An opportunity to be heard shall be given as soon as practicable after ordered.

2.12(5) Notice of hearing. The notice given by the superintendent concerning the hearing shall set forth the subject matter of the application, the legal authority for such hearing, and the date, time, and place of the hearing. The notice shall be sent to the person or persons requesting the hearing, to the applicant and to other interested persons who have sent written comments to the superintendent.

2.12(6) Attendance at hearing. Each person who wishes to be heard shall notify the superintendent within five days after the date of the notice described in subrule 2.12(5) of the person's intention to attend and shall submit the number and names of witnesses to be presented.

2.12(7) Presiding officer. The presiding officer at the hearing shall be the superintendent or such other person as may be designated by the superintendent.

2.12(8) Hearing rules. The applicant and each participant may make opening statements of a length within the discretion of the presiding officer. Such opening statements should concisely state what the participant intends to show. The applicant shall have the opportunity to present a statement first. Following the opening statements, the applicant shall present data and materials, oral or documentary. Following the applicant's presentation, the persons protesting the application shall present their data and materials, oral or documentary. The protesters may agree, with the approval of the presiding officer, to have one of their number make their presentation. Following the evidence of the applicant and the protester, the presiding officer may recognize other interested persons who may present their views with respect to the application under consideration. After all the above presentations have been concluded, the participants before the panel may make short and concise summary statements reviewing their positions. The applicant shall present a concluding summary statement.

a. The obtaining and use of witnesses is the responsibility of the parties. All witnesses will be present on their own volition, but any person appearing as a witness may be subject to questioning by

any participant. The refusal of a witness to answer questions may be considered by the superintendent in determining the weight to be accorded the testimony of that witness. Witnesses shall be sworn.

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

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

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

e. The public file described in subrule 2.12(2) shall automatically be deemed a part of the record of these proceedings, as well as all evidence submitted and the transcript described in paragraph 2.12(8) "d."

2.12(9) *Closing of the public file.* If requested by any participant, the public file shall remain open for five days following receipt of the transcript by the superintendent, during which time the applicant and protesters may submit additional written statements. A copy of any statement so submitted during this period of time shall also be sent simultaneously to the other persons represented at the hearing.

2.12(10) *Decision.* The applicant and all persons so requesting in writing shall be notified of the final disposition of the application by the superintendent.

2.12(11) *Computation of time.* In computing any period of days provided for in this rule, the day of the event from which the period begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday, or a legal holiday. As used in this subrule, "legal holiday" means a day on which the office of the superintendent remains closed.

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

[ARC 4055C, IAB 10/10/18, effective 11/14/18]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This rule is intended to implement Iowa Code chapter 524.

187—2.15(524) Securities activities.

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

2.15(2) *Board responsibilities.* The board of directors of a state bank shall evaluate the risks associated with the securities activities proposed and the method by which the securities activities will be conducted on its premises. The board of directors shall be responsible for ensuring that any securities activities conducted on its premises will comply with all applicable state and federal laws and regulations as well as any policy statements issued which relate to securities activities. Specifically, if a state bank develops and implements a particular program where nondeposit investment products are recommended and sold to retail customers, that program shall ensure that customers are clearly and fully informed of the nature of and risks associated with those types of products. If an affiliate, a

subsidiary, or a third-party vendor is used to recommend and sell nondeposit investment products, all signs, advertisements and other promotional material should clearly identify the affiliate, subsidiary, or third-party vendor as the seller and should not suggest by use of a trade name that the state bank is the seller. The board of directors shall be responsible for complying with the joint federal Interagency Statement on Retail Sales of Nondeposit Investment Products or any substitution therefor or revision thereof.

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

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

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

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

d. A commitment that the location(s) on bank premises where the proposed securities activities will be conducted will be physically distinct and separate from the area where deposits are taken. Proper signs or other means must be used to distinguish the area where the sale of retail nondeposit investments products will be conducted from the area where insured deposits are normally taken. If securities activities are to be conducted on bank premises by an affiliate, a subsidiary, or a third-party vendor, all signs or other means used to identify this area shall provide to the retail customer a clear and accurate representation of the entity conducting the securities activities.

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

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

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

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

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

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

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

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

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

This rule is intended to implement Iowa Code section 524.825.

187—2.16(524) Contracts.

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

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

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

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

- a. A description of the type(s) of contracts the state bank proposes to purchase and sell.
- b. A copy of the board of directors' resolution authorizing the specific type(s) of contracts proposed to be purchased and sold.
- c. A copy of the policy adopted by the state bank's board of directors which shall include specific policy objectives that outline permissible contract strategies and their relationship to overall investment activities and asset-liability management; the names, responsibilities, and authority limits of the personnel authorized to engage in futures, forward and standby contracts; limitations applicable to futures, forward and standby contract positions; the personnel to be used to review at least monthly the bank's contract positions to ascertain compliance with such limits; the exchanges and firms through which authorized personnel may conduct futures, forward and standby contracts; and the dollar limit on transactions with each firm.
- d. A representation that the state bank has sufficient managerial resources to engage in futures, forward and standby contracts.

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

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

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

- a. The financial condition of the state bank has significantly deteriorated.
- b. The superintendent determines the futures, forward or standby contract activities are being conducted unlawfully or in an unsafe or unsound manner.

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

This rule is intended to implement Iowa Code section 524.901.
[ARC 4055C, IAB 10/10/18, effective 11/14/18]

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

2.17(1) Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

2.17(3) Publication requirements. Rescinded IAB 10/10/18, effective 11/14/18.

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

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

This rule is intended to implement Iowa Code section 524.1201.

[ARC 4055C, IAB 10/10/18, effective 11/14/18]

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CHAPTER 7
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

The Iowa division of banking hereby adopts, with the following exceptions and amendments, the Uniform Rules of Agency Procedure relating to public records and fair information practices, which are published on the Iowa general assembly's website at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf.
[ARC 4056C, IAB 10/10/18, effective 11/14/18]

187—7.1(17A,22) Definitions. As used in this chapter:

“Agency” means the Iowa division of banking.

“Superintendent” means the superintendent of banking.

187—7.3(17A,22) Requests for access to records.

7.3(1) Location of records. A request for access to a record should be directed to the office where the record is kept. If the location of the record is not known by the requester, the request shall be directed to the Iowa Division of Banking, 200 East Grand Avenue, Suite 300, Des Moines, Iowa 50309-1827. If a request for access to a record is misdirected, agency personnel will promptly forward the request to the appropriate person within the agency.

7.3(2) Office hours. Open records shall be made available during all customary office hours, which are 8 a.m. to 4:30 p.m. daily, excluding Saturdays, Sundays and legal holidays.

7.3(7) Fees.

c. Supervisory fee. In lieu of “(specify time period)” insert “one-half hour”. Delete the parenthetical sentence at the end of the paragraph.

187—7.9(17A,22) Disclosures without the consent of the subject.

7.9(1) Open records are routinely disclosed without the consent of the subject.

7.9(2) To the extent allowed by law, disclosure of confidential records may occur without the consent of the subject. Following are instances where disclosure, if lawful, will generally occur without notice to the subject:

a. For a routine use as defined in rule 187—7.10(17A,22) or in any notice given for a particular record system.

b. To a recipient who has provided the agency with advance written assurance that the record will be used solely as a statistical research or reporting record, provided that the record is transferred in a form that does not identify the subject.

c. To another government agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if the head of such government agency or instrumentality has submitted a written request to the agency specifying the record desired and the law enforcement activity for which the record is sought.

d. To an individual pursuant to a showing of compelling circumstances affecting the health or safety of any individual if a notice of the disclosure is transmitted to the last known address of the subject.

e. To the legislative services agency under Iowa Code section 2A.3.

f. Disclosures in the course of employee disciplinary proceedings.

g. In response to a court order or subpoena.

187—7.10(17A,22) Routine use.

7.10(1) “Routine use” means the disclosure of a record without the consent of the subject or subjects for a purpose which is compatible with the purpose for which the record was collected. It includes disclosures required to be made by statute other than the public records law, Iowa Code chapter 22.

7.10(2) To the extent allowed by law, the following uses are considered routine uses of all agency records:

a. Disclosure to those officers, employees, and agents of the agency who have a need for the record in the performance of their duties. The custodian of the record may upon request of any officer or employee, or on the custodian's own initiative, determine what constitutes legitimate need to use confidential records.

b. Disclosure of information indicating an apparent violation of the law to appropriate law enforcement authorities for investigation and possible criminal prosecution, civil court action, or regulatory order.

c. Disclosure to the department of inspections and appeals for matters in which it is performing services or functions on behalf of the agency.

d. Transfers of information within the agency, to other state agencies, or to local units of government as appropriate to administer the program for which the information is collected.

e. Information released to staff of federal and state entities for audit purposes or for purposes of determining whether the agency is operating a program lawfully.

f. Any disclosure specifically authorized by the statute under which the record was collected or maintained.

187—7.11(17A,22) Consensual disclosure of confidential records.

7.11(1) *Consent to disclosure by a subject individual.* To the extent permitted by law, the subject may consent in writing to agency disclosure of confidential records as provided in rule 187—7.7(17A,22).

7.11(2) *Complaints to public officials.* A letter from a subject of a confidential record to a public official which seeks the official's intervention on behalf of the subject in a matter that involves the agency may, to the extent permitted by law, be treated as an authorization to release sufficient information about the subject to the official to resolve the matter.

187—7.12(17A,22) Release to subject.

7.12(1) The subject of a confidential record may file a written request to review confidential records about that person, as provided in rule 187—7.6(17A,22). However, the agency need not release the following records to the subject:

a. The identity of a person providing information to the agency need not be disclosed directly or indirectly to the subject of the information when the information is authorized to be held confidential pursuant to Iowa Code subsection 22.7(18) or other provision of law.

b. Records need not be disclosed to the subject when they are the work product of an attorney or are otherwise privileged.

c. Peace officers' investigative reports may be withheld from the subject, except as required by the Iowa Code. (See Iowa Code subsection 22.7(5))

d. As otherwise authorized by law.

7.12(2) Where a record has multiple subjects with interest in the confidentiality of the record, the agency may take reasonable steps to protect confidential information relating to another subject.

187—7.13(17A,22) Availability of records.

7.13(1) *Open records.* Agency records are open for public inspection and copying unless otherwise provided by rule or law.

7.13(2) *Confidential records.* The following records may be withheld from public inspection. Records are listed by category, according to the legal basis for withholding them from public inspection.

a. Tax records made available to the agency (Iowa Code sections 422.20 and 422.72).

b. Records which are exempt from disclosure under Iowa Code section 22.7.

c. Minutes of closed meetings of a government body (Iowa Code subsection 21.5(4)).

d. Identifying details in final orders, decisions, and opinions to the extent required to prevent a clearly unwarranted invasion of personal privacy or trade secrets under Iowa Code section 17A.3(1) "d."

e. Those portions of agency staff manuals, instructions or other statements issued which set forth criteria or guidelines to be used by agency staff in auditing, in making inspections, in settling commercial disputes or negotiating commercial arrangements, or in the selection or handling of cases,

such as operational tactics or allowable tolerances or criteria for the defense, prosecution or settlement of cases, when disclosure of these statements would:

- (1) Enable law violators to avoid detection;
- (2) Facilitate disregard of requirements imposed by law; or
- (3) Give a clearly improper advantage to persons who are in an adverse position to the agency (Iowa Code sections 17A.2 and 17A.3).

f. All papers, documents, reports (including shareholder lists furnished to the superintendent pursuant to Iowa Code section 524.541), reports of examinations and other writings relating specifically to the supervision and regulation of any state bank or other person by the superintendent pursuant to the laws of this state (Iowa Code section 524.215).

g. Reports of examinations conducted by the superintendent and reports of examination received by or furnished to the superintendent pursuant to Iowa Code section 524.217.

h. All information obtained by examiners and described in Iowa Code section 524.212.

i. All applications, reports, materials, documents, information and other writings obtained from the Federal Deposit Insurance Corporation, Federal Reserve Bank, Comptroller of the Currency or any agency of the United States government which would cause the denial of services or information to the agency. (Iowa Code section 22.9; the Privacy Act of 1974 (5 U.S.C. 552a) and Part 310 of the Federal Deposit Insurance Corporation Rules and Regulations (12 CFR 310).)

j. Records which constitute attorney work product, attorney-client communications, or which are otherwise privileged. Attorney work product is confidential under Iowa Code sections 22.7(4), 622.10 and 622.11, Iowa R.C.P. 122(c), Fed. R. Civ. P. 26(b)(3), and case law. Attorney-client communications are confidential under Iowa Code sections 622.10 and 622.11, the rules of evidence, the Code of Professional Responsibility, and case law.

k. Any other information made confidential by law.

187—7.14(17A,22) Personally identifiable information. This rule describes the nature and extent of personally identifiable information that is collected, maintained, and retrieved by the agency by personal identifier in record systems as defined in rule 187—7.1(17A,22). The division of banking does not maintain groups of records to be retrieved by individual identifiers. Division records concerning regulated entities may contain financial and other personal information about individuals who are officers, shareholders, employees, or customers of regulated entities or do business with them. The division of banking does not currently have a data processing system which matches, collates, or permits the comparison of personally identifiable information in one record system with personally identifiable information in another record system. The record systems maintained by the agency are:

7.14(1) Personnel files. The agency maintains files containing information about employees, families and dependents, and applicants for positions with the agency. The files include an individual's employment history, such as hiring and recruitment correspondence, salary, payroll and benefit information, record of personnel actions, military status, affirmative action statistics, education and training completed, professional certification achievements, professional organizational involvement, performance evaluation reports, and other information concerning the employer-employee relationship. This information is collected pursuant to Iowa Code section 524.208, and some of the information is confidential under Iowa Code sections 22.7(11) and 22.7(18). The information is maintained on paper; and certain parts are also contained on the agency's data processing system, as well as the state's mainframe automated data processing system.

7.14(2) Payroll records. Records showing individual earnings, hours worked, leave usage, class, position, salary range, deductions, net pay with agency summaries, and other related information. These records contain personally identifiable information collected under the authority of Iowa Code section 524.208, and some of the information may be confidential under Iowa Code section 22.7(11). The information is maintained on paper, with certain records maintained on the state's payroll automated data processing system.

187—7.15(17A,22) Other groups of records routinely available for public inspection. This rule describes groups of records maintained by the agency other than record systems as defined in rule 187—7.1(17A,22). These records are routinely available to the public. However, the agency's files of these records may contain confidential information. In addition, the records listed in subrules 7.15(1) to 7.15(4) may contain information about individuals.

7.15(1) Rule making. Rule-making records may contain information about individuals making written or oral comments on proposed rules. This information is collected pursuant to Iowa Code section 17A.4. This information is not stored on an automated data processing system.

7.15(2) Banking council records. Agendas, minutes and materials presented to the Iowa division of banking council are available from the office of the Iowa division of banking, except those records concerning closed sessions which are exempt from disclosure under Iowa Code section 21.5, or which are otherwise confidential by law. Banking council records contain information about people who participate in meetings. This information is collected pursuant to Iowa Code section 21.3. This information is not retrieved by individual identifier and is not stored on an automated data processing system.

7.15(3) Publications. News releases, annual reports, project reports, agency newsletters, etc., are available from the office of the Iowa division of banking.

Agency news releases, project reports, and newsletters may contain information about individuals, including agency staff or members of agency councils or committees. This information is not retrieved by individual identifier and is not stored on an automated data processing system.

7.15(4) Orders issued by the superintendent. All findings of fact, conclusions of law, and orders issued by the superintendent subsequent to a public hearing under the provisions of chapter 17A, except as otherwise provided by law. (See Iowa Code section 17A.3.) These records may contain information about individuals.

7.15(5) Published materials. The agency uses many legal and technical publications in its work. The public may inspect these publications upon request. Some of these materials may be protected by copyright law.

7.15(6) Policy manuals. The agency's employees' manual, containing information concerning policies and procedures for programs administered by the agency, is available in the office of the agency. Policy manuals do not contain information about individuals.

7.15(7) Reports to superintendent. Reports obtained by the superintendent pursuant to the provisions of Iowa Code section 524.220. These reports are considered open records.

7.15(8) Officers and directors. Lists of officers and directors filed with the superintendent pursuant to the provisions of Iowa Code section 524.541. These reports are considered open records, with the exception that lists of shareholders are confidential and not open to the public.

7.15(9) Other. All other records that are not exempted from disclosure by law.

[ARC 4056C, IAB 10/10/18, effective 11/14/18]

187—7.16(17A,22) Applicability. This chapter does not:

1. Require the agency to index or retrieve records which contain information about individuals by that person's name or other personal identifier.
2. Make available to the general public records which would otherwise not be available under the public records law, Iowa Code chapter 22.
3. Govern the maintenance or disclosure of, notification of or access to, records in the possession of the agency which are governed by the rules of another agency.
4. Apply to grantees, including local governments or subdivisions thereof, administering state-funded programs, unless otherwise provided by law or agreement.
5. Make available records compiled by the agency in reasonable anticipation of court litigation or formal administrative proceedings. The availability of such records to the general public or to any subject individual or party to such litigation or proceedings shall be governed by applicable legal and constitutional principles, statutes, rules of discovery, evidentiary privileges, and applicable rules of the agency.

These rules are intended to implement Iowa Code section 22.11.

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CHAPTER 8
GENERAL BANKING POWERS
[Prior to 4/22/87, see Banking Department[140] Ch 8]

187—8.1 to 8.6 Rescinded, effective 7/1/79.

187—8.7 Rescinded, effective 7/10/81.

187—8.8(12B) Approved rating services. Rating services approved by the superintendent as provided by Iowa Code section 12B.10 for use by the treasurer of state and the treasurer of each political subdivision in determining qualifying commercial paper investments are Moody's Investors Services and Standard & Poor's.

This rule is intended to implement Iowa Code section 12B.10.
[ARC 4057C, IAB 10/10/18, effective 11/14/18]

187—8.9(524) General definition of bank. It is the superintendent's intent that the term "bank" used in Iowa Code section 524.103(8) means a corporation organized under Iowa Code chapter 524 or a corporation organized under 12 U.S.C. §21. The general definition of "bank" as set forth in Iowa Code section 524.103(8) does not include a federal savings association, state credit union, or federal credit union.

This rule is intended to implement Iowa Code section 524.103(8).
[ARC 4057C, IAB 10/10/18, effective 11/14/18]

187—8.10(524) Courier services. A state bank may provide courier services to its bank customers by using a third-party provider operated under the provider's name or using the state bank's employees operating in the bank's own name. Customer deposits picked up by a courier service become deposits of the bank at the time the deposits are picked up by the courier service.

8.10(1) *Third-party courier services.* A state bank that uses a third party to provide courier services to its customers may pay the third party directly for those services and may charge its customers for third-party courier services as the state bank deems appropriate. Superintendent approval is not required for a state bank to provide courier services to its customers by using a third party.

8.10(2) *Bank-owned courier services.* A state bank that establishes and operates courier services in its own name using its own employees must establish the vehicle it uses to provide courier services as a bank office in accordance with the provisions of rule 187—2.17(17A,524).

This rule is intended to implement Iowa Code section 524.213.

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CHAPTER 9
INVESTMENT AND LENDING POWERS

[Prior to 4/22/87, see Banking Department[140] Ch 9]

187—9.1(524) Bonds or securities investment characteristics. Rescinded IAB 10/9/96, effective 11/13/96.

187—9.2(17A,524) Real estate lending. This rule is promulgated to provide more uniformity with the final guidelines adopted by the Federal Deposit Insurance Corporation, the Federal Reserve System, and the Department of the Treasury. This rule shall apply to real estate loans either originated by the state bank or acquired by purchase, assignment, or otherwise.

9.2(1) Written policy. The board of directors of the state bank shall formulate and maintain a written real estate lending policy that is appropriate for its size and the nature and scope of its operation. Each policy must be comprehensive and consistent with safe and sound lending practices. The standards and limits established in the policy must be reviewed and approved at least annually by the board. The real estate lending policy should reflect the level of risk that is acceptable to the board and should provide clear and measurable underwriting standards that enable the state bank's lending staff to evaluate all relevant credit factors. The real estate lending policy, at a minimum, should:

- a. Identify the geographic area where the state bank will consider lending.
- b. Establish loan portfolio diversification standards.
- c. Set appropriate terms and conditions by type of real estate loan.
- d. Establish loan origination and approval procedures.
- e. Establish prudent underwriting standards which include clear and measurable loan-to-value limitations.
- f. Establish review and approval procedures for exempted loans.
- g. Establish loan administration procedures.
- h. Establish real estate appraisal and evaluation programs.
- i. Monitor the portfolio and provide timely reports to the board of directors.
- j. Establish procedures for conformance with secondary market investor requirements where applicable.

When formulating the real estate policy, the board should consider both internal and external factors, such as size and condition of the state bank, expertise of its lending staff, avoidance of undue concentrations of risk, compliance with all real estate-related laws and rules, and general market conditions.

9.2(2) Loan-to-value limits. The board of directors of the state bank shall establish its own internal loan-to-value (LTV) limits for real estate loans.

9.2(3) In transit loans. Real estate loans made for sale into the secondary market shall be considered in transit for a period of 90 days after being sold and shall not be considered risk assets for reserving purposes during this time period.

9.2(4) Evidence of title. The state bank shall obtain, when lending for the purpose of acquisition or for the purpose of refinance of acquisition when a new mortgage, deed of trust, or similar instrument is filed, one of the following:

- a. A written legal opinion by an attorney admitted to practice in the state in which the real estate is located showing marketable title in the mortgagor and describing any existing liens and stating that the state bank's mortgage, deed of trust, or similar instrument is a lien on the real estate. An Iowa title guaranty certificate issued by the Iowa title guaranty division of the Iowa finance authority satisfies this requirement.
- b. Title insurance written by an insurance company licensed to do business in the state in which the real property is located describing any existing liens and insuring the title to the real property and the validity and enforceability of the mortgage, deed of trust, or similar instrument as a lien on the real property.

9.2(5) Exceptions. There are certain real estate transactions in which other factors significantly outweigh the need to apply the provisions of this rule. Therefore, the following transactions are exempt from this rule:

a. Loans guaranteed, insured, or for which a written commitment for such has been issued by the U.S. government or its agencies.

b. Loans guaranteed, insured, or for which a written commitment for such has been issued by the state of Iowa, a political subdivision, or agency thereof, provided that the state bank has determined that the guarantor or insurer has the financial capacity and willingness to perform under the terms of the agreement.

c. Acceptance of real estate as collateral to secure debts previously contracted in good faith.

d. Securities collateralized by real estate, but in which a state bank may invest pursuant to Iowa Code section 524.901.

e. With the prior approval of the superintendent, any other loans approved, issued, insured or guaranteed by any other federal or state-sponsored program.

9.2(6) Exempted transactions. In addition to the exemptions set forth in subrule 9.2(5), it may be appropriate, in light of all relevant credit considerations, including community reinvestment factors, for state banks, in certain instances, to originate or purchase real estate loans that do not meet the requirements of this rule. State banks shall be allowed to make such loans; however, the aggregate amount of all real estate loans that fall into this category shall not exceed aggregate capital as reflected on the state bank's most recent consolidated report of condition, unless prior approval to exceed this limitation has been obtained from the superintendent. These exempted loans must be identified by the board of directors by name and outstanding balance and must be reviewed by the board no less frequently than annually. Examiners, during the course of their examinations, will determine whether these exempted loans are adequately documented and appropriate in light of overall safety and soundness considerations. No real estate loans to directors, officers, or principal shareholders or their related interests shall be allowed in the exempted category of this subrule.

This rule is intended to implement Iowa Code section 524.905.

[ARC 4058C, IAB 10/10/18, effective 11/14/18]

187—9.3(17A,524) Leasing.

9.3(1) Definitions. For purposes of this rule, the term:

“Aggregate rentals payable” shall include the total of minimum lease payments (net of unearned income) that the lessee is obligated to make or can be required to make plus any guarantee of the residual value or of rental payments beyond the lease term by an eligible guarantor, provided the guarantor is financially capable of discharging the obligation.

“Bank officer” means an administrative official of the bank elected by the state bank's board of directors to carry out the bank's operating rules, including the bank's loan and lease policies.

“Full payout lease” shall be one in which the lessor's service is limited to the financing of the asset, with the lessee paying all other costs, including maintenance and taxes, and has the option of purchasing the asset at the end of the lease for a nominal price. The lease shall be fully amortized over the term of the lease or lifetime of the asset, whichever is less.

“Inception of the lease” means the date of the lease agreement or commitment, if earlier, or the date the lease is purchased by the state bank. For purposes of this definition, a commitment shall be in writing, signed by the parties in interest to the transaction, and shall specifically set forth the principal terms of the transaction. However, if the property covered by the lease is a fixture yet to be constructed or has not been acquired by the lessor at the date of the lease agreement or commitment, the inception of the lease shall be the date that construction of the property is completed or the property is acquired by the lessor. The inception date of a lease assumed in a business combination accounted for as a purchase is the date the combination is recorded for accounting purposes.

“Independent third-party appraiser” means an individual not involved with the lease transaction, except as the appraiser, with no direct or indirect interest, financial or otherwise, in the property appraised

or the parties involved with the transaction. The bank shall take appropriate steps to ensure the appraiser exercises independent judgment and that the appraisal is adequate.

“Lease servicer” means an entity that collects monthly principal and interest payments from the lessee and then forwards the payments to the purchasing institution or maintains lease records for a fee.

“Leasing company” means an enterprise that makes leases or assembles leases for resale to a bank. Leases acquired by a state bank from an affiliated leasing company will be treated for purposes of this rule the same as if the lease was originated by the bank itself. In determining if an affiliate relationship exists, the provisions of Iowa Code section 524.1101 shall apply.

“Lessee” means the party using the leased property.

“Lessor” means the party owning the leased property.

“Residual value” means the estimated fair value of the leased property at the end of the lease term.

9.3(2) General direct and purchased lease guidelines.

a. The board of directors of the state bank shall formulate and maintain a written lease policy that is appropriate for the size, nature and scope of the bank’s operation. Each policy must be comprehensive and consistent with safe and sound banking practices. The standards and limits established in the policy must be reviewed and approved at least annually by the board. The bank’s lease policy, at a minimum, should:

- (1) Identify acceptable lease servicers and lessors (purchased leases only).
- (2) Establish aggregate volume of paper to be purchased from approved servicers and lessors (purchased leases only).
- (3) Identify geographic area where the bank will consider purchasing or originating leases.
- (4) Establish lease portfolio diversification standards.
- (5) Set appropriate terms and conditions by type of leases.
- (6) Establish lease origination and approval procedures.
- (7) Establish prudent underwriting standards.
- (8) Establish lease administration procedures.
- (9) Establish appraisal and evaluation programs.
- (10) Monitor the portfolio and provide timely reports to the board of directors.
- (11) Set forth permitted exceptions to the policy.

When formulating the lease policy, the board should consider both internal and external factors, such as size and condition of the state bank, expertise of the lending staff, avoidance of undue concentrations of risk, and general market conditions.

b. Whether the bank is serving as lessor or acquiring a lease through purchase, a bank officer shall perform an independent credit analysis of the lessee.

c. The bank or an affiliated leasing company shall obtain collateral values, lien status, lease agreements, participation agreements, and title documentation within 45 calendar days from the date of inception with original documentation being maintained in the bank’s or affiliated leasing company’s credit files.

d. A bank officer, an officer of an affiliated lease originator, or an independent third-party appraiser shall conduct at inception, and then at least annually thereafter, an inspection of the leased tangible personal property, unless prior approval to waive the inspection requirements has been obtained from the superintendent.

For a lease to a governmental unit, the bank shall conduct an inspection at time of inception or maintain written verification by an official of the governmental unit to confirm the existence of the leased property.

e. Ongoing documentation requirements to support the lease shall be the same as if the bank had made a direct loan to the lessee for purchase of the asset being leased.

f. The lease shall be a full-payout, noncancelable obligation of the lessee with the obligation serving the same purpose as other forms of bank financing. For purposes of this rule, a lease to a governmental unit which contains a fiscal funding clause would be considered a noncancelable lease if the likelihood of exercise of the fiscal funding clause is assessed as being remote.

g. Property covered by the lease shall be limited to tangible personal property, excluding livestock. In addition, a state bank may purchase or construct a municipal building, such as a school building, or other similar public facility and, as holder of legal title, lease the same to a municipality or other public authority having resources sufficient to make payment of all rentals as they become due. The lease agreement shall address liability issues and shall provide that upon its expiration the lessee will become owner of the building or facility.

h. The lease shall require rental payments to be made on a periodic basis, but no less frequently than annually.

i. The term of a lease shall not exceed seven years if made to a nongovernmental unit or ten years if made to a governmental unit without the prior approval of the superintendent.

j. Aggregate rentals payable by the customer under leases of personal property shall conform to the limits imposed by Iowa Code section 524.904.

k. All lease receivables shall be booked in accordance with the instructions for preparation of the consolidated reports of condition and income.

l. Unguaranteed residual value established by the lessor for any lease, whether originated by the state bank or acquired through purchase, shall not exceed 25 percent of the original cost of the leased property. The amount of any estimated residual value guaranteed by a manufacturer, the lessee, or a third party which is not an affiliate of the bank may exceed 25 percent of the original cost of property where the bank has determined and can provide full supporting documentation that the guarantor has the resources to meet the guarantee.

While this guideline prohibits unguaranteed residual values to exceed 25 percent of the original cost, the estimated residual value shall be reasonable in relation to the type of property leased so the primary risk taken by the bank is the creditworthiness of the lessee and not the market value of the leased property. All estimated residual values shall be reviewed at least annually.

If the state bank carries the estimated residual value on its books and a review of the estimated residual value results in a lower estimate than had been previously established, the accounting for the transactions shall be revised using the new estimate. The resulting reduction in the net investment shall be recognized as a loss in the period in which the estimate is changed. An upward adjustment of the residual value shall not be made.

m. Consumer leases, whether originated or purchased by a state bank, shall conform to Iowa Code section 537.3202 and Chapter 5 of the Truth-in-Lending Act (15 U.S.C. 1601 et seq.).

n. If an affiliate of a state bank is regarded as the originator of a lease, the affiliate shall be subject to provisions of Iowa Code section 524.1105.

9.3(3) *Specific purchased lease guidelines.*

a. If the obligations acquired carry full recourse endorsements, guaranty, or an agreement to repurchase of the lessor or servicer negotiating the sale of the leases, then the endorser, guarantor, or repurchaser shall also be deemed to be a customer of the bank. This customer's obligation would be limited to 35 percent of aggregate capital of the state bank if the amounts exceeding 15 percent of aggregate capital consist of obligations as endorser of negotiable chattel paper negotiated by endorsement with recourse, or as unconditional guarantor of nonnegotiable chattel paper, or as transferor of chattel paper endorsed without recourse subject to a repurchase agreement.

b. Financial information or evidence of insurance coverage for errors, omissions, and fraudulent acts shall be obtained no less frequently than annually on any lease servicer. The financial information shall be evaluated to determine the creditworthiness of the lease servicer. The insurance coverage shall be in an amount sufficient for the volume of leases being serviced by the lease servicer. This documentation is to be maintained on file by the bank.

9.3(4) *Specific direct leasing guidelines.* Acceptable methods of accounting for investment tax credits shall be used.

9.3(5) *Exempted transactions.* In some instances, it may be appropriate, in light of all relevant credit considerations, to originate or purchase leases that do not conform with the requirements of 9.3(2) "c," "d," and "e." The outstanding aggregate rentals payable of all originated and purchased leases that fall into this category shall not exceed 25 percent of aggregate capital as reflected on the state bank's

most recent consolidated report of condition, unless prior approval to exceed this limitation has been obtained from the superintendent. These exempted leases shall be identified by the board of directors by name and outstanding balance and shall be reviewed by the board no less frequently than annually. Examiners, during the course of their examinations, will determine whether these exempted leases are adequately documented and appropriate in light of overall safety and soundness considerations. No leases to directors, officers, or substantial shareholders or their related interests shall be allowed in the exempted category of this subrule.

This rule is intended to implement Iowa Code section 524.908.

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CHAPTER 11
CONTESTED CASES

187—11.1(17A) Scope and applicability of the Iowa Rules of Civil Procedure. Except when inconsistent with Iowa Code chapter 524, this chapter applies to contested case proceedings conducted by the division of banking. Except as expressly provided in Iowa Code chapter 17A and these rules, the Iowa Rules of Civil Procedure do not apply to contested case proceedings. However, upon application by a party, the division may permit the use of procedures provided for in the Iowa Rules of Civil Procedure unless doing so would unreasonably complicate the proceedings or impose an undue hardship on a party.

[ARC 4059C, IAB 10/10/18, effective 11/14/18]

187—11.2(17A) Definitions. Except where otherwise specifically defined by law:

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

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

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

“*Presiding officer*” means the superintendent of banking, the superintendent’s designee or, under certain circumstances, an administrative law judge.

“*Proposed decision*” means the presiding officer’s recommended findings of fact, conclusions of law, decision, and order in a contested case in which the superintendent did not preside.

[ARC 4059C, IAB 10/10/18, effective 11/14/18]

187—11.3(17A) Time requirements.

11.3(1) Time shall be computed as provided in Iowa Code subsection 4.1(34).

11.3(2) For good cause, the presiding officer may extend or shorten the time to take any action, except as precluded by statute. Except for good cause stated in the record, before extending or shortening the time to take any action, the presiding officer shall afford all parties an opportunity to be heard or to file written arguments.

187—11.4(17A) Requests for contested case proceeding. Any person claiming an entitlement to a contested case proceeding shall file a written request for such a proceeding within the time specified by the particular rules or statutes governing the subject matter or, in the absence of such law, the time specified in the division action in question. The request for a contested case proceeding should state the name and address of the requester, identify the specific division action which is disputed and, where the requester is represented by a lawyer, identify the provisions of law or precedent requiring or authorizing the holding of a contested case proceeding in the particular circumstances involved, and include a short and plain statement of the issues of material fact in dispute.

187—11.5(17A) Notice of hearing.

11.5(1) Delivery. Delivery of the notice of hearing constitutes the commencement of the contested case proceeding. Delivery may be executed by:

- a. Personal service as provided in the Iowa Rules of Civil Procedure; or
- b. Certified mail, return receipt requested; or
- c. First-class mail; or
- d. Publication, as provided in the Iowa Rules of Civil Procedure.

11.5(2) Contents. The notice of hearing shall contain the following information:

- a. A statement of the time, place, and nature of the hearing;
- b. A statement of the legal authority and jurisdiction under which the hearing is to be held;
- c. A reference to the particular sections of the statutes and rules involved;

d. A short and plain statement of the matters asserted. If the division or other party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter, upon application, a more definite and detailed statement shall be furnished;

e. Identification of all parties including the name, address, and telephone number of the person who will act as advocate for the division or the state and of parties' counsel where known;

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

g. Reference to the procedural rules governing informal settlement;

h. Identification of the presiding officer, if known. If not known, a description of who will serve as presiding officer (e.g., superintendent, superintendent's designee, administrative law judge from the department of inspections and appeals);

i. Notification of the time period in which a party may request, pursuant to Iowa Code section 17A.11 and rule 187—11.6(17A), that the presiding officer be an administrative law judge;

j. A statement requiring the respondent to submit an answer of the type specified in subrule 11.11(2) within 20 days after service of the notice of hearing;

k. Information on whom to contact if, because of a disability, auxiliary aids or services are needed to enable a person to participate in the matter;

l. If applicable, the date, time, and manner of conduct of a prehearing conference under rule 187—11.16(17A); and

m. The mailing address and email address for filing with the division and notice of the option of email service as provided in subrule 11.12(6).

[ARC 4059C, IAB 10/10/18, effective 11/14/18]

187—11.6(17A) Presiding officer.

11.6(1) Any party who wishes to request that the presiding officer assigned to render a proposed decision be an administrative law judge employed by the department of inspections and appeals must file a written request within 20 days after service of a notice of hearing which identifies or describes the presiding officer as the division head or members of the division.

11.6(2) The superintendent may deny the request only upon a finding that one or more of the following apply:

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

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

c. An administrative law judge with the qualifications identified in subrule 11.6(4) is unavailable to hear the case within a reasonable time.

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

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

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

g. The request was not timely filed.

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

11.6(3) The superintendent shall issue a written ruling specifying the grounds for the decision within 20 days after a request for an administrative law judge is filed. If the ruling is contingent upon the availability of an administrative law judge with the qualifications identified in subrule 11.6(4), the parties shall be notified at least 10 days prior to hearing if a qualified administrative law judge will not be available.

11.6(4) An administrative law judge assigned to act as presiding officer shall have the following technical expertness unless waived by the division: an administrative law judge shall have at least five years' experience as an executive officer in a bank or in the regulation or examination of banks.

11.6(5) Except as provided otherwise by another provision of law, all rulings by an administrative law judge acting as presiding officer are subject to appeal to the superintendent. A party must seek any available intradivision appeal in order to exhaust adequate administrative remedies.

11.6(6) Unless otherwise provided by law, the superintendent, when reviewing a proposed decision upon intradivision appeal, shall have the powers of and shall comply with the provisions of this chapter which apply to presiding officers.

187—11.7(17A) Waiver of procedures. Unless otherwise precluded by law, the parties in a contested case proceeding may waive any provision of this chapter. However, the division in its discretion may refuse to give effect to such a waiver when it deems the waiver to be inconsistent with the public interest.

187—11.8(17A) Telephone and electronic proceedings. The presiding officer may resolve preliminary procedural motions by telephone conference or other electronic means in which all parties have an opportunity to participate. Other proceedings may be held by telephone or other electronic means with the consent of all parties. The presiding officer will determine the location of the parties and witnesses for hearings held by telephone or other electronic means. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when location is chosen. Disciplinary hearings will generally not be held by telephone or electronic means in the absence of consent by all parties, but the presiding officer may permit any witness to testify by telephone or other electronic means. Parties shall disclose at or prior to the prehearing conference whether any witness will be testifying by telephone or other electronic means. Objections, if any, shall be filed with the division and served on all parties at least three business days in advance of hearing.

[ARC 4059C, IAB 10/10/18, effective 11/14/18]

187—11.9(17A) Disqualification.

11.9(1) A presiding officer or other person shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

- a. Has a personal bias or prejudice concerning a party or a representative of a party;
- b. Has personally investigated, prosecuted or advocated in connection with that case, the specific controversy underlying that case, another pending factually related contested case, or a pending factually related controversy that may culminate in a contested case involving the same parties;
- c. Is subject to the authority, direction or discretion of any person who has personally investigated, prosecuted or advocated in connection with that contested case, the specific controversy underlying that contested case, or a pending factually related contested case or controversy involving the same parties;
- d. Has acted as counsel to any person who is a private party to that proceeding within the past two years;
- e. Has a personal financial interest in the outcome of the case or any other significant personal interest that could be substantially affected by the outcome of the case;
- f. Has a spouse or relative within the third degree of relationship that: (1) is a party to the case, or an officer, director or trustee of a party; (2) is a lawyer in the case; (3) is known to have an interest that could be substantially affected by the outcome of the case; or (4) is likely to be a material witness in the case; or
- g. Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

11.9(2) The term “personally investigated” means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term “personally investigated” does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person’s investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other division functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. A person voluntarily appearing before the division waives any objection to a division staff member’s participation in the appearance and later

participation as a decision maker or aid to the decision maker in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by Iowa Code section 17A.17(3) and subrules 11.9(3) and 11.23(9).

11.9(3) In a situation where a presiding officer or other person knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

11.9(4) If a party asserts disqualification on any appropriate ground, including those listed in subrule 11.9(1), the party shall file a motion supported by an affidavit pursuant to Iowa Code sections 17A.11(3) and 17A.17(7). The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party.

11.9(5) If, during the course of the hearing, a party first becomes aware of evidence of bias or other grounds for disqualification, the party may move for disqualification but must establish the grounds by the introduction of evidence into the record.

11.9(6) A motion to disqualify a division staff member or other person shall first be directed to the affected division staff member or other person for determination. If the division staff member or other person determines that disqualification is appropriate, the division staff member or other person shall withdraw from further participation in the case. If the division staff member or other person determines that withdrawal is not required, the presiding officer shall promptly review that determination, provided that, if the person at issue is an administrative law judge, the review shall be by the division. If the presiding officer determines that disqualification is appropriate, the presiding officer or other person shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal under rule 187—11.25(17A), if applicable, and seek a stay under rule 187—11.29(17A).

[ARC 4059C, IAB 10/10/18, effective 11/14/18]

187—11.10(17A) Consolidation—severance.

11.10(1) Consolidation. The presiding officer may consolidate any or all matters at issue in two or more contested case proceedings where (a) the matters at issue involve common parties or common questions of fact or law; (b) consolidation would expedite and simplify consideration of the issues involved; and (c) consolidation would not adversely affect the rights of any of the parties to those proceedings.

11.10(2) Severance. The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

187—11.11(17A) Pleadings.

11.11(1) Petition. A petition in a contested case proceeding shall state in separately numbered paragraphs the following:

- a. The persons or entities on whose behalf the petition is filed;
- b. The particular provisions of statutes and rules involved;
- c. The relief demanded and the facts and law relied upon for such relief; and
- d. The name, address and telephone number of the petitioner and the petitioner's attorney, if any.

11.11(2) Answer. An answer shall be filed within 20 days of service of a petition unless otherwise ordered. A party may move to dismiss or apply for a more definite and detailed statement when appropriate.

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

Unless otherwise provided in the notice of hearing, an answer shall state the name, address and telephone number of the person filing the answer, the person or entity on whose behalf it is filed, and the attorney representing that person, if any.

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

11.11(3) Amendment. Any notice of hearing, petition, or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed and to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.
[ARC 4059C, IAB 10/10/18, effective 11/14/18]

187—11.12(17A) Service and filing of pleadings and other papers.

11.12(1) When service required. Except where otherwise provided by law, every pleading, motion, document, or other paper filed in a contested case proceeding and every paper relating to discovery in such a proceeding shall be served upon each of the parties of record to the proceeding, including the person designated as advocate or prosecutor for the state or the division, simultaneously with their filing. Except for the original notice of hearing and an application for rehearing as provided in Iowa Code section 17A.16(2), the party filing a document is responsible for service on all parties.

11.12(2) Service—how made. Service upon a party represented by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivery or by mailing a copy to the person's last-known address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule, or order.

11.12(3) Filing—when required. After the notice of hearing, all pleadings, motions, documents or other papers in a contested case proceeding shall be filed with Division of Banking, Attn: Superintendent, 200 East Grand Avenue, Suite 300, Des Moines, Iowa 50309-1827. All pleadings, motions, documents or other papers that are required to be served upon a party shall be filed simultaneously with the division of banking.

11.12(4) Filing—how and when made. Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the division of banking, delivered to an established courier service for immediate delivery to that office, mailed by first-class mail or state interoffice mail to that office so long as there is proof of mailing, or delivered by electronic transmission to the email address specified in the notice of hearing. Filing by electronic transmission is complete upon transmission unless the party making the filing learns the attempted filing did not reach the division. The division will not provide a mailed file-stamped copy of documents that are filed by email or other approved electronic means.

11.12(5) Proof of mailing. Proof of mailing includes either a legible United States Postal Service postmark on the envelope, a certificate of service, a notarized affidavit, or a certification in substantially the following form:

I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the Division of Banking, Attn: Superintendent, 200 East Grand Avenue, Suite 300, Des Moines, Iowa 50309-1827 and to the names and addresses of the parties listed below by depositing the same in (a United States post office mailbox with correct postage properly affixed or state interoffice mail).

(Date)

(Signature)

11.12(6) Electronic service. The presiding officer may by order or a party or a party's attorney may by consent permit service of particular documents by email or similar electronic means, unless precluded by a provision of law. In the absence of such an order or consent, electronic transmission shall not satisfy service requirements but may be used to supplement service when rapid notice is desirable. Consent to electronic service by a party or a party's counsel shall be in writing, may be accomplished through electronic transmission to the board and other parties, and shall specify the email address for such service. Service by electronic transmission is complete upon transmission unless the board or party making service learns the attempted service did not reach the party to be served.

[ARC 4059C, IAB 10/10/18, effective 11/14/18]

187—11.13(17A) Discovery.

11.13(1) The scope of discovery described in Iowa Rule of Civil Procedure 1.503 shall apply to contested case proceedings.

11.13(2) The following discovery procedures available in the Iowa Rules of Civil Procedure are available to the parties in a contested case proceeding: depositions upon oral examination or written questions; written interrogatories; production of documents, electronically stored information, and things; and requests for admission. The time frames for discovery in the specific Iowa Rules of Civil Procedure govern those specific procedures, unless they are lengthened or shortened by the presiding officer.

a. Iowa Rules of Civil Procedure 1.701 through 1.717 regarding depositions shall apply to any depositions taken in a contested case proceeding. Any party taking a deposition in a contested case shall be responsible for any deposition costs, unless otherwise specified or allocated in an order. Deposition costs include, but are not limited to, reimbursement for mileage of the deponent, costs of a certified shorthand reporter, and expert witness fees, as applicable.

b. Iowa Rule of Civil Procedure 1.509 shall apply to any interrogatories propounded in a contested case proceeding.

c. Iowa Rule of Civil Procedure 1.512 shall apply to any requests for production of documents, electronically stored information, and things in a contested case proceeding.

d. Iowa Rule of Civil Procedure 1.510 shall apply to any requests for admission in a contested case proceeding. Iowa Rule of Civil Procedure 1.511 regarding the effect of an admission shall apply in contested case proceedings.

11.13(3) The mandatory disclosure and discovery conference requirements in Iowa Rules of Civil Procedure 1.500 and 1.507 do not apply to contested case proceedings. However, upon application by a party, the presiding officer may order the parties to comply with these procedures unless doing so would unreasonably complicate the proceedings or impose an undue hardship. As a practical matter, the purpose of the disclosure requirements and discovery conference is served by the division's obligation to supply the information that is described in Iowa Code section 17A.13(2) upon request while a contested case is pending and by the mutual exchange of information that is required in a prehearing conference under rule 187—11.16(17A).

11.13(4) Iowa Rule of Civil Procedure 1.508 shall apply to discovery of any experts identified by a party to a contested case proceeding.

11.13(5) Discovery shall be served on all parties to the contested case proceeding but shall not be filed with the division.

11.13(6) A party may file a motion to compel or other motion related to discovery in accordance with this subrule. Any motion filed with the division relating to discovery shall allege that the moving party has previously made a good-faith attempt to resolve the discovery issues involved with the opposing party. Motions in regard to discovery shall be ruled upon by the presiding officer. Opposing parties shall be afforded the opportunity to respond within ten days of the filing of the motion unless the time is lengthened or shortened by the presiding officer. The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

11.13(7) Evidence obtained in discovery may be used in the contested case proceeding if that evidence would otherwise be admissible in that proceeding.

[ARC 4059C, IAB 10/10/18, effective 11/14/18]

187—11.14(17A) Subpoenas.**11.14(1) Issuance.**

a. A division subpoena shall be issued to a party on request. Such a request must be in writing. In the absence of good cause for permitting later action, a request for a subpoena must be received at least three days before the scheduled hearing. The request shall include the name, address, email address, and telephone number of the requesting party.

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

11.14(2) *Motion to quash or modify.* The presiding officer may quash or modify a subpoena for any lawful reason upon motion in accordance with the Iowa Rules of Civil Procedure. A motion to quash or modify a subpoena shall be set for argument promptly.

[ARC 4059C, IAB 10/10/18, effective 11/14/18]

187—11.15(17A) Motions.

11.15(1) No technical form for motions is required. However, prehearing motions must be in writing, state the grounds for relief, and state the relief sought.

11.15(2) Any party may file a written response to a motion within ten days after the motion is served, unless the time period is extended or shortened by rules of the division or the presiding officer. The presiding officer may consider a failure to respond within the required time period in ruling on a motion.

11.15(3) The presiding officer may schedule oral argument on any motion.

11.15(4) Motions pertaining to the hearing must be filed and served at least ten days prior to the date of hearing unless there is good cause for permitting later action or the time for such action is lengthened or shortened by rule of the division or an order of the presiding officer.

187—11.16(17A) Prehearing conference and disclosures.

11.16(1) Any party may request a prehearing conference. A written request for prehearing conference or an order for prehearing conference on the presiding officer's own motion shall be filed not less than seven days prior to the hearing date. A prehearing conference shall be scheduled not less than three business days prior to the hearing date.

Written notice of the prehearing conference shall be given by the presiding officer to all parties. For good cause the presiding officer may permit variances from this rule.

11.16(2) Each party shall disclose at or prior to the prehearing conference:

a. A final list of the witnesses who the party anticipates will testify at hearing. Witnesses not listed may be excluded from testifying unless there was good cause for the failure to include their names; and

b. A final list of exhibits which the party anticipates will be introduced at hearing. Exhibits other than rebuttal exhibits that are not listed may be excluded from admission into evidence unless there was good cause for the failure to include them.

c. Witness or exhibit lists may be amended subsequent to the prehearing conference within the time limits established by the presiding officer at the prehearing conference. Any such amendments must be served on all parties.

11.16(3) In addition to the requirements of subrule 11.16(2), the parties at a prehearing conference may:

a. Enter into stipulations of law or fact;

b. Enter into stipulations on the admissibility of exhibits;

c. Identify matters which the parties intend to request be officially noticed;

d. Enter into stipulations for waiver of any provision of law; and

e. Consider any additional matters which will expedite the hearing.

11.16(4) Prehearing conferences shall be conducted by telephone unless otherwise ordered. Parties shall exchange and receive witness and exhibit lists in advance of a telephone prehearing conference. Unless otherwise provided in the order setting a prehearing conference, the prehearing conference shall be conducted by an administrative law judge.

11.16(5) The parties shall exchange copies of all exhibits marked for introduction at hearing in the manner provided in subrule 11.21(4) no later than three business days in advance of hearing, or as ordered by the presiding officer at the prehearing conference.

[ARC 4059C, IAB 10/10/18, effective 11/14/18]

187—11.17(17A) Continuances. Unless otherwise provided, applications for continuances shall be made to the presiding officer.

11.17(1) A written application for a continuance shall:

- a. Be made at the earliest possible time and no less than seven days before the hearing except in case of unanticipated emergencies;
- b. State the specific reasons for the request; and
- c. Be signed by the requesting party or the party's representative.

An oral application for a continuance may be made if the presiding officer waives the requirement for a written motion. However, a party making such an oral application for a continuance must confirm that request by written application within five days after the oral request unless that requirement is waived by the presiding officer. No application for continuance shall be made or granted without notice to all parties except in an emergency where notice is not feasible. The division may waive notice of such requests for a particular case or an entire class of cases.

11.17(2) In determining whether to grant a continuance, the presiding officer may consider:

- a. Prior continuances;
- b. The interests of all parties;
- c. The likelihood of informal settlement;
- d. The existence of an emergency;
- e. Any objection;
- f. Any applicable time requirements;
- g. The existence of a conflict in the schedules of counsel, parties, or witnesses;
- h. The timeliness of the request; and
- i. Other relevant factors.

The presiding officer may require documentation of any grounds for continuance.

187—11.18(17A) Withdrawals. A party requesting a contested case proceeding may withdraw that request prior to the hearing only in accordance with division rules. Unless otherwise provided, a withdrawal shall be with prejudice.

187—11.19(17A) Intervention.

11.19(1) Motion. A motion for leave to intervene in a contested case proceeding shall state the grounds for the proposed intervention, the position and interest of the proposed intervenor, and the possible impact of intervention on the proceeding. A proposed answer or petition in intervention shall be attached to the motion. Any party may file a response within 14 days of service of the motion to intervene unless the time period is extended or shortened by the presiding officer.

11.19(2) When filed. Motion for leave to intervene shall be filed as early in the proceeding as possible to avoid adverse impact on existing parties or the conduct of the proceeding. Unless otherwise ordered, a motion for leave to intervene shall be filed before the prehearing conference, if any, or at least 20 days before the date scheduled for hearing. Any later motion must contain a statement of good cause for the failure to file in a timely manner. Unless inequitable or unjust, an intervenor shall be bound by any agreement, arrangement, or other matter previously raised in the case. Requests by untimely intervenors for continuances which would delay the proceeding will ordinarily be denied.

11.19(3) Grounds for intervention. The movant shall demonstrate that (a) intervention would not unduly prolong the proceedings or otherwise prejudice the rights of existing parties; (b) the movant is likely to be aggrieved or adversely affected by a final order in the proceeding; and (c) the interests of the movant are not adequately represented by existing parties.

11.19(4) Effect of intervention. If appropriate, the presiding officer may order consolidation of the petitions and briefs of different parties whose interests are aligned with each other and limit the number of representatives allowed to participate actively in the proceedings. A person granted leave to intervene is a party to the proceeding. The order granting intervention may restrict the issues that may be raised by the intervenor or otherwise condition the intervenor's participation in the proceeding.

187—11.20(17A) Hearing procedures.

11.20(1) The presiding officer presides at the hearing, and may rule on motions, require briefs, issue a proposed decision, and issue such orders and rulings as will ensure the orderly conduct of the proceedings.

11.20(2) All objections shall be timely made and stated on the record.

11.20(3) Parties have the right to participate or to be represented in all hearings or prehearing conferences related to their case. Partnerships, corporations, or associations may be represented by any member, officer, director, shareholder, or duly authorized agent. Any party may be represented by an attorney, or another person authorized by law, at the party's expense.

11.20(4) Subject to terms and conditions prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, and submit briefs and engage in oral argument.

11.20(5) The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly.

11.20(6) Witnesses may be sequestered during the hearing.

11.20(7) The presiding officer shall conduct the hearing in the following manner:

a. The presiding officer shall give an opening statement briefly describing the nature of the proceedings;

b. The parties shall be given an opportunity to present opening statements;

c. Parties shall present their cases in the sequence determined by the presiding officer;

d. Each witness shall be sworn or affirmed by the presiding officer or the court reporter, and be subject to examination and cross-examination. The presiding officer may limit questioning in a manner consistent with law;

e. When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

11.20(8) Depositions may be used at hearing to the extent permitted by Iowa Rule of Civil Procedure 1.704.

11.20(9) Witnesses are entitled to be represented by an attorney at their own expense. The attorney may assert legal privileges personal to the client but may not make other objections. The attorney may only ask questions of the client to prevent a misstatement from entering the record.

11.20(10) The parties in a contested case shall be responsible for any witness fees and expenses incurred by witnesses appearing at the contested case hearing, unless otherwise specified or allocated in an order. The costs for lay witnesses shall be determined in accordance with Iowa Code section 622.69. The costs for expert witnesses shall be determined in accordance with Iowa Code section 622.72. Witnesses are entitled to reimbursement for mileage and may be entitled to reimbursement for meals and lodging, as incurred.

[ARC 4059C, IAB 10/10/18, effective 11/14/18]

187—11.21(17A) Evidence.

11.21(1) The presiding officer shall rule on admissibility of evidence and may, where appropriate, take official notice of facts in accordance with all applicable requirements of law.

11.21(2) Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

11.21(3) Evidence in the proceeding shall be confined to the issues as to which the parties received notice prior to the hearing unless the parties waive their right to such notice or the presiding officer determines that good cause justifies expansion of the issues. If the presiding officer decides to admit evidence on issues outside the scope of the notice over the objection of a party who did not have actual notice of those issues, that party, upon timely request, shall receive a continuance sufficient to amend pleadings and to prepare on the additional issue.

11.21(4) The party seeking admission of an exhibit must provide opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents should normally be provided to opposing parties. All exhibits admitted into evidence shall be appropriately

marked and be made part of the record. The state's exhibits shall be marked numerically, and the applicant's or respondent's exhibits shall be marked alphabetically.

11.21(5) Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. Such an objection shall be accompanied by a brief statement of the grounds upon which it is based. The objection, the ruling on the objection, and the reasons for the ruling shall be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision.

11.21(6) Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly summarize the testimony or, with permission of the presiding officer, present the testimony. If the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record.

[ARC 4059C, IAB 10/10/18, effective 11/14/18]

187—11.22(17A) Default.

11.22(1) If a party fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

11.22(2) Where appropriate and not contrary to law, any party may move for default against a party who has requested the contested case proceeding and has failed to file a required pleading or has failed to appear after proper service.

11.22(3) Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final division action unless, within 15 days after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided by rule 11.27(17A). A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, which affidavit(s) must be attached to the motion.

11.22(4) The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

11.22(5) Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party. Adverse parties shall have ten days to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to the issue of good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

11.22(6) "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.971.

11.22(7) A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party pursuant to rule 11.25(17A).

11.22(8) If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall issue another notice of hearing and the contested case shall proceed accordingly.

11.22(9) A default decision may award any relief consistent with the request for relief made in the petition and embraced in its issues.

11.22(10) A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for stay under rule 11.29(17A).

[ARC 4059C, IAB 10/10/18, effective 11/14/18]

187—11.23(17A) Ex parte communication.

11.23(1) Prohibited communications. Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the division or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating as defined in subrule 11.9(2), prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

11.23(2) Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

11.23(3) Written, oral or other forms of communication are “ex parte” if made without notice and opportunity for all parties to participate.

11.23(4) To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications shall be provided in compliance with rule 11.12(17A) and may be supplemented by telephone, facsimile, electronic mail or other means of notification. Where permitted, oral communications may be initiated through conference telephone call including all parties or their representatives.

11.23(5) Persons who jointly act as presiding officer in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

11.23(6) The executive director or other persons may be present in deliberations or otherwise advise the presiding officer without notice or opportunity for parties to participate as long as they are not disqualified from participating in the making of a proposed or final decision under any provision of law and they comply with subrule 11.23(1).

11.23(7) Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines pursuant to rule 11.17(17A).

11.23(8) Disclosure of prohibited communications. A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be submitted for inclusion in the record under seal by protective order. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

11.23(9) Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

11.23(10) The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the division. Violation of ex parte

communication prohibitions by division personnel shall be reported to the superintendent for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

187—11.24(17A) Recording costs. Upon request, the division shall provide a copy of the whole or any portion of the record at cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party.

Parties who request that a hearing be recorded by certified shorthand reporters rather than by electronic means shall bear the cost of that recordation, unless otherwise provided by law.

187—11.25(17A) Interlocutory appeals. Upon written request of a party or on its own motion, the superintendent may review an interlocutory order of the presiding officer. In determining whether to do so, the superintendent shall weigh the extent to which its granting the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order by the division at the time it reviews the proposed decision of the presiding officer would provide an adequate remedy. Any request for interlocutory review must be filed within 14 days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.

187—11.26(17A) Final decision.

11.26(1) When the superintendent presides over the reception of evidence at the hearing, the superintendent's decision is a final decision.

11.26(2) When the superintendent does not preside at the reception of evidence, the presiding officer shall make a proposed decision. The proposed decision becomes the final decision of the division without further proceedings unless there is an appeal to, or review on motion of, the superintendent within the time provided in rule 11.27(17A).

187—11.27(17A) Appeals and review.

11.27(1) Appeal by party. Any adversely affected party may appeal a proposed decision to the superintendent within 30 days after issuance of the proposed decision. Such an appeal is required to exhaust administrative remedies and is a jurisdictional prerequisite to seeking judicial review.

11.27(2) Review. The superintendent may initiate review of a proposed decision on the superintendent's own motion at any time within 30 days following the issuance of such a decision.

11.27(3) Notice of appeal. An appeal of a proposed decision is initiated by filing a timely notice of appeal with the division of banking. The notice of appeal must be signed by the appealing party or a representative of that party and contain a certificate of service. The notice shall specify:

- a. The parties initiating the appeal;
- b. The proposed decision or order appealed from;
- c. The specific findings or conclusions to which exception is taken and any other exceptions to the decision or order;
- d. The relief sought;
- e. The grounds for relief.

11.27(4) Requests to present additional evidence. A party may request the taking of additional evidence only by establishing that the evidence is material, that good cause existed for the failure to present the evidence at the hearing, and that the party has not waived the right to present the evidence. A written request to present additional evidence must be filed with the notice of appeal or, by a nonappealing party, within 14 days of service of the notice of appeal. The superintendent may remand a case to the presiding officer for further hearing or may personally preside at the taking of additional evidence.

11.27(5) Scheduling. The division shall issue a schedule for consideration of the appeal.

11.27(6) Briefs and arguments. Unless otherwise ordered, within 20 days of the notice of appeal or order for review, each appealing party may file exceptions and briefs. Within 20 days thereafter, any party may file a responsive brief. Briefs shall cite any applicable legal authority and specify relevant

portions of the record in that proceeding. Written requests to present oral argument shall be filed with the briefs.

The superintendent may resolve the appeal on the briefs or provide an opportunity for oral argument. The superintendent may shorten or extend the briefing period as appropriate.

[ARC 4059C, IAB 10/10/18, effective 11/14/18]

187—11.28(17A) Applications for rehearing.

11.28(1) *By whom filed.* Any party to a contested case proceeding may file an application for rehearing from a final order.

11.28(2) *Content of application.* The application for rehearing shall state on whose behalf it is filed, the specific grounds for rehearing, and the relief sought. In addition, the application shall state whether the applicant desires reconsideration of all or part of the division decision on the existing record and whether, on the basis of the grounds enumerated in subrule 11.27(4), the applicant requests an opportunity to submit additional evidence.

11.28(3) *Time of filing.* The application shall be filed with the division of banking within 20 days after issuance of the final decision.

11.28(4) *Notice to other parties.* A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the division of banking shall serve copies on all parties.

11.28(5) *Disposition.* Any application for a rehearing shall be deemed denied unless the division grants the application within 20 days after its filing.

187—11.29(17A) Stays of division actions.

11.29(1) *When available.*

a. Any party to a contested case proceeding may petition the division of banking for a stay of an order issued in that proceeding or for other temporary remedies, pending review by the division. The petition shall be filed with the notice of appeal and shall state the reasons justifying a stay or other temporary remedy. The superintendent may rule on the stay or authorize the presiding officer to do so.

b. Any party to a contested case proceeding may petition the division of banking for a stay or other temporary remedies pending judicial review of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy. Seeking a stay from the division is required to exhaust administrative remedies prior to seeking a stay from the district court.

11.29(2) *When granted.* In determining whether to grant a stay, the presiding officer or superintendent shall consider the factors listed in 1998 Iowa Acts, chapter 1202, section 23(5c).

11.29(3) *Vacation.* A stay may be vacated by the issuing authority upon application of the division or any other party.

[ARC 4059C, IAB 10/10/18, effective 11/14/18]

187—11.30(17A) No factual dispute contested cases. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as practicable. If the parties cannot agree, any party may file and serve a motion for summary judgment pursuant to the rules governing such motions.

187—11.31(17A) Emergency adjudicative proceedings.

11.31(1) *Necessary emergency action.* To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare and, consistent with the Constitution and other provisions of law, the superintendent may issue a written order in compliance with 1998 Iowa Acts, chapter 1202, section 21, to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the superintendent by emergency

adjudicative order. Before issuing an emergency adjudicative order the superintendent shall consider factors including, but not limited to, the following:

- a. Whether there has been a sufficient factual investigation to ensure that the division is proceeding on the basis of reliable information;
- b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;
- c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;
- d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and
- e. Whether the specific action contemplated by the division is necessary to avoid the immediate danger.

11.31(2) Issuance of order.

a. An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the superintendent's decision to take immediate action.

b. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by utilizing one or more of the following procedures:

- (1) Personal delivery;
- (2) Certified mail, return receipt requested, to the last address on file with the division;
- (3) Certified mail to the last address on file with the division;
- (4) First-class mail to the last address on file with the division; or
- (5) Electronic service. Fax or email may be used as the sole method of delivery if the person required to comply with the order has filed a written request that division orders be sent by fax or email and has provided a fax number or email address for that purpose.

c. To the degree practicable, the division shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

11.31(3) Oral notice. Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the division shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

11.31(4) Completion of proceedings. After the issuance of an emergency adjudicative order, the division shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

Issuance of a written emergency adjudicative order shall include notification of the date on which division proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further division proceedings to a later date will be granted only in compelling circumstances upon application in writing.

[ARC 4059C, IAB 10/10/18, effective 11/14/18]

These rules are intended to implement Iowa Code chapter 17A.

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CHAPTER 12
UNIFORM WAIVER AND VARIANCE RULES

187—12.1(17A,524) Scope of chapter. This chapter outlines a uniform process for the granting of waivers or variances from rules adopted by the superintendent in situations where no other more specifically applicable law provides for waivers. The intent of this chapter is to allow persons to seek exceptions to the application of rules issued by the superintendent. This chapter shall not apply to rules that merely define the meaning of a statute or other provision of law or precedent if the division does not possess delegated authority to bind the courts to any extent with its definition. To the extent another more specific provision of law governs the issuance of a waiver from a particular rule, the more specific provision shall supersede this chapter with respect to any waiver from that rule.

12.1(1) Definitions.

“*Person*” means an individual, corporation, limited liability company, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any legal entity.

“*Superintendent*” means the superintendent of banking appointed by the governor to direct and regulate banks pursuant to Iowa Code chapter 524.

“*Waiver or variance*” means an agency action which suspends in whole or in part the requirements or provisions of a rule as applied to an identified person on the basis of the particular circumstances of that person.

12.1(2) Applicability.

a. The superintendent may grant a waiver or variance from a rule adopted by the superintendent only if (1) the superintendent has jurisdiction over the rule; (2) no statute or rule otherwise controls the granting of a waiver or variance from the rule from which waiver or variance is requested; and (3) the requested waiver or variance is consistent with applicable statutes, constitutional provisions, or other provisions of law.

b. No waiver or variance may be granted from a requirement which is imposed by statute.
[ARC 4060C, IAB 10/10/18, effective 11/14/18]

187—12.2(17A,524) Superintendent discretion. The decision on whether the circumstances justify the granting of a waiver or variance shall be made at the discretion of the superintendent upon consideration of all relevant factors. Each petition for a waiver or variance shall be evaluated by the superintendent based on the unique, individual circumstances set out in the petition.

12.2(1) Criteria for waiver or variance. The superintendent may, in response to a completed petition or on the superintendent’s own motion, grant a waiver or variance from a rule, in whole or in part, as applied to the circumstances of a specified situation if the superintendent finds all of the following:

a. The application of the rule would result in an undue hardship on the person for whom the waiver or variance is requested;

b. The waiver or variance from the requirements of the rule in the specific case would not prejudice the substantial legal rights of any person;

c. The provisions of the rule subject to the petition for waiver are not specifically mandated by statute or another provision of law; and

d. Substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver or variance is requested.

In determining whether a waiver or variance should be granted, the superintendent shall consider the public interest, policies and legislative intent of the statute on which the rule is based. When the rule from which a waiver or variance is sought establishes administrative deadlines, the superintendent shall balance the special individual circumstances of the petitioner with the overall goal of uniform treatment of all similarly situated persons.

12.2(2) Special waiver or variance rules not precluded. These uniform waiver and variance rules shall not preclude the superintendent from granting waivers or variances in other contexts if a statute or other rule authorizes the superintendent to do so and the superintendent deems it appropriate to do so.
[ARC 4060C, IAB 10/10/18, effective 11/14/18]

187—12.3(17A,524) Requester's responsibilities in filing a waiver or variance petition.

12.3(1) Application. All petitions for waiver or variance must be submitted in writing to the Banking Division, 200 East Grand Avenue, Suite 300, Des Moines, Iowa 50309. If the petition relates to a pending contested case, a copy of the petition shall also be filed in the contested case proceeding.

12.3(2) Content of petition. A petition for waiver or variance shall include the following information where applicable and known to the requester (for an example of a petition for waiver or variance, see Exhibit A at the end of this chapter):

- a. A description and citation of the specific rule from which a waiver or variance is requested.
- b. The specific waiver or variance requested, including the precise scope and operative period that the waiver or variance will extend.
- c. The relevant facts that the petitioner believes would justify a waiver or variance under each of the four criteria specified in subrule 12.2(1).
- d. A signed statement from the petitioner attesting to the accuracy of the facts provided in the petition and a statement of reasons that the petitioner believes will justify a waiver or variance.
- e. A history of any prior contacts between the superintendent and the petitioner relating to the regulated activity, license, grant, loan or other financial assistance affected by the proposed waiver or variance, including a description of each affected license, grant, loan or other financial assistance held by the requester, any notices of violation, contested case hearings, or investigative or examination reports relating to the regulated activity, license, grant or loan within the past five years.
- f. Any information known to the requester regarding the treatment of similar cases by the superintendent.
- g. The name, address, and telephone number of any public agency or political subdivision which also regulates the activity in question or which might be affected by the granting of a waiver or variance.
- h. The name, address, and telephone number of any person or entity that would be adversely affected by the granting of a petition.
- i. The name, address, and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver or variance.
- j. Signed releases of information authorizing persons with knowledge regarding the request to furnish the superintendent with information relevant to the waiver or variance.

12.3(3) Burden of persuasion. When a petition is filed for a waiver or variance from a rule, the burden of persuasion shall be on the petitioner to demonstrate by clear and convincing evidence that the superintendent should exercise the superintendent's discretion to grant the petitioner a waiver or variance.

[ARC 4060C, IAB 10/10/18, effective 11/14/18]

187—12.4(17A,524) Notice. The superintendent shall acknowledge a petition upon receipt. The superintendent shall ensure that, within 30 days of the receipt of the petition, notice of the pendency of the petition and a concise summary of its contents have been provided to all persons to whom notice is required by any provision of law. In addition, the superintendent may give notice to other persons. To accomplish this notice provision, the superintendent may require the petitioner to serve the notice on all persons to whom notice is required by any provision of law and provide a written statement to the superintendent attesting that notice has been provided.

[ARC 4060C, IAB 10/10/18, effective 11/14/18]

187—12.5(17A,524) Superintendent's responsibilities regarding petition for waiver or variance.

12.5(1) Additional information. Prior to issuing an order granting or denying a waiver or variance, the superintendent may request additional information from the petitioner relative to the petition and surrounding circumstances. If the petition was not filed in a contested case, the superintendent may, on the superintendent's own motion or at the petitioner's request, schedule a telephonic or in-person meeting between the petitioner and the superintendent or the superintendent's designee.

12.5(2) Hearing procedures. The provisions of Iowa Code sections 17A.10 to 17A.18A regarding contested case hearings shall apply in three situations: (a) to any petition for a waiver or variance of a

rule filed within a contested case; (b) when the superintendent so provides by rule or order; or (c) when a statute so requires.

12.5(3) *Ruling.* An order granting or denying a waiver or variance shall be in writing and shall contain a reference to the particular person and rule or portion thereof to which the order pertains, a statement of the relevant facts and reasons upon which the action is based, and a description of the precise scope and operative period of the waiver if one is issued.

12.5(4) *Conditions.* The superintendent may place any condition on a waiver or variance that the superintendent finds desirable to protect the public health, safety, and welfare.

12.5(5) *Narrowly tailored exception.* A waiver, if granted, shall provide the narrowest exception possible to the provisions of a rule.

12.5(6) *Time period of waiver.* A waiver shall not be permanent unless the petitioner can show that a temporary waiver would be impracticable. If a temporary waiver is granted, there is no automatic right to renewal. At the sole discretion of the superintendent, a waiver may be renewed if the superintendent finds that grounds for a waiver continue to exist.

12.5(7) *Time for ruling.* The superintendent shall grant or deny a petition for a waiver or variance as soon as practicable but, in any event, shall do so within 120 days of its receipt, unless the petitioner agrees to a later date. However, if a petition is filed in a contested case, the superintendent shall grant or deny the petition no later than the time at which the final decision in that contested case is issued.

12.5(8) *When deemed denied.* Failure of the superintendent to grant or deny a petition within the required time period shall be deemed a denial of that petition by the superintendent.

12.5(9) *Service of order.* Within seven days of its issuance, any order issued under this chapter shall be transmitted to the petitioner or the person to whom the order pertains and to any other person entitled to such notice by any provision of law.

[ARC 4060C, IAB 10/10/18, effective 11/14/18]

187—12.6(17A,524) Public availability. All orders granting or denying waivers and variances under this chapter shall be indexed, filed and available for public inspection as provided in Iowa Code section 17A.3. Petitions for a waiver or variance and orders granting or denying a waiver or variance petition are public records under Iowa Code chapter 22. Some petitions or orders may contain information that the superintendent is authorized or required to keep confidential. The superintendent may accordingly redact confidential information from petitions or orders prior to public inspection.

[ARC 4060C, IAB 10/10/18, effective 11/14/18]

187—12.7(17A,524) Voiding or cancellation. A waiver or variance is void if the material facts upon which the request or petition is based are not true or if material facts have been withheld. A waiver or variance issued by the superintendent pursuant to this chapter may be withdrawn, canceled, or modified if, after appropriate notice and opportunity for hearing, the superintendent issues an order finding any of the following:

1. The petitioner or the person who was the subject of the waiver order withheld or misrepresented material facts relevant to the propriety or desirability of the waiver; or

2. The alternative means for ensuring that the public health, safety and welfare will be adequately protected after issuance of the waiver order have been demonstrated to be insufficient; or

3. The subject of the waiver order has failed to comply with any conditions contained in the order.

[ARC 4060C, IAB 10/10/18, effective 11/14/18]

187—12.8(17A,524) Violations. Violation of conditions in the waiver or variance order is the equivalent of violation of the particular rule for which the waiver or variance is granted and is subject to the same remedies or penalties.

[ARC 4060C, IAB 10/10/18, effective 11/14/18]

187—12.9(17A,524) Defense. After the superintendent issues an order granting a waiver or variance, the order is a defense within its terms and the specific facts indicated therein for the person to whom the order pertains in any proceeding in which the rule in question is sought to be invoked.

[ARC 4060C, IAB 10/10/18, effective 11/14/18]

187—12.10(17A,524) Appeals. Granting or denying a request for waiver or variance is final agency action under Iowa Code chapter 17A. An appeal to district court shall be taken within 30 days of the issuance of the order in response to the request unless a contrary time is provided by rule or statute. [ARC 4060C, IAB 10/10/18, effective 11/14/18]

187—12.11(17A,524) Summary reports. Semiannually, the superintendent shall prepare a summary report identifying the rules for which a waiver has been granted or denied, the number of times a waiver was granted or denied for each rule, a citation to the statutory provisions implemented by these rules, and a general summary of the reasons justifying the superintendent's actions on waiver requests. If practicable, the report shall detail the extent to which the granting of a waiver has affected the general applicability of the rule itself. Copies of this report shall be available for public inspection and shall be provided semiannually to the administrative rules coordinator and the administrative rules review committee.

Exhibit A

Sample Petition (Request) for Waiver/Variance

BEFORE THE SUPERINTENDENT OF BANKING

Petition by (insert name of petitioner)
for the waiver of (insert rule citation)
relating to (insert the subject matter).



PETITION FOR
WAIVER

A request for waiver or variance from a rule adopted by the superintendent shall include the following information in the petition for waiver or variance where applicable and known:

- a. Provide the petitioner's (person asking for a waiver or variance) name, address, and telephone number.
- b. Describe and cite the specific rule from which a waiver or variance is requested.
- c. Describe the specific waiver or variance requested; include the exact scope and operative time period that the waiver or variance will extend.
- d. Explain the important facts that the petitioner believes justify a waiver or variance. Include in your answer (1) why applying the rule will result in undue hardship on the petitioner; and (2) how granting the waiver or variance will not prejudice the substantial legal rights of any person; and (3) that the provisions of the rule subject to the petition for waiver are not specifically mandated by statute or another provision of law; and (4) where applicable, how substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver or variance is requested.
- e. Provide a history of prior contacts between the superintendent and petitioner relating to the regulated activity, license, grant, loan or other financial assistance that would be affected by the waiver or variance; include a description of each affected license, grant, loan or other financial assistance held by the petitioner, any notices of violation, contested case hearings, or investigative or examination reports relating to the regulated activity, license, grant or loan within the past five years.
- f. Provide information known to the petitioner regarding the treatment by the superintendent of similar cases.
- g. Provide the name, address, and telephone number of any public agency or political subdivision which also regulates the activity in question or which might be affected by the granting of a waiver or variance.
- h. Provide the name, address, and telephone number of any person or entity that would be adversely affected or disadvantaged by the granting of the waiver or variance.
- i. Provide the name, address, and telephone number of any person with knowledge of the relevant or important facts relating to the requested waiver or variance.
- j. Provide signed releases of information authorizing persons with knowledge regarding the request to furnish the superintendent with information relevant to the waiver or variance.

I hereby attest to the accuracy and truthfulness of the above information.

Petitioner's signature

Date

Petitioner should note the following when requesting or petitioning for a waiver or variance:

1. The petitioner has the burden of proving to the superintendent, by clear and convincing evidence, the following: (a) application of the rule to the petitioner would result in an undue hardship on the petitioner; and (b) waiver or variance in the specific case would not prejudice the substantial legal rights of any person; and (c) the provisions of the rule subject to the petition for waiver are not specifically mandated by statute or another provision of law; and (d) where applicable, how substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver or variance is requested.

2. The superintendent may request additional information from or request an informal meeting with the petitioner prior to issuing a ruling granting or denying a request for waiver or variance.

3. All petitions for waiver or variance must be submitted in writing to the Banking Division, 200 East Grand Avenue, Suite 300, Des Moines, Iowa 50309. If the petition relates to a pending contested case, a copy of the petition shall also be filed in the contested case proceeding.

[ARC 4060C, IAB 10/10/18, effective 11/14/18]

These rules are intended to implement Iowa Code section 17A.9A and chapter 524.

[Filed 9/26/01, Notice 8/22/01—published 10/17/01, effective 11/21/01]

[Filed ARC 4060C (Notice ARC 3950C, IAB 8/15/18), IAB 10/10/18, effective 11/14/18]

CHAPTER 20
DEBT MANAGEMENT

187—20.1(17A,533A) Definitions. For the purposes of this chapter, the definitions in Iowa Code chapter 533A shall apply. In addition, unless the context otherwise requires:

“*Debt management business*” means a person that performs debt management as defined in Iowa Code section 533A.1(2) or debt settlement as defined in Iowa Code section 533A.1(3).

“*Nationwide multistate licensing system*” or “*NMLS*” means a multistate licensing system developed and maintained by the Conference of State Bank Supervisors and the American Association of Residential Mortgage Regulators for the licensing and registration of nondepository financial institutions.

“*Upon completion of a settlement of a debtor’s debt*” means when all of the payments necessary to completely satisfy a debtor’s debt have been remitted to the creditor.

[ARC 4061C, IAB 10/10/18, effective 11/14/18]

187—20.2(17A,533A) Utilization of the NMLS. All application and licensing information shall be submitted through the NMLS including but not limited to the following: original application information; changes in application information; license renewal information; changes in name, location, and control; and notices of significant events. The applicant or licensee shall pay any fees required by the NMLS including but not limited to the following: system processing fees, background check fees, and credit background check fees.

[ARC 4061C, IAB 10/10/18, effective 11/14/18]

187—20.3(17A,533A) Application for license.

20.3(1) An application for a license to operate a debt management business in Iowa shall be submitted to the superintendent, on the form provided and with the information requested, through the NMLS. The superintendent may consider an application withdrawn if it does not contain all of the information required and the missing information is not submitted to the superintendent within 30 days after the superintendent requests the missing information. The applicant may also request that the application be withdrawn at any time before the superintendent has decided to grant or deny the application.

20.3(2) Each officer, director, and individual who has control of an applicant must provide fingerprints, authorize a fingerprint background check through the NMLS, and pay the appropriate fees for the purpose of conducting a national criminal history background check through the Federal Bureau of Investigation.

20.3(3) The applicant shall submit with the application an application fee of \$100 and an initial license fee of \$250. The superintendent shall refund the initial license fee if the application is denied, but the application fee is not subject to refund.

20.3(4) If any information material to the application changes after the applicant files the initial application, the applicant shall provide updated information to the superintendent within ten days of the change. When such a material change in information has occurred, the superintendent may deny an application if the applicant fails to provide updated information within the prescribed time frame.

20.3(5) An applicant for a license to operate a debt management business must file with the superintendent a \$25,000 surety bond in compliance with the provisions of Iowa Code section 533A.2(4).

20.3(6) Licenses expire on the next December 31 after they are issued, but licenses granted on or after November 1 but before January 1 will not expire until December 31 of the following year. For example, a license granted on November 17, 2017, would not expire until December 31, 2018.

[ARC 4061C, IAB 10/10/18, effective 11/14/18]

187—20.4(17A,533A) Grounds for approval or denial.

20.4(1) The superintendent shall approve or deny a license application in accordance with the provisions of Iowa Code section 533A.3.

20.4(2) The following may be considered evidence that the business of the applicant may not be operated lawfully and honestly consistent with the purposes of Iowa Code chapter 533A and may therefore be considered grounds for denial of an application:

a. An applicant, or an officer, director, or individual who has control of an applicant, has had a mortgage loan originator license or any lending license revoked in any governmental jurisdiction.

b. An applicant, or an officer, director, or individual who has control of an applicant, has been convicted of, or pled guilty or no contest to, a felony in a domestic, foreign, or military court if such felony involved an act of fraud, dishonesty, or breach of trust, or money laundering.

[ARC 4061C, IAB 10/10/18, effective 11/14/18]

187—20.5(17A,533A) Renewal of license.

20.5(1) To remain authorized to operate a debt management business, a licensee must renew a license before the expiration date of the license. A licensee who fails to renew a license before the expiration date is not authorized to operate a debt management business in Iowa after the expiration date.

20.5(2) An application to renew a license shall be submitted to the superintendent, on the form provided and with the information requested, through the NMLS by December 1 of the year of expiration. For example, for a license that will expire on December 31, 2017, an application for renewal shall be submitted by December 1, 2017. All requested information, including any material change to information contained in the original application, shall be provided to the superintendent. The superintendent may assess late fees of up to \$10 per day for applications submitted and accepted for processing after December 1.

20.5(3) The superintendent shall grant an application to renew a license if:

a. The licensee submits the application and the appropriate renewal fee by December 1 or the licensee submits the application after December 1 but before January 1 and pays the appropriate renewal fee and the appropriate late fee;

b. The application is fully completed and includes all necessary information; and

c. The application does not reveal grounds to deny a license.

20.5(4) It is within the discretion of the superintendent to reject for processing a renewal application submitted after December 31 or to treat such an application as an application for a new license. A licensee who fails to renew a license before the expiration date is not authorized to operate a debt management business in Iowa after the expiration date.

[ARC 4061C, IAB 10/10/18, effective 11/14/18]

187—20.6(17A,533A) Changes in the licensee's name, location, or control.

20.6(1) A licensee wishing to change the name or location of a debt management business shall notify the superintendent at least 30 days prior to the requested change. The request shall include proof that the licensee has either obtained a new bond or amended the existing bond to reflect the new name or location. The licensee shall submit a \$25 fee per license in conjunction with the request. A licensee may not operate a debt management business under a different name without providing such notice and submitting the required fee.

20.6(2) A licensee wishing to establish a branch office must submit the application to the superintendent, on the form provided and with the information requested, through the NMLS, along with a fee of \$250. Licenses issued to branch offices are treated as independent licenses and are subject to the renewal requirements, fees, and procedures specified in rule 187—20.5(17A,533A).

20.6(3) When change in control of a licensee is proposed, the party that will assume control of the licensee shall give notice to the superintendent at least 60 days before the proposed change will take effect. Change in control is defined in Iowa Code section 533A.5A. The party that will assume control of the licensee shall furnish the superintendent with the same information required of initial applicants for a license, along with a fee of \$100. The party that will assume control may be required to provide fingerprints, authorize a fingerprint background check through the NMLS, and pay the appropriate fees for the purpose of conducting a national criminal history background check through the Federal Bureau of Investigation. The superintendent shall approve or deny the request in accordance with the provisions of Iowa Code section 533A.3.

20.6(4) Failure to notify the superintendent within the prescribed time as required by this rule may subject the licensee to disciplinary action.

[ARC 4061C, IAB 10/10/18, effective 11/14/18]

187—20.7(17A,533A) Notice of significant events. A licensee shall notify the superintendent immediately and in writing within ten days of the occurrence of any of the following events.

20.7(1) The licensee or any of the licensee's officers, directors, principal stockholders, or affiliates file for bankruptcy protection or commence reorganization proceedings.

20.7(2) A prosecuting authority files criminal charges against the licensee or any of the licensee's officers, directors, principal stockholders, or affiliates.

20.7(3) Another state or jurisdiction institutes license denial, cease and desist, suspension or revocation procedures, or other formal or informal regulatory action against the licensee or any of the licensee's officers, directors, principal stockholders, or affiliates.

20.7(4) The attorney general of Iowa, the Federal Trade Commission, or the enforcer of the consumer protection laws of any other jurisdiction initiates an action to enforce the consumer protection laws against the licensee or any of the licensee's officers, directors, principal stockholders, or affiliates.

[ARC 4061C, IAB 10/10/18, effective 11/14/18]

187—20.8(17A,533A) Administrative fees.

20.8(1) *Examination or investigation fees.* A licensee shall pay an investigation or examination fee as determined by the superintendent based on the actual cost of the operation of the finance bureau of the banking division, as described in Iowa Code section 533A.10(1).

20.8(2) *Late fees for failing to respond.* In the process of administering this chapter, the superintendent may require a person to provide responses to formal orders, examinations, or complaint inquiries. If a person fails to respond within 30 days of the request, the superintendent may assess a penalty of \$10 per day after the initial 30 days.

20.8(3) *NMLS system processing fees.* In addition to the fees set forth in this chapter, the applicant or licensee shall pay any fee assessed by the NMLS attributed to the licensee's record in the NMLS including but not limited to the initial set-up fee and annual processing fee.

[ARC 4061C, IAB 10/10/18, effective 11/14/18]

187—20.9(17A,533A) Licensee records.

20.9(1) *General record requirements.* A licensee must keep records that allow the superintendent to determine the licensee's compliance with relevant statutes and regulations.

a. The licensee may keep the records as a hard copy or in an electronic equivalent.

b. The licensee shall keep records for at least 36 months from the date of the final transaction with the debtor.

c. The licensee shall maintain all books and records in good order and shall produce books and records for the superintendent upon request. Failure to produce such books and records within 30 days of the superintendent's request may be grounds for disciplinary action against the licensee.

d. The obligation to maintain records continues even after the licensee ceases business operations in Iowa and turns in or surrenders its license. The owners and directors of the licensee are responsible for ensuring that this requirement is met.

20.9(2) *Required records.* A licensee operating a debt management business shall keep, at its principal place of business, an index, a client log, an account file, and an account ledger.

20.9(3) *Index.* All records kept by a debt management business shall be accessible by the debtor's name and account number.

20.9(4) *Client log.* The client log is a chronological list of active and inactive clients. The client log shall include the name of the client, the account number, the date the account was opened, the date the account was closed, and the expiration date of the account.

20.9(5) *Account file.* The account file consists of the application, the licensee's comprehensive review of the debtor's debts and monthly budget as required by Iowa Code section 533A.8(2), a copy

of the debt management contract, and all disclosures to the debtor required by Iowa Code section 533A.8(3).

20.9(6) *Account ledger.* A licensed debt management business whose debt management program is based on a model which requires the licensee or any licensee to receive money or evidences thereof from the debtor to distribute to the debtor's creditors shall maintain an account ledger for each debtor, which shall show:

a. The name and address of the debtor, the account number, the amount of the debtor's outstanding debts, and the total of payments the debtor has made to the licensee.

b. A transaction history that lists all transactions with the debtor and the debtor's creditors. Payments from the debtor shall be posted to the account ledger, effective the date the payments were received, and shall show the date payment was received and the total amount of the payment. Payments to the debtor's creditors made from the debtor's account shall be posted to the account ledger effective the date the payments were made. The account ledger shall show the date the payment was made, the total amount of the payment, and a description of how the payment was applied to the debtor's account. Fees that the licensee deducts from the debtor's account shall be posted to the account ledger effective the date the fees were collected, and the account ledger shall show the date the fees were collected and the total amount of fees collected. Other transactions shall be fully described. Corrections to the transaction history shall be made by corrective entry and not by erasure.

20.9(7) *General business records.* A licensee must keep the following general business records for at least 36 months:

a. All checkbooks, check registers, bank statements, deposit slips, withdrawal slips, and canceled checks (or copies thereof) relating to the debt management business of the licensee.

b. Complete records (including invoices and supporting documentation) for all expenses and fees paid on behalf of each applicant for debt management or debt settlement, including a record of the date and amount of all such payments actually made by each applicant.

c. Copies of all federal tax withholding forms, reports of income for federal taxation, and evidence of payments to all employees, independent contractors, and others compensated by a licensee in connection with the conduct of the debt management business.

d. All correspondence and other records relating to the maintenance of any surety bond required by Iowa Code chapter 533A.

e. Copies of all reports of audits, examinations, inspections, reviews, investigations, or other similar functions performed by any third party, including but not limited to the superintendent or any other regulatory or supervisory authority.

f. Copies of all advertisements and solicitations concerning debt management or debt settlement directed at Iowa residents, including advertisements and solicitations on the Internet or by other electronic means, in the format (e.g., recorded sound, video, print) in which the advertisements and solicitations were published or distributed.

20.9(8) *Disposal of records.* If a licensee or former licensee disposes of records at the end of the retention period, the licensee or former licensee shall dispose of the records in a reasonable manner that safeguards any identification information, as defined in Iowa Code section 715A.8(1) "a." The owners and directors of licensees and former licensees are responsible for ensuring that this requirement is met. [ARC 4061C, IAB 10/10/18, effective 11/14/18]

187—20.10(17A,533A) Complaints and investigations.

20.10(1) The superintendent may, at any time and as often as the superintendent deems necessary, investigate a licensee and examine the licensee's books, accounts, records, and files.

20.10(2) The superintendent may investigate complaints about, or alleged violations by, any licensee.

20.10(3) The following shall constitute a complaint or alleged violation:

a. A written complaint received from a consumer, member of the public, employee, business affiliate, or governmental agency.

b. Notice to the superintendent from any source that the licensee has been the subject of disciplinary proceedings in another jurisdiction.

c. Notice to the superintendent from any source that the licensee has been convicted of forgery, embezzlement, obtaining money under false pretenses, extortion, conspiracy to defraud, or other similar offense, in a court of competent jurisdiction in this state or in any other state, territory, or district of the United States, or in any foreign jurisdiction.

[ARC 4061C, IAB 10/10/18, effective 11/14/18]

187—20.11(17A,533A) Disciplinary action.

20.11(1) The superintendent has authority pursuant to Iowa Code chapters 533A and 17A to impose discipline for violations of Iowa Code chapter 533A and the rules promulgated thereunder.

20.11(2) Grounds for discipline. The superintendent may impose any of the disciplinary sanctions set out in Iowa Code section 533A.7(2) when the superintendent finds any of the following:

a. The licensee has violated a provision of Iowa Code chapter 533A or a rule adopted under Iowa Code chapter 533A or any other state or federal law applicable to the conduct of the licensee's business.

b. A fact or condition exists which, had it existed at the time of the licensee's original application for a license, would have warranted the superintendent to refuse to issue the original license.

c. The licensee is found upon investigation to be insolvent, in which case the license shall be revoked immediately.

d. The licensee has violated an order of the superintendent.

e. The licensee fails to fully cooperate with an examination or investigation, including failing to respond to an inquiry from the superintendent within 30 days of the date the superintendent mails a written communication directed to the licensee's last-known address on file with the superintendent.

f. The licensee has engaged in any conduct that subverts or attempts to subvert an examination or investigation by the superintendent.

g. The licensee continues to operate a debt management business without an active and current license.

h. The licensee operates a debt management business in the same location as another business without the superintendent's written approval.

i. The licensee has abandoned its place of business for 60 or more days.

j. The licensee fails to notify the superintendent within ten days of the occurrence of one of the significant events set forth in rule 187—20.7(17A,533A).

k. Another state or jurisdiction has denied, suspended, revoked, or refused to renew the licensee's license, registration, or authorization to operate a debt management business under the other state's or jurisdiction's law.

l. The licensee fails to create and maintain complete and accurate records as required by state or federal law, regulation, or rule.

m. The licensee fails to notify the superintendent of a change in ownership, name, or principal place of business.

n. The licensee fails to pay a license fee required by Iowa Code chapter 533A or to maintain a bond required by Iowa Code chapter 533A.

20.11(3) The superintendent shall not refund a license fee, in whole or in part, for a license that has been suspended, revoked, or surrendered.

[ARC 4061C, IAB 10/10/18, effective 11/14/18]

187—20.12 Reserved.

187—20.13(17A,533A) Restrictions on operating a debt management business. A licensee shall adhere to the following restrictions related to operating a debt management business.

20.13(1) Licensees shall not engage in any of the acts prohibited by Iowa Code section 533A.11.

20.13(2) Licensees may not establish branch locations outside the United States.

[ARC 4061C, IAB 10/10/18, effective 11/14/18]

These rules are intended to implement Iowa Code chapter 533A.

[Filed ARC 4061C (Notice ARC 3954C, IAB 8/15/18), IAB 10/10/18, effective 11/14/18]

CHAPTERS 21 to 24
Reserved

TITLE II
INSTITUTIONS
CHAPTER 20
INSTITUTIONS ADMINISTRATION
[Prior to 10/1/83, Social Services[770] Ch 16]
[Prior to 3/20/91, Corrections Department[291]]

201—20.1(904) Application of rules. The rules in this chapter apply to all adult correctional institutions unless otherwise stated. The institutions covered by these rules are the Iowa state penitentiary, Fort Madison, the Anamosa state penitentiary, Anamosa, the Iowa correctional institution for women, Mitchellville, the Iowa medical and classification center, Oakdale, the Newton correctional facility, Newton, the Mt. Pleasant correctional facility, Mt. Pleasant, the Clarinda correctional facility, Clarinda, the north central correctional facility, Rockwell City, and the Fort Dodge correctional facility, Fort Dodge.

201—20.2(904) Title II definitions.

“*Class I Disciplinary Report*” means the same as a major report and is defined in department policy IO-RD-03.

“*Class II Disciplinary Report*” means the same as a minor report and is defined in department policy IO-RD-02.

“*Commercially published information or material*” means any book, booklet, pamphlet, magazine, periodical, newsletter, photograph or other pictorial depiction, or similar document, including stationery and greeting cards, published by any individual, organization, company, or corporation, which is distributed or made available through any means or media for commercial purposes. This definition includes any portion extracted, photocopied, or clipped from such items.

“*Contraband*” means weapons; alcohol; drugs; money; obscene materials; or materials advocating disruption of or injury to incarcerated individuals, employees, programs, or physical facilities. Contraband shall also include anything which is illegal to possess under federal or state law; anything which is against institutional regulations; drugs or alcohol or materials which are used in the production or use of drugs or alcohol or weapons, explosives, or potential weapons and explosives; and altered authorized property. The term also includes possession or use of any prohibited communication device.

“*Department*” means the Iowa department of corrections.

“*Features*” means that the publication contains depictions of nudity or sexually explicit conduct on a routine or regular basis or promotes itself based upon such depictions in the case of individual one-time issues. Publications containing nudity illustrative of medical, educational, or anthropological content may be excluded from this definition.

“*Furlough*” means any temporary release from custody as granted in accordance with Iowa Code section 904.108(2).

“*Furlough residence*” means any private dwelling, apartment, house, trailer court, hotel, motel or community dwelling place.

“*Immediate family*” means an incarcerated individual’s spouse, mother, father, sister, brother, child, grandparent, established legal guardian or other who acted in place of parents, and step- or half-relation if the step- or half-relation and the incarcerated individual were raised as cohabiting siblings.

For the purpose of visitation, all the above will be included as immediate family provided a positive relationship exists. Immediate family members may be subject to criminal background investigation.

“*Law enforcement checks*” means prescheduled, in person, check-ins at designated law enforcement agencies such as police departments, sheriff’s offices and highway patrol offices.

“*Medical practitioner*” means medical doctor, osteopathic physician or physician assistant employed by the department.

“*Nudity*” means a pictorial depiction where genitalia or female breasts are exposed. When the pictorial depiction of the female breast displays the areola or nipple, this material will be rejected.

“*Obscene material*” means the same as that described in 20.6(5).

“Performance evaluation” means evaluation of work and program participation as well as other areas of behavior.

“Plan of payment” means the method by which the incarcerated individual is to make restitution. The plan may include legal financial obligations. The plan is to reflect the incarcerated individual’s present circumstances, such as income, physical and mental health, education, employment and family circumstances.

“Plan of restitution” means a plan stating the amount of restitution as set by the court.

“Publication” means a book, booklet, pamphlet, or similar document, or a single issue of a magazine, periodical, newsletter, newspaper, plus such other materials addressed to a specific incarcerated individual, such as advertising brochures, flyers, and catalogs.

“Responsible person” means an individual on the incarcerated individual’s visiting list of legal age and, in the judgment of the staff, is a person of accountability, is able to think and act rationally, and is willing to facilitate the incarcerated individual’s successful completion of furloughs within the furlough rules and facilitate the return of the incarcerated individual to the institution. A responsible person shall further mean an individual not now under indictment, sentence or conviction of an indictable public offense. Ex-felons will not be permitted to act as responsible persons for furlough until the demonstration of two years’ successful adjustment in the community after release from any supervision.

“Sexually explicit” means a pictorial depiction of actual or simulated sexual acts including sexual intercourse, oral sex, or masturbation. Sexually explicit material does not include material of a news or information type. Publications concerning research or opinions on sexual, health, or reproductive issues should be admitted unless the publications are otherwise a threat to legitimate institutional interests.

This rule is intended to implement Iowa Code section 904.108(1)“k.”

[ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter; ARC 4062C, IAB 10/10/18, effective 11/14/18]

201—20.3(904) Visits to incarcerated individuals. Visiting is a privilege which allows incarcerated individuals to maintain and strengthen relationships with family members and friends. Though visits are encouraged, institutions’ space, schedules, personnel constraints, treatment considerations, or other safety and security issues of the institutions and their operations may result in limiting the number and length of visits. Visitation is additionally governed by the provisions of department of corrections policy OP-MTV-04.

20.3(1) Definitions.

“Application” means a written application identifying the visitor and the visitor’s relationship to the incarcerated individual.

“Background investigation” means the process by which central visiting authority staff verify the accuracy of a visitor’s application for any reason.

“Central visiting authority” or *“CVA”* means the department office that conducts the visitor application approval process.

“Extended family” means the incarcerated individual’s aunts, uncles, nieces, nephews, cousins, great-grandparents, great-grandchildren, and in-laws.

“Group” means a family unit (e.g., aunt, uncle and minor nieces and nephews) residing at the same address.

“Immediate family” means an incarcerated individual’s spouse, mother, father, sister, brother, child, grandparent, grandchild (when minors become adults, they will be required to complete the formal visiting application process), established legal guardian or other who acted in place of parents, and step- or half-relation if the step- or half-relation and the incarcerated individual were raised as cohabiting siblings.

“Incarcerated individual” means a person who has been committed to the custody of the department of corrections or to a judicial district department of correctional services.

“Personal search” means a pat-down search on top of the visitor’s clothes or the nonintrusive use of an electronic search process.

“*Visiting list*” means the screened list of approved visitors with authorized visiting privileges at all department of corrections institutions.

20.3(2) *Schedule.* Each department of corrections institution will structure a visiting schedule allowing visitation for a minimum of four days per week. Each institution’s visiting room will be open a minimum of four hours on each authorized day of visiting. The warden will designate the time for visiting on certain days/holidays and advise the incarcerated individuals. The incarcerated individual is responsible for informing the visitor of the days and hours for visitation.

20.3(3) *Authorized visitors.*

a. The central visiting authority will establish an approved visiting list for each incarcerated individual. This visiting list remains valid when the incarcerated individual is transferred to another institution.

b. To meet facility design limitations and security considerations, the visiting list shall be limited to the following individuals:

(1) Immediate family members.
(2) A total of six other individuals or groups who are the incarcerated individual’s friends or extended family members.

(3) Minor children under the immediate supervision of their parent or legal guardian. The minor children of an incarcerated individual shall also be allowed to visit under the immediate supervision of any adult on the incarcerated individual’s approved visiting list.

c. Limitation. An individual on the approved visiting list of one incarcerated individual shall not be on the approved visiting list of another incarcerated individual, regardless of the location(s) of the incarcerated individuals. An exception may only be granted pursuant to 20.3(5) “*b.*”

20.3(4) *Nonauthorized visitors.*

a. The following persons shall not be authorized to visit:

(1) Individuals whose behavior represents a control problem or is counterproductive to stable behavior of an incarcerated individual. This determination may be reflected in the background investigation report which shows that the individual has a record of carrying concealed weapons, use of a controlled substance, previous violation of institutional rules, or similar behavior.

(2) Individuals under criminal indictment.

(3) Individuals on probation, work release, or parole.

(4) Individuals found to be involved with or convicted of incidents of aiding an escape or introducing contraband in any detention or supervised correctional setting.

(5) Individuals who intentionally give false information on the visitor’s application form.

(6) Individuals convicted of a felony.

(7) Individuals who may compromise the order and security of the institution.

b. A person working in any institution as a volunteer shall not be on an incarcerated individual’s visiting list except with the permission of the warden or designee.

c. Neither a victim of a sex offense, whether registered or not, nor the victim’s family members will be approved for the visiting list of the perpetrator in the victim’s case until department staff consult with the victim and restorative justice administrator of the department. Visitation requests from victims shall be considered only when the incarcerated individual has successfully completed all recommended treatment programs of the department or board of parole. If the victim’s or victim’s family member’s visitation request is denied, the victim or victim’s family member may file an appeal pursuant to 20.3(6) “*d.*”

d. A sex offender whose victim was a minor shall not be permitted to have any children on the incarcerated individual’s visiting list until the incarcerated individual has completed the sex offender treatment program. After the incarcerated individual’s completion of the treatment program, a minor victim of the incarcerated individual may be added to the incarcerated individual’s visiting list only with the approval of the institutional treatment team and the victim and restorative justice administrator of the department. Other children may be added to the incarcerated individual’s visiting list after the incarcerated individual’s completion of the treatment program and approval of the institutional treatment team.

e. An application from a victim of a crime other than a sex offense who seeks to be added to the visiting list of the perpetrator in the victim's case shall be reviewed with the victim and restorative justice administrator of the department prior to any approval or denial.

20.3(5) Exceptions. The following exceptions may be implemented by the central visiting authority upon the approval of the warden or designee.

a. The incarcerated individual's spouse, child, mother or father who is currently under department supervision or on probation, work release, or parole may be approved to visit the incarcerated individual by the warden or designee after consultation with the supervising parole/probation officer. The warden or designee may authorize either contact or noncontact visiting.

b. The warden or designee may grant an exception to the limitation in 20.3(3) "c" when the person is an immediate family member of more than one incarcerated individual and seeks to be added to the visiting lists of only those incarcerated individuals.

c. A former or current department employee or volunteer who is a member of an incarcerated individual's immediate family may be approved to visit the incarcerated individual by the warden or designee.

d. A former department employee or volunteer who is not an immediate family member of an incarcerated individual may be allowed to visit six months after leaving employment or ceasing volunteer service if the former employee or volunteer passes the normal background investigation, there are no security issues arising from the person's prior employment or volunteer service, and the CVA receives approval from the warden or designee.

e. An incarcerated individual who is an immediate family member discharged from prison without correctional supervision must wait six months before contact visits may be arranged. Noncontact visiting may be authorized only for the spouse, child, mother or father of an incarcerated individual.

20.3(6) Application process.

a. Visitor application forms shall be provided to incarcerated individuals at each institution. Incarcerated individuals are responsible for mailing visitor application forms to prospective visitors, who may then apply to be added to the incarcerated individual's visiting list. The completed visitor application form must be sent for processing to the central visiting authority at the following address: Mt. Pleasant Correctional Facility, Attn: Central Records, 1200 E. Washington, Mt. Pleasant, Iowa 52641.

b. All adults, including the incarcerated individual's own children if they are 18 years of age or older, must complete the visitor application process in order to be considered for inclusion on an incarcerated individual's visiting list.

c. Written notification. Written notification of denial of a visitor application will be given to both the incarcerated individual and the applicant within 30 days from the CVA's receipt of the application. Notification of approval of a visitor application will be given only to the incarcerated individual. The incarcerated individual is responsible for notifying the approved visitor.

d. Appeals. When an application is denied, the applicant and the incarcerated individual shall be apprised of the reasons for denial.

(1) Applicants may appeal to the warden or designee in writing. An appeal by an applicant who is the victim of a sex offense, or who is the victim's family member, and is seeking to visit the perpetrator of the crime shall be reviewed in consultation with the department sex offender treatment director or the institution's treatment director for the moderate intensity family violence prevention program.

(2) The decision of the warden or designee may be appealed to the director of the department of corrections or the director's designee. The decision of the director or the director's designee constitutes final agency action.

20.3(7) Removal from visiting list. If an incarcerated individual wishes to have a visitor removed from the incarcerated individual's visiting list, the incarcerated individual shall complete the Removal of Visitor form contained in department policy OP-MTV-04 and send it to the central visiting authority. Upon receipt of the removal request, the central visiting authority shall respond to the request within seven business days and send a copy of the removal form to the incarcerated individual. Once a visitor has been removed from a visiting list, six months must elapse before reapplication by the removed visitor.

20.3(8) Searches. Approved visitors shall be subject to search. In accordance with 20.3(14), the search may include a pat down, search by an electronic detection device, or visual search.

20.3(9) Identification. All visitors shall present proper identification upon entrance to the institution. Photo identification is preferred, but any identification presented shall identify personal characteristics, such as color of hair and eyes, height, weight, and birth date.

a. Signature cards may be required from visitors.

b. All visitors may be required to be photographed for future identification purposes only.

20.3(10) Special visitors.

a. Law enforcement. Division of criminal investigation agents, Federal Bureau of Investigation agents, and law enforcement officials shall present proof of identity upon entrance to the institution.

b. Attorneys. Attorneys must complete an initial visitor application form to visit an incarcerated individual; however, this initial application shall apply to multiple visiting lists. After initial approval is established, attorneys must contact the central visiting authority at (319)385-9511 to be added to the visiting lists of additional incarcerated individuals. Background checks are not required, and attorneys shall not be counted as a friend on an incarcerated individual's visiting list as set forth in 20.3(3) "b."

Attorneys shall present proof of identity upon entrance to the institution. The incarcerated individual must express a desire to visit with an attorney before the attorney will be admitted. Attorney visits shall be during normal visiting hours unless a special visit has been requested by the incarcerated individual and approved by the warden or designee prior to the visit.

An attorney testing positive by an electronic detection device may be required to visit without direct contact.

c. Ministers. Ministers must complete an initial visitor application form to visit an incarcerated individual; however, this initial application shall apply to multiple visiting lists. After initial approval is established, ministers must contact the central visiting authority at (319)385-9511 to be added to the visiting lists of additional incarcerated individuals. Background checks are required. Ministers shall not be counted as a friend on an incarcerated individual's visiting list as set forth in 20.3(3) "b."

Ministers shall present proof of identity upon entrance to the institution. The incarcerated individual must express a desire to visit with a minister before the minister will be admitted. Minister visits shall be during normal visiting hours unless a special visit has been requested by the incarcerated individual and approved by the warden or designee prior to the visit.

A minister testing positive by an electronic detection device may be required to visit without direct contact.

20.3(11) Termination of visiting privileges. Individuals may have visiting privileges modified or terminated when:

a. The incarcerated individual or visitor engages in behavior that may in any way be disruptive to the order and control of the institution.

b. The visitor or incarcerated individual fails to follow the established rules and procedures of the institution.

c. The visitor and incarcerated individual directly exchange or attempt to exchange any object or article. This restriction does not apply to purchases from the canteen or visiting room vending machines that are consumed during the visit.

d. The visitor tests positive for drugs or explosives as determined by an authorized electronic detection device calibrated and operated for testing for the presence of drugs or other contraband.

e. The visit or future visiting is detrimental to the health or welfare of the incarcerated individual or visitor.

f. The visitor does not supervise the visitor's children to prevent them from interfering with or disrupting other visits.

Incarcerated individuals may request reconsideration of denied visitors six months after resolution of the reason for denial or when approved by the warden or designee or institutional deputy director.

20.3(12) Noncontact visiting. The warden or designee may allow noncontact visits when the order or security of the institution may be threatened or when disciplinary rules or procedures have been violated. Noncontact visiting hours will be provided on a scheduled basis. The hours and days will be posted by

the warden or designee, and notice will be posted at least one week prior to any change. Visitors on the noncontact list at the time of a schedule change will be notified of the schedule change by regular mail sent to the last-known address.

20.3(13) *Clothing.* Visitors shall be properly attired prior to entering a correctional setting. All visitors shall wear shoes. Visitors wearing miniskirts, shorts (that are above the knee), muscle shirts, see-through clothing or halter tops will not be allowed to visit. Visitors wearing clothing with slogans, pictures, or words intended to deprecate race, sex, or cultural values will not be allowed entry. Visitors may be required to remove for the duration of the visit outerwear such as, but not limited to, coats, hats, gloves, or sunglasses. A medical need for sunglasses must be verified by prescription.

20.3(14) *Security procedures.* Visitors may be requested to submit to a personal search (pat down) or an electronic search for weapons or contraband. "Personal search" means a pat-down search on top of the visitor's clothes or the nonintrusive use of an electronic search process. If the initial electronic test confirms the presence of a controlled substance, the visitor will be given a second confirmation test. When the electronic detection device alarm is activated, the visitor shall produce the item that set off the alarm or a personal search may be made to find the item. If the visitor refuses to submit to a search, access to visiting shall be denied and entrance shall be denied. All searches shall be conducted in a courteous manner to respect the visitor's privacy. Minors are subject to personal and electronic searches. When a visitor accompanied by a minor refuses to leave the minor with a staff person and does not want the minor present during the search, the visit will be denied. When a minor is searched, the supervising adult shall be present in the room at all times.

a. The warden or designee will maintain records of all searches which produce positive results, including the name of each person subjected to a search, the names of the persons conducting and in attendance at the search, and the time, date, and place of the search. The written record shall reflect the reason for the search and the results of the search. The written authorization for the search shall be included in the record. Testing records will be maintained by the institution for one year and then expunged. Records of positive tests will be maintained for five years and then expunged. All testing records are confidential and will be released only upon the order of a court of proper jurisdiction.

b. When a visitor tests positive by an electronic search device, the visitor may appeal to the warden or designee in writing. The decision of the warden or designee may be appealed to the director of the department of corrections or the director's designee. The decision of the director or the director's designee constitutes final agency action.

c. Staff may request that local law enforcement search visitors if search procedures or an electronic testing device shows that there is a clear, reliable reason to believe a particular visitor is attempting to smuggle contraband into the facility. If the search reveals drugs or illegal contraband, the item shall be confiscated and preserved by local law enforcement. Visitors found in possession of contraband shall be referred by local law enforcement to the county attorney for prosecution.

20.3(15) *Money orders, cashier's checks, and electronic funds transfers.* Money orders and cashier's checks for deposit in the incarcerated individual's account must be made payable to the Iowa Department of Corrections Incarcerated Individual Fiduciary Account (IDOC IIFA) and sent to: Fort Dodge Correctional Facility, 1550 L Street, Suite B, Fort Dodge, Iowa 50501, and must include the incarcerated individual's name and ID number and the sender's name and complete address. Funds will also be accepted via electronic funds transfers from authorized vendors. Personal checks and cash will not be accepted. An incarcerated individual's suspected abuse of requests for money from the public may be cause for limits or restrictions on the amounts of money which can be received and from whom money can be received.

20.3(16) *Limits.* Each institution, according to its facilities and conditions, shall limit the number of visitors an incarcerated individual may have at any one time and the length of visits.

20.3(17) *Segregation status.* Incarcerated individuals who are assigned to special units such as disciplinary detention or administrative segregation status may have visits modified in regard to place, time, and visitor, depending on the staff and space available.

20.3(18) *Abuse of visiting privileges.* Visiting privileges may be modified, suspended, or terminated when abuses are evidenced or planned.

20.3(19) *Special visits.* The warden or designee may permit special visits not otherwise provided for in this rule. These may include, but are not limited to, extended visits for close family members traveling extended distances, immediate visits for close relatives or friends about to leave the area, visits necessary to straighten out critical personal affairs, and other visits for similar reasons. All these visits shall be at the sole discretion of the warden or designee. When ruling on such visits, the warden or designee shall consider appropriate factors including the uniqueness of the circumstances involved for both the incarcerated individual and the visitor; security, order, and administrative needs of the institution; and available alternatives to a special visit. The decision of the warden or designee in these cases constitutes final agency action.

20.3(20) *Temporary modifications.* Visiting procedures may be temporarily modified or suspended in the following circumstances: riot, disturbance, fire, labor dispute, space and personnel restrictions, natural disaster, or other emergency.

This rule is intended to implement Iowa Code section 904.512.
[ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter]

201—20.4(904) Mail. Constructive, unlimited correspondence with family, friends, and community sources will be encouraged and facilitated. Incarcerated individuals have the responsibility in the use of correspondence to be truthful and honest. Institutions have the responsibility to maintain a safe, secure, and orderly procedure for use of the mail by an incarcerated individual. Mail is additionally governed by the provisions of department of corrections policy OP-MTV-01.

20.4(1) *Nonconfidential.*

a. In an effort to maintain proper security measures, mail may be monitored and read on a random basis.

b. All nonconfidential mail shall be inspected for contraband.

20.4(2) *Confidential.*

a. Confidential mail, as defined in this rule, will not be read or censored.

b. Confidential mail will be delivered unopened and then, in the presence of the incarcerated individual, will be opened and inspected for contraband and to ensure that the contents are from the return addressee.

Confidential mail may be read only after a finding of probable cause by a court of competent jurisdiction that a threat to the order and security of the institution or abuse of correspondence exists.

c. Confidential letters may be written to: (the sender's name and address must be appropriately identified on the envelope)

(1) Officers of federal, state, or municipal courts (judges, judges' law clerks, prosecuting attorneys, court administrators).

(2) Federal agencies chief administrative officer, elected or appointed officials.

(3) State agencies chief administrative officer, elected or appointed officials.

(4) Clerk of court.

(5) The sentencing state department of corrections chief executive officer, deputy directors.

(6) Sentencing state board of parole.

(7) Attorney.

(8) The office of ombudsman.

(9) Any additional exception by law or policy.

(10) Civil rights commission.

d. Envelopes containing confidential correspondence shall be marked as "confidential" by the sender.

20.4(3) *General.*

a. Pursuant to Iowa Code chapter 2C, mail received from the ombudsman office shall be delivered unopened.

b. When sending confidential mail, incarcerated individuals may be requested to seal the envelope in the presence of staff after the envelope and letters have been inspected for contraband.

c. All letters mailed by incarcerated individuals will be left unsealed for inspection of the contents only. Envelopes shall contain letters to the addressee only.

d. All other nonconfidential correspondence and packages, both incoming and outgoing, shall be opened for inspection to remove items of contraband.

To facilitate institutional inspection of first-class mail, writers should avoid enclosures other than the written correspondence. Traditional items such as snapshots of appropriately clothed individuals and clippings from published material may be permitted. Each institution shall have guidelines for the amount and type allowed.

e. With the exception of weekends and holidays, incoming and outgoing mail will not be retained for more than 24 hours prior to delivery unless unusual circumstances exist such as staff shortage, suspected correspondence violations, disturbance, or similar constraints.

f. Persons under the age of 18 must provide written permission to the warden from parents or guardian before correspondence with incarcerated individuals will be allowed.

g. Incarcerated individuals under correctional supervision or detention will not be allowed to correspond with other incarcerated individuals unless the individuals are immediate family and approved by the authority of the institution or both authorities in the case of correspondence between facilities.

“Immediate family” means mother, father, sister, brother, half sister, half brother, spouse, son, daughter, natural grandparents, and natural grandchildren. Legal guardian, foster parents, stepparents, stepchildren, stepsister, and stepbrother will be included provided a positive relationship exists or contact will confer a benefit to the incarcerated individual.

h. Incarcerated individuals will be denied mail privileges with persons that might present a risk to the order and security of the institution.

i. All outgoing mail must be sent directly to the individual that the correspondence is written to, and all incoming mail must be sent directly from the individual that wrote the correspondence.

j. No limit will be placed on the number of letters mailed for incarcerated individuals able to pay the mailing costs. Incarcerated individuals who are unable to pay mailing costs for legal mail will receive limited assistance which may be recoverable.

k. Stamped, return-addressed envelopes will be sold through canteen services for all outgoing letters and will be purchased by the incarcerated individual.

l. Special equipment may be used to review envelopes for items in the envelopes other than the letter. When the contents of the correspondence is inappropriate or contraband items which are not illegal to possess under the law are found in the mail, the mail will be rejected and the incarcerated individual shall be notified with the option to return to sender or destroy.

m. When mail is rejected due to inappropriate contents of the correspondence or contraband is found, provided the correspondence is not retained for investigation or prosecution, the incarcerated individual to whom the mail was addressed will have the option of paying the postage to return the mail to the sender or having the mail destroyed by institutional staff. The incarcerated individual must choose one of the two options within three days of the rejection notice. This rule is in reference to the return of opened mail per United States Postal Service, Office of Classification and Rates Administration, Ruling #206.

The sender of rejected correspondence may protest the decision in writing to the warden.

n. All outgoing parcel post items will be packed and sealed by the mail room and postage charged to the incarcerated individual.

o. Letters will not be delivered which are written in a foreign language or code unless the foreign language is the only language of the incarcerated individual (exceptions may be made by the warden).

p. The sender’s name shall be signed in full at the end of the letter. The sender’s name and address shall appear in the upper left-hand corner of the envelope.

q. The incarcerated individual’s name, ID number, box number or street address, city, state, and zip code shall also appear on the envelope of incoming mail.

r. All outgoing mail shall contain a return address including the incarcerated individual’s name and ID number as well as the name of the institution, address, and zip code.

s. Reasonable size restrictions of envelopes may be imposed.

t. Each institution shall have written procedures for disposition (safekeeping and preservation) of contraband.

u. Only first-class letters and packages will be forwarded after an incarcerated individual's transfer or release.

v. An individual may deposit funds in an incarcerated individual's account by money order, cashier's check, or electronic funds transfer. Personal checks and cash will not be accepted. Only money orders and cashier's checks will be accepted for deposit into an incarcerated individual's account by mail. Money orders and cashier's checks must be made payable to the Iowa Department of Corrections Incarcerated Individual Fiduciary Account (IDOC IIFA) and sent to: Fort Dodge Correctional Facility, 1550 L Street, Suite B, Fort Dodge, Iowa 50501, and must include the incarcerated individual's name and ID number and the sender's name and complete address. Funds will also be accepted via electronic funds transfers from authorized vendors. An incarcerated individual's suspected abuse of requests for money from the public may be cause for limits or restrictions on the amounts of money which can be received and from whom money can be received.

w. Misuse of mails will result in institution discipline and be reported to the United States Postal Inspector or other state or federal agencies for action.

x. O-mail. "O-mail" is electronic mail that can be sent to and from incarcerated individuals and the public.

(1) The incarcerated individual's family and friends shall be responsible for registering on the corrlinks Internet site to enroll in the O-mail system: www.corrlinks.com.

(2) Each O-mail message is limited to two pages, and attachments are not allowed.

(3) There is a cost for sending an O-mail message, which shall be the responsibility of the sender.

(4) Incoming and outgoing O-mail shall meet the same standards as referenced in this rule for incarcerated individuals' mail.

(5) Staff may review the contents of O-mail messages.

[ARC 9097B, IAB 9/22/10, effective 10/27/10; ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter]

201—20.5(904) Money orders, cashier's checks, and electronic funds transfers for incarcerated individuals. An individual may deposit funds in an incarcerated individual's account by money order, cashier's check, or electronic funds transfer. Personal checks and cash will not be accepted. Only money orders and cashier's checks will be accepted for deposit into an incarcerated individual's account by mail. Money orders and cashier's checks must be made payable to the Iowa Department of Corrections Incarcerated Individual Fiduciary Account (IDOC IIFA) and sent to: Fort Dodge Correctional Facility, 1550 L Street, Suite B, Fort Dodge, Iowa 50501, and must include the incarcerated individual's name and ID number and the sender's name and complete address. Funds will also be accepted via electronic funds transfers from authorized vendors. An incarcerated individual's suspected abuse of requests for money from the public may be cause for limits or restrictions on the amounts of money which can be received and from whom money can be received.

[ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter]

201—20.6(904) Publications.

20.6(1) The institution shall allow incarcerated individuals access to publications when doing so is consistent with institutional goals of maintaining internal order, safety, security, and rehabilitation. Publications are additionally governed by the provisions of department of corrections policy OP-MTV-02.

20.6(2) Publications include any periodical, newspaper, book, pamphlet, magazine, newsletter, or similar material published by any individual, organization, company, or corporation, and made available for a commercial purpose. All publications shall be unused and sent directly from an approved publisher or bookstore which does mail order business. Any exceptions must be authorized by the warden. No publication will be denied solely on the basis of its appeal to a particular ethnic, racial, religious, or political group. The quantity of printed materials, as with other personal property, will be controlled for safety and security reasons.

20.6(3) All publications not on the approved list shall be reviewed by a publication review committee for approval or denial.

a. The committee shall be appointed by the director or designee, department of corrections, and shall include:

- (1) A person with broad exposure to various publications.
- (2) Two representatives of correctional operations.

b. The committee shall fairly review all types of publications to be received by incarcerated individuals in accordance with these rules.

20.6(4) The following procedures shall be used when a publication not on the approved list is reviewed:

a. The committee shall approve or deny publications within 30 working days of receipt of the publication.

b. When a publication is denied, the committee shall send the incarcerated individual a written notice stating the publication involved, the reason for denial, and the incarcerated individual's available appeal process.

c. The incarcerated individual shall have ten days from receipt of the notice of denial to notify the designated institution staff to destroy the publication, to specify where to send the publication at the incarcerated individual's expense, or to notify the institution that the decision is being appealed.

d. A list of approved publications shall be maintained.

20.6(5) A publication may be denied when the publication presents a danger to the security or order of an institution or is inconsistent with rehabilitation goals. Authorized reasons for denying a publication are that the publication:

- a.* Is likely to be disruptive or produce violence.
- b.* Contains material which portrays or simulates a minor (any person 17 years of age or younger) engaged in or simulating any act that is sexual in nature.
- c.* Contains lewd exhibition of the genitals or material which is sexually explicit or features nudity.
- d.* Contains information relating to escapes or formulating escape plans.
- e.* Contains information relating to provoking a riot or disturbance.
- f.* Contains information relating to obtaining an emotional or behavioral state comparable to those produced by a controlled substance, by using aerosols, glue, or other chemical materials.
- g.* Contains materials which illustrate, explain, describe, or teach martial arts, or other manufacture of weapons or explosives, or advocate behavior contrary to duly established institution rules or Iowa statutes. Contains materials which illustrate, explain, describe, or teach ability to frustrate crowd or riot control methods. Contains materials which illustrate, explain, describe, or teach ability to sabotage or disrupt communications networks, including a prison's internal and external communications and automated information systems.
- h.* Contains information concerning criminal activities.
- i.* Contains encoded material. This shall not automatically include foreign language publications not otherwise prohibited in these rules.
- j.* May violate postal regulations, such as threats, blackmail, contraband, or similar violations.
- k.* Is a pamphlet, catalog, or other publication whose purpose is primarily or significantly to sell items or materials that are expressly prohibited inside any of the department institutions. The warden can make exceptions for materials that serve reentry efforts.

[ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter; ARC 4062C, IAB 10/10/18, effective 11/14/18]

201—20.7(904) Interviews and statements.

20.7(1) When incarcerated individuals are selected to be interviewed and photographed within the institution, either individually or as part of a group, identifiable interviews or pictures shall have the written consent of the incarcerated individual involved as well as prior consent of the warden or designee.

20.7(2) The warden is responsible for all communications with mass media.

[ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter]

201—20.8(904) Guests of institution. Persons wishing to visit the institution shall give prior notice of their intended visit and receive approval for the visit. The prior notice and approval may be waived by the warden or designee for emergencies.

20.8(1) Any guest must agree to comply with the policy and procedures of the institution when signing in at the control center.

20.8(2) Persons under 18 years of age may only visit with prior approval of the warden or designee and shall be accompanied by a responsible adult. An adult shall be in charge of no more than four children. Persons under 18 years of age shall not be allowed to make institutional tours of maximum security prisons.

20.8(3) Guests shall be escorted by a staff member. Any exception shall have prior approval of the warden or designee.

20.8(4) Guests shall be allowed personal contact with an incarcerated individual only when it serves the best interests of the incarcerated individual as determined by the warden or designee.

20.8(5) All contacts with incarcerated individuals shall be absent of any encouragement, support, or suggestion of activity which would bring disorder to the institution.

[ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter]

201—20.9(904) Donations. Donations of money, books, games, recreation equipment or other such gifts shall be made directly to the warden. The warden shall evaluate the donation in terms of the nature of the contribution to the institution program. The warden is responsible for accepting the donation and reporting the gift to the institutional deputy director on a monthly basis.

[ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter]

201—20.10(904) Incarceration fees. The director may charge incarcerated individuals an incarceration fee, pursuant to Iowa Code section 904.108.

[ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter]

201—20.11(904,910) Restitution.

20.11(1) Every incarcerated individual required by a court order to pay restitution shall have a restitution plan and a restitution plan of payment developed, unless a court-ordered restitution plan has been completed.

20.11(2) The restitution plan of payment shall consider the present circumstances of an incarcerated individual's physical/mental health and other legal financial obligations.

20.11(3) The deputy director of institutions shall ensure that there are written procedures governing the development and modification of each restitution plan and plan of payment.

20.11(4) Each incarcerated individual shall be given a Predeprivation Notice: Notice of Intent to Deduct Restitution From All Account Credits and Notice of Opportunity to Respond during initial reception following admission to the Iowa medical and classification center (IMCC) or the Iowa correctional institution for women (ICIW).

20.11(5) Initial complaints by incarcerated individuals regarding restitution plans of payment or modifications may be addressed via the grievance procedure for incarcerated individuals.

20.11(6) The staff shall explain the restitution plan of payment to the incarcerated individual. Each incarcerated individual shall receive a copy of the restitution plan of payment.

20.11(7) Restitution payments shall be deducted from all credits to an incarcerated individual's account. Up to 50 percent may be deducted. The following are exempt for deductions from credits to an incarcerated individual's account from an outside source:

a. An amount, assessed by the warden or designee, specifically for medical costs. The same percent as established in the restitution plan will be deducted from any amount over the total amount assessed. If the medical procedures are not performed or carried out, the money shall be returned to the sender at the incarcerated individual's expense.

b. An amount, assessed by the warden or designee, specifically for the cost of a funeral trip. The same percent as established in the restitution plan will be deducted from any amount over the total amount assessed.

c. An amount as assessed by the appropriate authority specifically for transportation fees as a result of work release/OVI violations or compact transfers. The same percent as established in the restitution plan will be deducted from any amount over the total amount assessed.

d. An account transfer from one institution to another.

e. Refunds from outside vendors or institution commissaries.

f. Property tort claims.

g. Any other exception approved by the warden or designee.

20.11(8) Restitution deductions shall be forwarded to the clerk of court in the county of commitment on a quarterly basis.

20.11(9) When the department of corrections has knowledge of other income or assets the district court clerk of the sentencing county shall be so notified.

20.11(10) A percent greater than that established in the restitution plan of payment may be deducted from a credit to an incarcerated individual's account by authorization of either the incarcerated individual or the warden or designee or by court order.

20.11(11) The restitution plan of payment may be modified through each level of commitment. (This includes preinstitutional services and postinstitutional services.)

This rule is intended to implement Iowa Code chapter 904 and sections 910.2, 910.3 and 910.5.
[ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter]

201—20.12(904) Furloughs.

20.12(1) Furloughs are a privilege, not a right, and may be denied or canceled at any time for reasons deemed sufficient by the warden. Reasons for denial or cancellation shall be given to the incarcerated individual.

20.12(2) Emergency family furlough shall be considered in the event of a death or imminent death in the immediate family.

20.12(3) Emergency medical furlough is for those incarcerated individuals whose medical condition has deteriorated to the point of incapacitation or to a comatose state.

20.12(4) Both emergency family furloughs and emergency medical furloughs shall have approval of the warden and the institutional deputy director.

20.12(5) Furloughs are additionally governed by the provisions of the department's furlough policy IS-RL-04.

[ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter]

201—20.13(904) Board of parole interviews. Each institution provides space for the conduct of interviews between the Iowa board of parole and institutional incarcerated individuals. When these meetings are held in correctional institutions, attendance is subject to security and safety regulations as stated herein. Any exception to these rules must have prior approval of the director of the department of corrections or designee.

20.13(1) Persons desiring to attend a board of parole interview who are not on an incarcerated individual's visiting list shall notify the warden of the respective institution of their intent to attend. A visitor's application will be sent to the person, and the completed application must be received back by the institution at least 15 days prior to the scheduled date of the parole interview in order that a background investigation with law enforcement officials may be completed prior to attendance at the parole interview. Following a successful background investigation, authorization to attend parole interviews will be continuous subject to these rules and any subsequent background investigations conducted at the discretion of the warden .

20.13(2) Due to security considerations, those persons excluded from applying for visitation privileges pursuant to subparagraphs 20.3(4) "a" (1) to (7), inclusive, are also excluded from attending parole board interviews as listed below:

a. Individuals who have been discharged from a correctional institution within the last 18 months.

b. Individuals whose behavior represents a control problem or is counterproductive to the rehabilitation of the incarcerated individual. This may be reflected in the background investigation

report which shows the individual's having a record of carrying concealed weapons, irresponsible or illegal use of a controlled substance, previous violation of institutional rules, or similar behavior.

- c. Individuals on probation, work release or parole.
- d. Individuals who have been convicted of incidents of aiding an escape or introducing contraband in any detention or supervised correctional setting.
- e. Individuals who intentionally give false information.
- f. Ex-felons.
- g. When the interview is held inside the institution proper, no children under the age of 18 are allowed.

20.13(3) Due to security considerations the following rules shall apply:

- a. Written notification of approval or denial will be given to the requester.
 - (1) When approved, the requester shall be informed on the notification:
 - 1. That the attendee may be subject to a search (paragraph 20.13(3) "f") when a staff member has an articulable reason to believe that the attendee is concealing contraband;
 - 2. That the search may include a pat down, a strip search, or a visual body cavity probe search; and
 - 3. That the requester need not submit to a strip search although refusal may result in the forfeiture of attendance.
 - (2) When denied, the applicant shall be apprised of the reasons for denial.
- b. All requesters shall present proper identification upon entrance to the institution. Photo identification is preferred, but all identification shall identify personal characteristics, such as color of hair and eyes, height, weight and birth date.
 - (1) Signature cards may be required from requesters.
 - (2) All requesters may be required to be photographed for future identification purposes only.
- c. Individuals may be required to leave the institution when:
 - (1) The incarcerated individual or attendee engages in behavior that may in any way be disruptive to order and control of the institution.
 - (2) The attendee fails to follow the established rules and procedures of the institution.
 - (3) The attendee and incarcerated individual directly exchange any object or article.
 - (4) The attendee talks or communicates with an incarcerated individual.
 - (5) The effect of alcohol or narcotic drugs is detected on the attendee before or during the interview.
 - (6) There is detriment to the health of the incarcerated individual or attendee.
 - (7) The attendee does not manage children.
- d. Minors outside the immediate family shall have written permission from their parent or guardian and be accompanied by an adult. All children shall have adult supervision. Exceptions shall have prior approval of the warden or designee.
- e. Attendees shall be properly attired as would be expected in a public meeting place. Adults and teenagers shall wear shoes and may not wear miniskirts, shorts, muscle shirts, see-through clothing, halter tops, clothing with obscene or lewd slogans, pictures or words, and similar apparel. Attendees may be required to remove, for the duration of the interview, outerwear such as, but not limited to, coats, hats, gloves, and sunglasses. A medical need for sunglasses must be verified by prescription.
- f. Attendees may be requested to submit to a personal search (pat down) or review by an electronic device for weapons or contraband. When the electronic device alarm is activated, the attendee shall produce the item or a personal search may be made to find the item that set off the alarm. Attendees may be requested to submit to a strip search when there is an articulable reason to believe the person is concealing a weapon or contraband. Each institution shall designate the level of authority required to request a search through institutional policy. This person shall authorize the search in writing. The designation required pursuant to subrule 20.3(8) for visitation will suffice for this subrule as well. Entrance may be denied when the attendee is not willing to submit to a search. The request for a search shall be conducted in an inconspicuous manner. The attendee may verbally request a review by the warden or designee at the time of request for a search.

(1) Strip search means having a person remove or arrange some or all of their clothing so as to permit an inspection of the genitalia, buttocks, anus, female breasts, or undergarments of that person or a physical probe of any body cavity. Personal search means a pat down search on top of the attendee's clothing.

(2) The search will be to the degree deemed appropriate or necessary. A strip search will be conducted only when the following conditions exist:

1. The search is conducted in a place where it cannot be observed by persons not conducting the search.

2. The search is conducted by a person of the same sex as the visitor, unless conducted by a medical practitioner or licensed registered nurse. A second correctional employee of the same sex as the attendee shall also be present during the search. In addition, the attendee may request a third person of the same sex as the attendee to be present during the search.

3. A visual search or probing of any body cavity shall be performed under sanitary conditions. A physical probe of a body cavity other than the mouth, ear, or nose shall be performed only by a medical practitioner. In the absence of a medical practitioner, a licensed registered nurse will conduct the search and report the findings to the on-call medical practitioner.

4. It will be permissible and not considered a body cavity search to request that a female attendee remove a sanitary napkin or tampon.

(3) An attendee accompanied by a minor child has the option of not having the child present during a strip search or pat down. The child will be attended by a staff person. When attendee refuses to leave the child with a staff person and does not want the child present during the search, attendance will be denied. At all times when a minor child is searched, the supervising adult may be present in the room.

(4) When an attendee is arrested, the attendee may be searched for weapons which may inflict harm on the arresting officer.

(5) Records shall be kept of all strip searches and shall include the name of the person subjected to the search, the names of the persons conducting and in attendance at the search, the time, date, and place of the search. The written record shall reflect the reason for the search and the results of the search. The written authorization for the search shall be included in the record.

(6) Attendees found in possession of contraband shall be referred to the county attorney for prosecution.

20.13(4) The space provided for the parole interviews shall have a posted maximum capacity set by the fire marshal. The number of individuals in the room shall not exceed the maximum capacity. Individuals will be admitted on a first-come, first-serve basis.

20.13(5) Cameras and recording devices are permitted with the following exceptions:

a. Media equipment is subject to search prior to admittance and at any time said equipment is inside the institution. Search shall be conducted in the presence of the photographer.

b. Should the attendees be required to pass through areas of the institution where for reasons of security or right to privacy media equipment is disallowed, the use of such equipment is prohibited in those areas.

20.13(6) Interviews may be temporarily modified or suspended in the following circumstances: riot, disturbance, fire, labor dispute, space restriction, natural disaster, or other extreme emergency.

20.13(7) Refer to Iowa Administrative Code, Parole Board[205] for rules governing conduct at the hearings as required by the Iowa board of parole.

20.13(8) Rules that apply to registered victims are found in subrule 20.15(7).

This rule is intended to implement Iowa Code sections 904.102 and 904.103.

[ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter]

201—20.14(80A) Transportation for incarcerated individuals.

20.14(1) Companies under contract to county or state agencies to transport Iowa incarcerated individuals must meet the requirements of this rule to qualify for exemption under Iowa Code section 80A.2.

20.14(2) To comply with the exemption in Iowa Code section 80A.2, the following requirements shall apply:

a. Companies contracting with any jurisdiction/agency within the state of Iowa shall provide, upon request, training and compliance with policy standards governing weapons, security, transportation, and management procedures for incarcerated individuals essential to accomplishing safe and secure movement of incarcerated individuals.

b. Companies contracting to provide transportation for incarcerated individuals with a jurisdiction/agency within the state of Iowa shall provide proof of insurance coverage including, but not limited to, comprehensive general liability, automobile liability, workers' compensation insurance, all inclusive policies, general liability, and errors or omissions.

c. Companies contracting with any jurisdiction/agency within the state of Iowa shall provide the names, dates of birth, and social security numbers of all transportation personnel for criminal history checks.

d. All transporting personnel shall possess appropriate and valid driver's licenses as required by the regulatory agencies.

e. All transporting vehicles shall be licensed under the appropriate Interstate Commerce Commission (ICC) regulations and the state where the vehicle is registered.

f. All transmitting/receiving radios and communication equipment shall comply with Federal Communications Commission (FCC) regulations.

g. This exemption applies only to transportation companies for incarcerated individuals. This exemption does not provide exemption for any other part of this statute.

This rule is intended to implement Iowa Code section 80A.2.
[ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter]

201—20.15(910A) Victim notification.

20.15(1) Definitions.

"Notification" means mailing by regular mail or providing for hand delivery of appropriate information or papers. However, this notification procedure does not prohibit an agency from also providing appropriate information to a registered victim by telephone.

"Registered" means having provided the appropriate office, agency, or department with the victim's written request for notification and current mailing address and telephone number.

"Victim" means a person who has suffered physical, emotional, or financial harm as the result of a public offense, other than a simple misdemeanor, committed in this state. The term also includes the immediate family members of a victim who died or was rendered incompetent as a result of the offense or who was under 18 years of age at the time of the offense.

"Violent crime" means a forcible felony, as defined in Iowa Code section 702.11, and includes any other felony or aggravated misdemeanor which involved the actual or threatened infliction of physical or emotional injury on one or more persons.

20.15(2) A victim of a violent crime may become registered with the department of corrections which entitles the victim to be notified when the incarcerated individual is to be released in any of the following situations:

a. Work release. Approximate date of release and whether the incarcerated individual is expected to return to the community where the victim resides will be provided.

b. Furlough. Date of leave, date of return and whether the incarcerated individual is expected to return to the community where the victim resides will be provided.

c. Escape. Date of escape will be provided.

d. Expiration of sentence. Date of discharge from an institution will be provided.

e. Recommendations for parole. The institution has submitted a recommendation for parole.

f. Parole. Approximate date of release and whether the incarcerated individual is expected to return to the community where the victim resides.

20.15(3) A victim will become registered upon official request by the county attorney to the Director, or designee, Iowa Department of Corrections, 510 East 12th Street, Des Moines, Iowa 50319.

20.15(4) Assistance for registering may be obtained through the county attorney or by contacting the department of corrections, director of victim programs, at (515)725-5701.

20.15(5) All information with regard to a registered victim will be kept confidential.

20.15(6) A registered victim is responsible for notifying the department of corrections of address or telephone changes.

20.15(7) Registered victims of the Iowa board of parole may attend hearings in accordance with the following rules:

a. Registered victims by the parole board have the right to appear at the parole/work release hearing of the incarcerated individual(s) either personally or by counsel.

b. The parole board notifies victims of any scheduled parole/work release hearings where the board will interview the incarcerated individual not less than 20 days prior to the hearing.

c. The parole board notification will request any victim(s) planning to attend a hearing to notify the warden of the intention to attend prior to the hearing.

d. A victim may only be denied attendance when, in the opinion of the warden or designee, the victim(s) presents a threat to the security and order of the institution.

e. If a victim is denied attendance at a hearing, the parole board shall be notified immediately.

f. The security director or designee should consider separation of the victim(s) and family/friends in attendance at the same hearing. If there are any signs of conflict between the victim(s) and family/friends of incarcerated individuals, the victim(s) shall be escorted out of the institution to avoid an unsupervised contact situation on institution grounds.

This rule is intended to implement Iowa Code section 910A.9.
[ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter]

201—20.16 Reserved.

201—20.17(904) Institutional community placement.

20.17(1) *Home care program.* This program allows for selected incarcerated individuals to be released from institutional confinement for a set period of time for the purpose of caring for the incarcerated individual's immediate family. Release may be to a community correction residential facility/halfway house or to the incarcerated individual's home, home of an immediate family member, or other approved arrangements, provided the living environment is suitable to institutional requirements. Release may be for a set number of hours or days as appropriate.

a. Eligibility criteria.

(1) The incarcerated individual must be the natural parent or legal guardian of the child/children.

(2) The incarcerated individual must show cause that this program can provide more suitable care than the present living situation of the child/children.

(3) The child/children must be minor(s).

(4) The incarcerated individual must have been the primary caretaker of the child/children prior to incarceration.

(5) Investigating staff must be able to confirm that the incarcerated individual had satisfactorily served this care prior to incarceration.

(6) The proposed living arrangements shall provide a suitable environment for the incarcerated individual and dependents.

(7) The physical structure of the residence shall provide for adequate space, meet sanitary, health and safety requirements, and be in good repair. A functional telephone must be maintained in the residence at all times.

(8) It will be verified that the incarcerated individual, including spouse or immediate family member living at the same residence, can and will provide adequate support towards the child, children, or other dependent. Eligibility requirements for assistance through the department of human services programs (FIP, food stamps, etc.) will be verified prior to final approval.

(9) It will be verified that the incarcerated individual or immediate family living at the residence can provide adequate transportation or that public transportation is available.

(10) Adequate support services (medical, psychological, educational, as well as other treatment programs) must be arranged and available to both the incarcerated individual and dependents.

(11) Dependent care for an adult member of the incarcerated individual's immediate family must include a medically documented need with periodic supervision or other approved arrangements by a health-trained professional.

b. Requirements.

(1) Education/employment/child care/adult dependent care. Where all dependents are involved in full-time school, participation in an educational or employment program may be required of the incarcerated individual. Where such dependents are not yet in school, child care may be considered as full-time employment.

(2) Child care/adult dependent care. Child care shall be provided in the home. Therefore, the residence will be considered as the designated place of assignment. Deviations from same shall be reported to staff in advance.

20.17(2) Work program—eligibility criteria. This program allows for selected incarcerated individuals to be released from institutional confinement for a period of time for gainful employment in the community. The program may also include placement in a community corrections residential facility/halfway house, or to the incarcerated individual's home, home of an immediate family member, or other approved arrangements, provided the living environment is suitable to institutional requirements. Release may be for a set number of hours or days as appropriate.

a. The incarcerated individual must show a substantial need and interest for participation in the program.

b. The incarcerated individual must seek and apply for employment through established procedures of the furlough program or through institutional correspondence, telephone, or visiting procedures.

c. Suitable employment and verification must be obtained by staff prior to consideration.

20.17(3) Educational program—eligibility criteria. This program allows for selected incarcerated individuals to be released from institutional confinement for a period of time for educational opportunities in the community. This program may also include placement in a community corrections residential facility/halfway house or to the incarcerated individual's home, home of an immediate family member, or other approved arrangements, provided the environment is suitable to institutional requirements. Release may be for a set number of hours or days as appropriate.

a. The incarcerated individual must show a substantial need and interest for participation in the program.

b. The incarcerated individual must seek educational opportunities and financial support through established procedures of the furlough program or through institutional correspondence, telephone, or visiting procedures (financial arrangements can only include family support or grants). Educational loans or loans of any type will not be allowed while on institutional count. Additional community corrections restriction may apply while under community supervision.

20.17(4) General requirements for all three programs.

a. Participation in any of these programs at any level is a privilege, not a right, of which participating incarcerated individuals are subject to and held accountable for all provisions of this policy as well as the specific program plan.

b. Institutional progress and recommended program participation must reflect an average or above rating.

c. Incarcerated individuals must be furlough-eligible in accordance with furlough eligibility standards in DOC policy IS-RL-04 and rule 201—20.12(904).

d. If applicable, community corrections residential/halfway house rules and regulations will apply as well as institutional rules including all program plan rules.

e. Local authorities will be contacted to determine possible concerns (correctional services, county attorney, law enforcement).

f. The incarcerated individual may be required to submit to periodic or regular U.A. Testing (this procedure may be completed at any correctional institution, community corrections facility/office, or at the residence).

g. All activity will be monitored by community corrections staff and institutional staff as agreed.

h. All employment and educational earnings, less payroll deductions including education grants and expenses, shall be surrendered to the residential facility/halfway house staff according to established procedures or to the institution business manager, whichever applies, according to the program plan. Employment earning deductions will be prioritized in accordance with Iowa Code section 904.905 for all levels of placement.

i. Contact frequency. A minimum of one home visit and one other face-to-face contact per month is required of staff. Furthermore, a sufficient number of collateral contacts will be made each month to ensure that the incarcerated individual is meeting requirements of the program plan.

j. Special needs. In situations where incarcerated individuals or the family have special needs, a case planning system shall be incorporated to address needs, capabilities, and specific goals. Special attention shall be given to past or immediate problems.

k. Travel. Supervisory staff may grant permission for travel within the state. Standard policy will apply to out-of-state travel.

l. Temporary absence. Incarcerated individuals may temporarily leave the residence for necessary purposes such as shopping, religious services, family recreation, medical appointments, employment, etc., as indicated on the plan.

20.17(5) Application procedures.

a. Applications must be made to the present institutional classification committee (utilizing Form 1).

b. The application must contain all pertinent information and resources for the requested program.

c. The classification committee shall review each case considering all standards and criteria.

d. The classification committee's recommendation must be approved by the warden.

e. If approved by the warden, the recommendation and all pertinent information shall be forwarded to the institutional deputy director for final approval.

f. If the recommendation is approved by the institutional deputy director, the incarcerated individual must agree to abide by all rules established in the program plan including institutional rules and community corrections rules as well as all local, state, and federal laws.

g. Each level of review has the authority to deny the application or to make changes in the program plan including level of placement, i.e., institutional, residential/halfway house, home, as well as electronic monitoring devices.

h. Incarcerated individuals placed in any of these programs will not be relieved of paying restitution or any other financial obligation as required by the court or institution.

20.17(6) Violations.

a. Violation of any rule set forth in the program plan including any additional rules set forth by any authority listed in this policy may constitute the revocation of participation in either program at any level.

b. Revocation may also occur for improper care of children or dependents, inadequate earnings, failure to maintain employment or unacceptable employment conduct, rule violations, or failure to meet program expectations.

20.17(7) Program activity. This rule does not create any liberty interest in the incarcerated individual's continued participation in any of the programs at any level listed under this rule, and the department of corrections or its designee(s) reserves the right to revoke, suspend, or limit/restrict program activity from the listed programs for any reason, without hearing.

20.17(8) Waiver of liberty interests. As a condition for an incarcerated individual to participate in any of the programs at any level listed under this rule, the incarcerated individual must voluntarily waive any and all liberty interests to a hearing should the department exercise its right to revoke, suspend or limit/restrict program activity. This waiver must be signed prior to an incarcerated individual's

acceptance into a program. The signed waiver shall remove any and all rights to due process should the department exercise its right to revoke, suspend or limit/restrict program activity.

This rule is intended to implement Iowa Code section 904.910.
[ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter]

201—20.18(904) Violator/shock probation programs. Rescinded ARC 3929C, IAB 8/1/18, effective 9/5/18; see Delay note at end of chapter.

201—20.19 Reserved.

201—20.20(904) Incarcerated individuals' telephone commissions.

20.20(1) Definitions.

“*Corrections board*” means the department of corrections board.

“*Deputy director of institutions*” means the person responsible for operation of institution services.

“*Director*” means the chief executive officer of the department of corrections.

“*Financial manager of administration*” means the person responsible for budgeting and planning.

“*Warden*” means the chief executive officer of the institution or correctional facility.

20.20(2) Deposit of funds. The department of corrections shall deposit and account for all telephone commissions in a clearing account within the central office. The financial manager of administration will determine commissions generated by each institution, based on a report from the vendor, for deposit in the institution's telephone rebate fund for incarcerated individuals.

20.20(3) Request for funds. Each warden will determine recurring needs and special projects and submit a written proposal to the deputy director of institutions for all expenditures and encumbrances.

20.20(4) Review and approval of expenditures. The deputy director of operations and the financial manager of administration will review the proposals for a quarterly presentation by the director to the corrections board for approval. The director will notify the chairpersons and ranking members of the justice system's appropriations subcommittee of the proposals prior to the corrections board approval. All expenditures and encumbrances shall require prior approval from the corrections board and the deputy director of operations. Institutions shall not be allowed to encumber or expend funds without approval. Revenues generated by telephone commissions at each institution shall be used to determine the availability of funds for each project.

20.20(5) Permitted expenditures. The director shall advance to the corrections board for approval only projects that benefit incarcerated individuals. Expenditures may include, but are not limited to, projects that provide educational, vocational or recreational services or projects, or work or treatment programs for incarcerated individuals. Expenditures may also be used to initiate new programs, services, or projects. Institutions shall give spending priority to programs, services, and projects that promote the health and welfare of incarcerated individuals.

This rule is intended to implement Iowa Code section 904.508A.
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[◊] Two or more ARCs

¹ September 5, 2018, effective date of ARC 3929C [amendments to chs 1, 5, 10, 11, 20, 38, 40, 41, 42, 43, 44, 45, 47, 50, 51] delayed 70 days by the Administrative Rules Review Committee at its meeting held August 14, 2018.

ECONOMIC DEVELOPMENT AUTHORITY[261]

[Created by 1986 Iowa Acts, chapter 1245]

[Prior to 1/14/87, see Iowa Development Commission[520] and Planning and Programming[630]]

[Prior to 9/7/11, see Economic Development, Iowa Department of[261];
renamed Economic Development Authority by 2011 Iowa Acts, House File 590]

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CHAPTER 403
IOWA ENERGY CENTER

261—403.1(15) Purpose. The Iowa energy center is established within the authority with the following purposes:

1. To expand workforce and career opportunities for workers in the energy sector to ensure that the state is able to attract and train professionals to meet the state's future energy needs.
2. To support technology-based development by encouraging public-private partnerships and innovative manufacturers to develop and bring to market new energy technologies.
3. To support rural and underserved areas and vulnerable populations by creating opportunities for greater access to energy efficiency expertise, training, programs, and cyber security preparedness for small utilities.
4. To support the expansion of natural gas infrastructure to rural and underserved areas of the state where the absence is a limiting factor to economic development.
5. To promote and fund research, development, and commercialization of biomass technology to benefit the state economically and environmentally by further realizing the value-added attributes of biomass in the development of bioenergy, biofuels, and biochemicals.
6. To encourage growth of the alternative fuel vehicle market, particularly for electric vehicles, and the infrastructure necessary to support the market.
7. To support efforts to modernize the electric grid infrastructure of the state to support increased capacity and new technologies.

[ARC 4063C, IAB 10/10/18, effective 11/14/18]

261—403.2(15) Definitions. As used in these rules, unless the context otherwise requires:

“*Authority*” means the economic development authority created in Iowa Code section 15.105.

“*Board*” means the governing board of the Iowa energy center established pursuant to Iowa Code section 15.120(2), and includes the members appointed to the board by the governor.

“*Center*” means the Iowa energy center established pursuant to Iowa Code section 15.120.

“*Committee*” means a committee established by the board.

“*Director*” means the director of the authority.

“*Internet site*” means the information and related content maintained by the authority and found at www.iowaeconomicdevelopment.com. “Internet site” may include content at affiliated sites whose content is integrated with that site, including the Iowa energy center website.

[ARC 4063C, IAB 10/10/18, effective 11/14/18]

261—403.3(15) Iowa energy center board.

403.3(1) Composition. A governing board is established consisting of the following members appointed by the governor:

- a. One member representing Iowa state university of science and technology, in consultation with the president of that university.
- b. One member representing the university of Iowa, in consultation with the president of that university.
- c. One member representing the university of northern Iowa, in consultation with the president of that university.
- d. One member representing private colleges and universities within the state, in consultation with the Iowa association of independent colleges and universities.
- e. One member representing community colleges, in consultation with the Iowa association of community college trustees.
- f. One member representing the economic development authority, in consultation with the director of the economic development authority.
- g. One member representing the state department of transportation, in consultation with the director of the department of transportation.

h. One member representing the office of consumer advocate, in consultation with the consumer advocate.

i. One member representing the utilities board, in consultation with the chair of the utilities board.

j. One member representing rural electric cooperatives, in consultation with the Iowa association of electric cooperatives.

k. One member representing municipal utilities, in consultation with the Iowa association of municipal utilities.

l. Two members representing investor-owned utilities, one representing gas utilities, and one representing electric utilities, in consultation with the Iowa utility association.

403.3(2) Terms. Members of the board are appointed for staggered terms of four years beginning and ending as provided in Iowa Code section 69.19. A person appointed to fill a vacancy serves only for the unexpired portion of the term. A member is eligible for reappointment. Any vacancy shall be filled by the governor as provided for in Iowa Code section 15.120(2). The terms of board members shall be staggered as determined by the director.

403.3(3) Quorum and voting requirements. A quorum of the board requires nine or more members, and any board action requires an affirmative vote by a majority of the members present.

403.3(4) Board officers. The board shall elect a chairperson and a vice chairperson annually and may elect other officers as necessary.

403.3(5) Meetings.

a. Meetings of the board are held at the call of the chairperson or when two members of the board request a meeting. The board generally meets quarterly at the authority's offices located at 200 East Grand Avenue in Des Moines, Iowa. By notice of the regularly published meeting agendas, the board and its committees may hold regular or special meetings at other locations within the state. Meeting agendas are available on the authority's website.

b. Meetings of the board and any committee it may establish are conducted in accordance with the provisions of Iowa Code chapter 21. Any person may attend and observe the proceedings of the board and committee meetings except for those portions of the meetings conducted in closed session pursuant to Iowa Code section 21.5. Persons observing may use cameras or recording devices during the meeting so long as the use of such devices does not interfere with the proceedings. The chairperson may order any person to discontinue the use of such a device if the chairperson believes it is causing an interference with the proceedings. The chairperson may have any person excluded who fails to comply with such an order. The chairperson may also exclude any person generally causing a disruption of the proceedings.

403.3(6) Committees. The board may, from time to time, establish advisory committees for purposes of overseeing the center, its programs, and its operations. Such committees include but are not limited to the following:

a. A grant committee, the purpose of which shall be to assist the board in making awards of grants under the center's programs.

(1) The grant committee is an advisory body comprised of voting members of the board who are selected annually by the voting members of the board. The membership and size of the committee as well as the terms of the committee members will be established annually by the board.

(2) The members of the grant committee will elect a chairperson. The chairperson may appoint members of the grant committee to serve on a grant committee subcommittee if necessary. Such a subcommittee is advisory only and may perform such duties as may be assigned by the chairperson.

(3) The duties of the grant committee may include reviewing applications for grant awards, conducting a thorough review of proposed grant applications, making recommendations to the board regarding the size and condition of grant awards, and any other duty assigned by the board in relation to the programs administered by the center.

(4) A majority of the committee members constitutes a quorum of the committee.

b. A loan committee, the purpose of which shall be to assist the board in making loan awards under the center's programs, including the alternate energy revolving loan program.

(1) The loan committee is an advisory body comprised of voting members of the board who are selected annually by the voting members of the board. The membership and size of the committee as well as the terms of the committee members will be established annually by the board.

(2) The members of the loan committee will elect a chairperson. The chairperson may appoint members of the loan committee to serve on a loan committee subcommittee if necessary. Such a subcommittee is advisory only and may perform such duties as may be assigned by the chairperson.

(3) The duties of the loan committee may include reviewing applications for loans, conducting a thorough review of proposed loan applications, making recommendations to the board regarding the size and condition of loans, and any other duty assigned by the board in relation to the programs administered by the center.

(4) A majority of the committee members constitutes a quorum of the committee.
[ARC 4063C, IAB 10/10/18, effective 11/14/18]

These rules are intended to implement Iowa Code section 15.120.

[Filed ARC 4063C (Notice ARC 3842C, IAB 6/20/18), IAB 10/10/18, effective 11/14/18]

CHAPTERS 404 to 409
Reserved

PART XIII
IOWA BROADBAND DEPLOYMENT GOVERNANCE BOARD

CHAPTER 410
BOARD STRUCTURE AND PROCEDURES
Rescinded **ARC 1573C**, IAB 8/20/14, effective 9/24/14

CHAPTER 7
APPEALS AND HEARINGS

[Ch 7, July 1973 IDR Supplement, renumbered as Ch 81]

[Prior to 7/1/83, Social Services[770] Ch 7]

[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter applies to contested case proceedings conducted by or on behalf of the department. The definitions in rule 441—7.1(17A) apply to the rules in both Division I and Division II of Chapter 7. [ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.1(17A) Definitions.

“*Administrative hearing*” means a type of hearing that an appellant may elect in which the presiding officer reviews the written record only and makes a decision based on the facts available within the appeal file. An administrative hearing does not require an in-person or teleconference hearing. The final determination to establish whether an administrative hearing may be held will be made by the appeals section or the presiding officer.

“*Administrative law judge*” means an employee of the department of inspections and appeals who conducts appeal hearings.

“*Agency*” means the Iowa department of human services, including any of its local, institutional, or central administrative offices.

“*Aggrieved person*” means a person against whom the department has taken an adverse action. This includes a person who meets any of the conditions in rule 441—7.2(17A).

“*Appeal*” denotes a review and hearing request made by a person who is affected by a decision made by the agency or its designee. An appeal shall be considered a contested case within the meaning of Iowa Code chapter 17A.

“*Appeals advisory committee*” means a committee consisting of central office staff who represent the department in the screening of proposed decisions for the director.

“*Appeals section*” means the unit within the department of human services that receives appeal requests, certifies requests for hearing, and issues final appeal decisions.

“*Appellant*” denotes the person who claims or asserts a right or demand or the party who takes an appeal from a hearing to an Iowa district court.

“*Attribution appeal*” means an appeal to determine if additional resources can be allocated for the community spouse when the other spouse has entered a medical institution or is applying for home-and community-based waiver services. The result of the attribution appeal may affect Medicaid eligibility. An appellant may elect to have an attribution appeal held by administrative hearing.

“*Authorized representative*” means a person or organization designated by an appellant to act on the appellant’s behalf or who has legal authority to act on behalf of the appellant, such as a guardian or power of attorney.

“*Bidder*” means an individual or entity that submits a proposal in response to a competitive procurement issued by the department of human services.

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

“*Department*” means the Iowa department of human services.

“*Department of inspections and appeals*” means the state agency that contracts with the department to conduct appeal hearings.

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

“*Due process*” denotes the right of a person affected by an agency decision to receive a notice of decision or notice of action and an opportunity to be heard at an appeal hearing and to present an effective defense.

“*Electronic account*” means a web-based account established by the department for an applicant or member for communication between the department and the applicant or member.

“Electronic case record” means an electronic file that includes all information collected and generated by the department regarding each individual’s Medicaid or healthy and well kids in Iowa eligibility and enrollment, including all documentation required for eligibility and any information collected or generated as part of a fair hearing process conducted by the department or through the exchange appeals process.

“Ex parte communication” means written, oral, or other forms of communication between a party to the appeal and the presiding officer while an appeal is pending when all parties were not given the opportunity to participate.

“Exchange” means an American health benefit exchange established pursuant to Section 1311 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148). This entity makes qualified health plans available to qualified individuals and qualified employers.

“First-level review” means a review process that must be exhausted through a managed care organization before an appeal hearing is granted. Once the first-level review process is complete, a notice of decision will be issued by the managed care organization and will identify further appeal rights, if applicable.

“FMAP-related” describes coverage groups whose eligibility criteria are derived in relation to the family medical assistance program, directed toward children and their parents or caretakers.

“Food assistance administrative disqualification hearing” means a type of hearing used to determine if an individual fraudulently received benefits for which the individual was not eligible. A presiding officer shall determine if the individual will be banned from participating in the food assistance program for a period of time.

“Group hearings” denotes an opportunity for two or more persons to present their case jointly when all have the same complaint against agency policy.

“Informal conference” means a type of meeting between the appellant and the appellant’s representative, unless precluded by federal law or state statute, and a representative of the department. The purpose of the informal conference is to provide information as to the reasons for the intended adverse action, to answer questions, to explain the basis for the adverse action, to provide an opportunity for the appellant to explain the appellant’s action or position, and to provide an opportunity for the appellant to examine the contents of the case record, including any electronic case record, plus all documents and records to be used by the department at the hearing in accordance with 441—Chapter 9.

“In person or face-to-face hearing” means an appeal hearing conducted by an administrative law judge who is physically present in the same location as the appellant.

“Intentional program violation” means deliberately making a false or misleading statement; or misrepresenting, concealing, or withholding facts; or committing any act that is a violation of the Food and Nutrition Act of 2008, food assistance program regulations, or any state law relating to the use, presentation, transfer, acquisition, receipt, possession, or trafficking of an electronic benefit transfer (EBT) card. An intentional program violation is determined through a food assistance administrative disqualification hearing. The hearing may result in a period of ineligibility for the program, a claim for overpayment of benefits, or both.

“Local office” means the county, institution or district office of the department of human services.

“Managed care organization” or *“MCO”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” in Iowa Code section 514B.1.

“Party” means a party as defined in Iowa Code subsection 17A.2(8).

“Prehearing conference” means a type of meeting between the appellant and the appellant’s representative, unless precluded by federal law or state statute, a representative of the department and a presiding officer. The purpose of the prehearing conference is to discuss the appealed issue, to inquire as to the potential for voluntary settlement, to establish the hearing date, to establish the location of the hearing including whether the hearing will be by telephone or in person, and to discuss procedural matters relevant to the case.

“*Presiding officer*” means an administrative law judge employed by the department of inspections and appeals. The presiding officer may also be the department’s director or the director’s designee. The presiding officer has the authority to conduct appeal hearings and render proposed and final decisions.

“*Presumption*” denotes an inference as to the existence of a fact not known or drawn from facts that are known.

“*PROMISE JOBS discrimination complaint*” means any written complaint filed in accordance with the provisions of rule 441—7.8(17A) by a PROMISE JOBS participant or the participant’s representative which alleges that an adverse action was taken against the participant on the basis of race, creed, color, sex, national origin, religion, age, physical or mental disability, or political belief.

“*PROMISE JOBS displacement grievance*” means any written complaint filed with a PROMISE JOBS contractee by regular employees or their representatives that alleges that the work assignment of an individual under the PROMISE JOBS program violates any of the prohibitions against displacement of regular workers described in rule 441—93.17(239B).

“*Proposed decision*” means the presiding officer’s recommended findings of fact, conclusions of law, and decision and order in contested cases where the department did not preside.

“*Reconsideration*” means a review process that must be exhausted before an appeal hearing is granted. Such review processes include, but are not limited to, a reconsideration request through:

1. The Iowa Medicaid enterprise (IME),
2. A division or bureau within the department,
3. The mental health and disability services commission,
4. A licensed health care professional as specified in 441—paragraph 9.9(1)“i,” or
5. Any division or bureau within the department, from a bidder in a competitive procurement bid process.

Once the reconsideration process is complete, a notice of decision or notice of action will be issued with appeal rights.

“*Sent*” means deposited in the mail with first-class postage or posted to an individual’s electronic account.

“*SSI-related*” describes medical assistance coverage groups whose eligibility criteria, except for income and resource limits, are derived from the supplemental security income (SSI) program for people who are aged, blind, or disabled.

“*Teleconference hearing*” means an appeal hearing conducted by an administrative law judge over the telephone.

“*Timely notice period*” is the time from the date a notice is sent to the effective date of action. That period of time shall be at least ten calendar days, except in the case of probable fraud of a beneficiary. When probable fraud exists, “timely notice period” shall be at least five calendar days from the date a notice is sent.

“*Vendor*” means a provider of health care under the medical assistance program or a provider of services under a service program.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 9254B, IAB 12/1/10, effective 1/1/11; ARC 0304C, IAB 9/5/12, effective 11/1/12; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 0583C, IAB 2/6/13, effective 4/1/13; ARC 0819C, IAB 7/10/13, effective 9/1/13; ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 1611C, IAB 9/3/14, effective 11/1/14; ARC 3093C, IAB 6/7/17, effective 7/12/17]

441—7.2(17A) Conditions of an aggrieved person. To be eligible for an appeal hearing, a person must meet the definition of “aggrieved person” in rule 441—7.1(17A) and qualify on a program-specific basis.

7.2(1) Financial assistance. Financial assistance includes, but is not limited to, the family investment program; refugee cash assistance; child care assistance; emergency or disaster assistance; family or community self-sufficiency grants; family investment program hardship exemptions; and state supplementary assistance dependent person, in-home health-related care, and residential care facility benefits. Issues may include:

- a. A request to be given an application was denied.
- b. An application for assistance has been denied or has not been acted on in a timely manner.
- c. The effective date of assistance is contested.

- d. The amount of benefits granted is contested.
- e. The assistance will be reduced or canceled.
- f. An overpayment of benefits has been established, and repayment is requested.

7.2(2) Food assistance. Issues may include:

- a. A request to be given an application was denied.
- b. An application for assistance has been denied or has not been acted on in a timely manner.
- c. The effective date of assistance is contested.
- d. The amount of benefits granted is contested.
- e. The assistance will be reduced or canceled.
- f. A request to receive a credit for benefits from an electronic benefit transfer (EBT) account has been denied.

- g. An overpayment of benefits has been established, and repayment is requested.

7.2(3) Medical assistance eligibility. Medical assistance eligibility includes, but is not limited to, FMAP-related coverage groups, SSI-related coverage groups, the breast and cervical cancer treatment program, the health insurance premium payment program, healthy and well kids in Iowa (HAWK-I), the Iowa Health and Wellness Plan, and waiver services. Issues may include:

- a. A request to be given an application was denied.
- b. An application has been denied or has not been acted on in a timely manner.
- c. The person's eligibility has been terminated, suspended or reduced.
- d. The level of benefits the person is eligible to receive has been reduced.
- e. A determination of the amount of medical expenses that must be incurred to establish income eligibility for the medically needy program or a determination of income for the purposes of imposing any premiums, enrollment fees or cost sharing is contested.

- f. The level of care requirements have not been met.

- g. The failure to take into account the appellant's choice in assignment to a coverage group.

- h. The effective date of assistance is contested.

- i. The amount or effective date of one of the following is contested:

- (1) Health insurance premiums,
- (2) Healthy and well kids in Iowa premiums,
- (3) Medicaid for employed people with disabilities premiums,
- (4) Iowa Health and Wellness Plan contributions,
- (5) Client participation, or
- (6) Medically needy program spenddown.

- j. An overpayment of benefits has been established, and repayment is requested.

7.2(4) Fee-for-service medical coverage. Issues may include:

- a. The level of services that the person is eligible to receive has been reduced.
- b. The level of services provided by a nursing facility is not needed based on a preadmission screening and resident review (PASRR) evaluation.
- c. The effective date of services is contested.
- d. A claim for payment or prior authorization has been denied.
- e. The medical assistance hotline has issued notification that services not received or services for which an individual is billed are not payable by medical assistance.

f. Nonemergency medical transportation services by the broker designated by the department pursuant to rule 441—78.13(249A) have been denied.

7.2(5) Managed care organization medical coverage.

a. A Medicaid member, an authorized representative or a provider who is acting on behalf of a member has been notified that the first-level review process through a managed care organization has been exhausted and remains dissatisfied with the outcome.

b. If a provider or authorized representative is acting on behalf of a member by filing this type of appeal, the member's written consent to appeal must be submitted on Form 470-5526, Authorized Representative for Managed Care Appeals, with the appeal request. If the appeal is filed verbally, the

managed care organization or agency is responsible for obtaining the member's written consent for the provider or authorized representative.

c. If the managed care organization fails to adhere to the notice and timing requirements in 42 CFR 438.408, the Medicaid member, authorized representative or provider who is acting on behalf of the member is deemed to have exhausted the managed care organization's appeals process. The Medicaid member, authorized representative or provider who is acting on behalf of the member may initiate a state fair hearing.

7.2(6) Providers. Providers can be an individual or an entity. Issues may include:

a. A license, certification, registration, approval or accreditation has been denied or revoked or has not been acted on in a timely manner.

b. A fee-for-service claim for payment or request for prior authorization of payment has been denied in whole or in part and the provider states that the denial was not made according to department policy.

c. A medical assistance patient manager contract has been terminated.

d. A payment has been withheld to recover a prior overpayment, or an order to repay an overpayment pursuant to 441—subrule 79.4(7) has been received.

e. An application for child care quality rating has not been acted upon in a timely fashion.

f. A child care quality rating decision is contested.

g. A certificate of child care quality rating has been revoked.

h. An adverse action has been taken relating to the Iowa electronic health record incentive program pursuant to rule 441—79.16(249A), including:

(1) Provider eligibility determination,

(2) Incentive payments, or

(3) Demonstration of adopting, implementing, upgrading and meaningful use of technology.

i. An application or reapplication for licensure was issued as a provisional license.

j. A license has been issued for a limited time.

7.2(7) Social services. Social services include, but are not limited to, adoption, foster care, and family-centered services. Issues may include:

a. A request to be given an application was denied.

b. An application for services or payment for adoption subsidy or foster care has been denied or has not been acted on in a timely manner.

c. An application or license has been denied based on a record check evaluation.

d. A determination that a person must participate in a service program is contested.

e. A claim for payment of services has been denied.

f. A protective or vendor payment has been established.

g. The services have been reduced or canceled.

h. An overpayment of services has been established, and repayment is requested.

i. An adoptive placement of a child has been denied or delayed when an adoptive family is available outside the jurisdiction with responsibility for handling the child's case.

j. A referral to community care was not made as provided in rule 441—186.2(234).

k. A referral to community care as provided in rule 441—186.2(234) was made and the community care provider's dispute resolution process has been exhausted.

7.2(8) Child support recovery. Issues may include:

a. A person is not entitled to a support payment in full or in part because of the date of collection, as provided under rule 441—95.13(17A), or a dispute based on the date of collection has not been acted on in a timely manner.

b. A claim or offset is contested as provided in 441—subrule 95.6(3), 95.7(8), or 98.81(3) by a person's alleging a mistake of fact. "Mistake of fact" means a mistake in the identity of the obligor or in whether the delinquency meets the criteria for referral or submission. The issue on appeal shall be limited to a mistake of fact. Any other issue may be determined only by a court of competent jurisdiction.

c. A name has been certified for passport sanction as provided in Iowa Code section 252B.5.

d. A termination in services has occurred as provided in rule 441—95.14(252B).

7.2(9) PROMISE JOBS. Issues may include:

- a. A claim for participation allowances has been denied, reduced, or canceled.
- b. The contents of the family investment agreement are not sufficient or necessary for the family to reach self-sufficiency.
- c. The results of informal grievance resolution procedures are contested, an opportunity for an informal grievance resolution has been declined, or a decision was not made within the 14-day period.
- d. PROMISE JOBS services will be canceled due to imposition of a limited benefit plan.
- e. An overpayment of benefits has been established, and repayment is requested.
- f. Acts of discrimination are alleged on the basis of race, creed, color, sex, age, physical or mental disability, religion, national origin, or political belief.

7.2(10) Child abuse registry, dependent adult abuse registry, or record check evaluation. Issues may include:

- a. A person is alleged responsible for child abuse.
- b. A correction of dependent adult abuse information has been requested.
- c. A record check evaluation restricted or denied employment in a health care facility, state institution, or other facility. "Employment" includes, but is not limited to, service as an employee, a volunteer, a provider, or a contractor. "Facility" includes, but is not limited to, county or multicounty juvenile detention homes and juvenile shelter care homes, child-placing agencies, substance abuse treatment programs, group living foster care facilities, child development homes, child care centers, state resource centers, mental health institutes, and state training schools.
- d. A record check evaluation results in the restriction of participation in an educational training program.

7.2(11) Mental health and disability services. Issues may include:

- a. An application for state payment under 441—Chapter 153, Division IV, has been denied or has not been acted upon in a timely manner.
- b. Services under the state payment program have been reduced or canceled.
- c. A request to be given an application was denied.
- d. The person's eligibility has been terminated, suspended or reduced.
- e. The level of benefits or services the person is eligible to receive has been reduced.
- f. The effective date of assistance or services is contested.
- g. The reconsideration process has been exhausted, and a person remains dissatisfied with the outcome.
- h. The amount or effective date of cost-sharing requirements for the autism support program is contested.
- i. A service authorization request for applied behavioral analysis services has been denied or reduced.

7.2(12) HIPAA (Health Insurance Portability and Accountability Act). A current or former applicant for or recipient of Medicaid or HAWK-I, or a person currently or previously in a department facility whose request:

- a. To restrict use or disclosure of protected health information was denied.
- b. To change how protected health information is provided was denied.
- c. For access to protected health information was denied. When the denial is subject to reconsideration under 441—paragraph 9.9(1) "i," persons denied access due to a licensed health care professional's opinion that the information would constitute a danger to that person or another person must first exhaust the reconsideration process.
- d. To amend protected health information was denied.
- e. For an accounting of disclosures was denied.

7.2(13) Drug manufacturers. A manufacturer that has received a notice of decision regarding disputed drug rebates pursuant to the dispute resolution procedures of a national drug rebate agreement or an Iowa Medicaid supplemental drug rebate agreement disagrees with the decision.

7.2(14) Bidders that have participated in a competitive procurement bid process. Appeals resulting from a competitive procurement bid process will be handled pursuant to Chapter 7, Division II.

7.2(15) Family planning program. Issues may include:

- a. A request to be given an application was denied.
- b. An application has been denied or has not been acted on in a timely manner.
- c. The person's eligibility has been terminated or reduced.
- d. Who contests the effective date of assistance or services.
- e. Whose claim for payment or prior authorization has been denied.
- f. Who has received notice from the medical assistance hotline that services not received or services for which an individual is being billed are not payable by the family planning program.
- g. Who has been notified that an overpayment of benefits has been established and repayment is requested.

7.2(16) Other individuals or providers. Individuals or providers that are not listed in rule 441—7.2(17A) may meet the definition of an aggrieved person if the department has taken an adverse action against that individual or provider.

[ARC 3093C, IAB 6/7/17, effective 7/12/17; ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17; ARC 3871C, IAB 7/4/18, effective 8/8/18]

DIVISION I

441—7.3(17A) Presiding officer. Appeal hearings shall be conducted by a presiding officer appointed by the department of inspections and appeals pursuant to Iowa Code section 10A.801. The presiding officer shall not be connected in any way with the previous actions or decisions on which the appeal is made. Nor shall the presiding officer be subject to the authority, direction, or discretion of any person who has prosecuted or advocated in connection with that case, the specific controversy underlying that case, or any pending factually related contested case or controversy involving the same parties.

441—7.4(17A) Notification of hearing procedures. Hearing procedures shall be published in the form of rules and shall be made available to all applicants, recipients, appellants, and other interested groups and individuals. Procedures for hearings shall be identified in the notice of hearing issued to all parties as provided in subrule 7.10(7).

7.4(1) Hearing procedures must be furnished in electronic and paper format and orally as appropriate. The procedures must be written in plain language and in a manner that is accessible:

- a. To individuals who are limited English proficient through oral interpretation, written translations, and taglines in non-English languages indicating the availability of language services. The services shall be at no cost to the individual.
- b. To individuals living with disabilities through the provision of auxiliary aids in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. The services shall be at no cost to the individual.

7.4(2) The department shall inform individuals of the availability of the services and how to access such services.

[ARC 1261C, IAB 1/8/14, effective 3/1/14]

441—7.5(17A) The right to appeal. An aggrieved person who qualifies for an appeal as stated in rule 441—7.2(17A) may file an appeal. The appeals section shall determine whether a hearing shall be granted.

7.5(1) When a hearing is granted. A hearing shall be granted to any appellant when the right to a hearing is granted by state or federal law, except as limited in subrules 7.5(2) and 7.5(4).

7.5(2) When a hearing is not granted. A hearing shall not be granted when:

- a. One of the following issues is appealed:
 - (1) The service is no longer available through the department.
 - (2) Repayment of food assistance benefits as a result of trafficking has been requested on Form 470-4179, Notice of Food Assistance Trafficking Debt.
 - (3) Payment for a medical claim has been made in accordance with the Medicaid payment schedule for the service billed.

- (4) Children have been removed from or placed in a specific foster care setting.
- (5) Children have not been placed with or have been removed from a preadoptive family.
- (6) A qualified provider or qualified entity has denied a person presumptive eligibility for Medicaid under 441—subrule 75.1(30), 75.1(40), or 75.1(44).
- (7) A qualified provider or qualified entity has determined a person to be presumptively eligible for Medicaid under 441—subrule 75.1(30), 75.1(40), or 75.1(44), but presumptive eligibility ends due to the person's failure to file an application.
- (8) Notice has been issued from the treasury offset program for a food assistance overpayment.
- (9) A rate determination for foster group care services has been reviewed under rule 441—152.3(234).
- (10) The maximum provider rate ceiling has been contested for child care assistance under 441—subrule 170.4(7).
- (11) The risk pool board has accepted or rejected an application for assistance from the risk pool fund or the tobacco settlement fund risk pool fund in whole or in part under rules 441—25.66(426B) and 441—25.77(78GA,ch1221).
- (12) The appellant has a complaint about child support recovery matters other than those described in numbered paragraph "5" of the definition of an aggrieved person in rule 441—7.1(17A). This includes collection of an annual fee for child support services as specified in Iowa Code chapter 252B.
- (13) The appellant has a complaint about a local office employee (when this is the only issue of the appeal).
- (14) A request for an exception to policy under 441—subrule 1.8(1) has been denied.
- (15) A final decision from a previous hearing with a presiding officer has been implemented.
- (16) The issue appealed is not eligible for further hearing based on the doctrine of issue preclusion.
- (17) The appeal involves patient treatment interventions outlined in the patient handbook of the civil commitment unit for sexual offenders.
- (18) A provider or an authorized representative, for a managed care appeal, fails to submit Form 470-5526, Authorized Representative for Managed Care Appeals, providing the member's approval of the request for appeal.
- (19) Notice was issued by the exchange regarding determination of eligibility for enrollment in a qualified health plan or for advance payment of the premium tax credit or cost-sharing reductions.
- (20) Notice has been issued regarding the completion of a family assessment that indicates no determination of child abuse or neglect has been made and no information has been reported to the child abuse registry.
- (21) Notice has been issued regarding an MCO grievance request.
- (22) Notice has been issued by an MCO to a provider regarding a claims dispute issue.
 - b.* Either state or federal law requires automatic grant adjustment for classes of recipients. The director of the department shall decide whether to grant a hearing in these cases. When the reason for an individual appeal is incorrect grant computation in the application of these automatic adjustments, a hearing may be granted.
 - c.* State or federal law or regulation provides for a different forum for appeals.
 - d.* The appeal is filed prematurely as:
 - (1) There is no adverse action by the department,
 - (2) The appellant has not exhausted the reconsideration process, or
 - (3) The appellant has not exhausted the first-level review process with a managed care organization except as provided at paragraph 7.2(5)"*c.*"
 - e.* Upon review, it is determined that the appellant does not meet the criteria of an aggrieved person as defined in rule 441—7.1(17A).
 - f.* The sole basis for denying, terminating or limiting assistance under 441—Chapter 47, 441—Chapter 58 or 441—Chapter 87 is that funds for the respective programs have been reduced, exhausted, eliminated or otherwise encumbered.
 - g.* Rescinded IAB 6/7/17, effective 7/12/17.
 - h.* The issue appealed is moot.

i. The issue appealed has previously been determined in another appeal by the same appellant.

7.5(3) Group hearings. The appeals section may respond to a series of individual requests for hearings by requesting the department of inspections and appeals to conduct a single group hearing in cases in which the sole issue involved is one of state or federal law or policy or change in state or federal law or policy. An appellant scheduled for a group hearing may withdraw and request an individual hearing.

7.5(4) Time limit for granting hearing to an appeal. Subject to the provisions of subrule 7.5(1), when an appeal is made, the granting of a hearing to that appeal shall be governed by the following timeliness standards:

a. General standards. In general, a hearing shall be held if the appeal is made within 30 days after official notification of an action or before the effective date of action. When the appeal is made more than 30 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

(1) The director may grant a hearing if one or more of the following conditions existed:

1. There was a serious illness or death of the appellant or a member of the appellant's family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The appellant offers a good cause beyond the appellant's control, which can be substantiated.
4. There was a failure to receive the department's notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

(2) The time in which to appeal an agency action shall not exceed 90 days. Appeals made more than 90 days after notification shall not be heard.

(3) The day after the official notice is sent is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

b. Food assistance, medical assistance eligibility, fee-for-service medical coverage, family planning program or autism support program standard. For appeals regarding food assistance, medical assistance eligibility, fee-for-service medical coverage, the family planning program or the autism support program, a hearing shall be held if the appeal is made within 90 days after official notification of an action.

c. Managed care organization medical coverage. For appeals regarding a health care decision made by a managed care organization, a hearing shall be held if the appeal is made within 120 days after written notification that the first-level review process through the managed care organization has been exhausted. A hearing shall be held if the appeal is made within 120 days after the appeal is deemed to have exhausted the managed care organization's appeals process, as provided in paragraph 7.2(5) "c."

d. Offset standards. For appeals regarding state or federal tax or debtor offsets, a hearing shall be held if the appeal is made within 15 days after official notification of the action. Counties have 30 days to appeal offsets, as provided in 441— subrule 14.4(3). When the appeal is made more than 15 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

(1) The director may grant a hearing if one or more of the following conditions existed:

1. There was a serious illness or death of the appellant or a member of the appellant's family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The appellant offers a good cause beyond the appellant's control, which can be substantiated.
4. There was a failure to receive the department's notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

(2) The time in which to appeal an offset action shall not exceed 90 days. Appeals made more than 90 days after notification shall not be heard.

(3) The day after the official notice is sent is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

e. Abuse standard.

(1) For appeals regarding dependent adult abuse, a hearing shall be held if the appeal is made within six months after official notification of the action as provided in Iowa Code section 235B.10.

(2) For appeals regarding child abuse, a hearing shall be held if the appeal is made by a person alleged responsible for the abuse within 90 days after official notification of the action as provided in Iowa Code section 235A.19. A subject of a child abuse report, other than the alleged person responsible for the abuse, may file a motion to intervene in the hearing within 10 calendar days after the appeal notification.

(3) The day after the official notice is sent is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

f. Displacement and discrimination standard. PROMISE JOBS displacement and discrimination appeals shall be granted hearing on the following basis:

(1) An appeal of an informal grievance resolution on a PROMISE JOBS displacement grievance shall be made in writing within 10 days of issuance (i.e., mailing) of the resolution decision or within 24 days of the filing of the displacement grievance, whichever is the shorter time period, unless good cause for late filing as described in subparagraph 7.5(4)“a”(1) is found.

(2) An appeal of a PROMISE JOBS discrimination complaint shall be made within the time frames provided in paragraph 7.5(4)“a” in relation to the action alleged to have involved discrimination.

g. Risk assessment standard. An appeal of a sex offender risk assessment shall be made in writing within 14 calendar days of issuance of the notice.

7.5(5) Informal settlements. The time limit for submitting an appeal is not extended while attempts at informal settlement are in progress.

7.5(6) Appeals of family investment program (FIP), refugee cash assistance (RCA), and PROMISE JOBS overpayments.

a. Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the existence, computation, and amount of a FIP, RCA, or PROMISE JOBS overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on:

- (1) Form 470-4683, Notice of FIP or RCA Overpayment; or
- (2) Form 470-4688, Notice of PROMISE JOBS Overpayment.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice as identified in paragraph “a.”

c. Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the recovery of an overpayment through benefit reduction, as described at rule 441—46.25(239B), but not the existence, computation, or amount of an overpayment, begins when the person receives Notice of Decision or Notice of Action, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), informing the person that benefits will be reduced to recover a FIP or RCA overpayment.

7.5(7) Appeals of medical assistance, state supplementary assistance (SSA), and HAWK-I program overpayments.

a. Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the existence and amount of a medical assistance, state supplementary assistance, or healthy and well kids in Iowa (HAWK-I) program overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on:

- (1) Form 470-2891, Notice of Medical Assistance Overpayment; or
- (2) Form 470-3984, Notice of Healthy and Well Kids in Iowa (HAWK-I) Premium Overpayment.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice as identified in paragraph “a.”

c. A program overpayment means medical assistance, state supplementary assistance, or healthy and well kids in Iowa (HAWK-I) assistance was received by or on behalf of a person in excess of that

allowed by law, rules or regulations for any given month or in excess of the dollar amount of assistance. Subrule 7.5(7) relates to overpayments received by recipients, not by providers of the medical assistance program.

7.5(8) *Appeal rights under the family investment program limited benefit plan.* A participant only has the right to appeal the establishment of the limited benefit plan once at the time the department issues the timely and adequate notice that establishes the limited benefit plan. However, when the reason for the appeal is based on an incorrect grant computation, an error in determining the eligible group, or another worker error, a hearing shall be granted when the appeal otherwise meets the criteria for hearing.

7.5(9) *Appeals of child care assistance benefit overpayments.*

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence, computation, and amount of a child care assistance benefit overissuance or overpayment begins when the department sends the first notice informing the person of the child care assistance overpayment. The notice shall be sent on Form 470-4530, Notice of Child Care Assistance Overpayment.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice about the same overpayment.

c. A program overpayment means child care assistance was received by or on behalf of a person in excess of that allowed by law, rules or regulations for any given month or in excess of the dollar amount of assistance. Subrule 7.5(9) relates to overpayments received by recipients and child care providers. Either entity may be responsible for repayment.

7.5(10) *Appeals of food assistance overpayments.*

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence, computation, and amount of a food assistance overpayment begins when the department sends the first notice informing the person of the food assistance overpayment. The notice shall be sent on Form 470-4668, Notice of Food Assistance Overpayment.

b. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the recovery of an overpayment through benefit reduction, but not the existence, computation, or amount of an overpayment, begins when the person receives Notice of Decision or Notice of Action, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), informing the person that benefits will be reduced to recover a food assistance overpayment.

7.5(11) *Appeals of family planning program overpayments.*

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence and amount of a family planning program overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on Form 470-5483, Notice of Family Planning Program Assistance Overpayment.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice as identified in paragraph 7.5(11) "a."

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 8439B, IAB 1/13/10, effective 3/1/10; ARC 9698B, IAB 9/7/11, effective 8/15/11; ARC 0304C, IAB 9/5/12, effective 11/1/12; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 0583C, IAB 2/6/13, effective 4/1/13; ARC 0819C, IAB 7/10/13, effective 9/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 3093C, IAB 6/7/17, effective 7/12/17; ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17; ARC 3787C, IAB 5/9/18, effective 7/1/18; ARC 3871C, IAB 7/4/18, effective 8/8/18]

441—7.6(17A) Informing persons of their rights.

7.6(1) *Written and oral notification.* The department shall advise each applicant and recipient of the right to appeal any adverse decision affecting the person's status.

a. Written notification of the following shall be given at the time of application and at the time of any agency action affecting the claim for assistance:

- (1) The right to request a hearing.
- (2) The procedure for requesting a hearing.
- (3) The right to be represented by others at the hearing unless otherwise specified by statute or federal regulation.
- (4) Provisions, if any, for payment of legal fees by the department.

b. Written notification shall be given on the application form and on all notices of decisions. Oral explanation shall also be given regarding the policy on appeals during the application process and at the time of any contemplated action by the agency when the need for an explanation is indicated.

c. Persons not familiar with English shall be provided a translation into the language understood by them in written form or orally. Appellants are entitled to have an interpreter present during appeal hearings. In all cases when a person is illiterate or semiliterate, the person shall be advised of each right to the satisfaction of the person's understanding.

d. Persons living with disabilities shall be provided assistance through the use of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

7.6(2) Authorized representation or responsible party. Persons may be represented for purposes of this chapter by an authorized representative or an individual, organization, or provider recognized by the department as acting responsibly for an applicant or beneficiary pursuant to policy governing a particular program (hereinafter referred to as a "responsible party"), unless otherwise specified by statute or federal regulations.

a. The designation of an authorized representative must be in writing and include the signature of the person designating the authorized representative. Medicaid members may appoint an authorized representative or provider to act on their behalf during the appeals process regarding an adverse benefit determination made by a managed care organization by signing Form 470-5526, Authorized Representative for Managed Care Appeals. Legal documentation of authority to act on behalf of a person, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a signed designation by the person.

b. An authorized representative or responsible party must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding an applicant or beneficiary provided by the department.

c. A provider or staff member or volunteer of an organization serving as an authorized representative or responsible party must affirm that such provider, staff member or volunteer will adhere to the regulations in Part 431, Subpart F, of 42 CFR Chapter IV and in 45 CFR 155.260(f) (relating to confidentiality of information), § 447.10 of 42 CFR Chapter IV (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflict of interest and confidentiality of information.

d. An authorized representative or responsible party may file an appeal on the appellant's behalf, receive copies of appeal correspondence, and act on behalf of the appellant in all other matters regarding the appeal.

e. The authorized representative or responsible party is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual the authorized representative or responsible party represents.

f. The power to act as an authorized representative is valid until the appellant modifies the authorization or notifies the department that the representative is no longer authorized to act on the appellant's behalf, or the authorized representative informs the agency that the authorized representative is no longer acting in such capacity, or there is a change in the legal authority upon which the individual's or organization's authority was based. Such notice must be in writing and include the appellant's, authorized representative's or responsible party's signature as appropriate.

g. Designations of authorized representatives, legal documentation of authority to act on behalf of a person, and modifications or terminations of designations or legal authority may be submitted by mail, by electronic mail, by facsimile transmission or in person.

h. Designations of authorized representatives, legal documentation of authority to act on behalf of a person, and modifications or terminations of designations or legal authority previously submitted to the department that comply with the requirements of this rule will continue to apply for purposes of appeals, consistent with their terms.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 3871C, IAB 7/4/18, effective 8/8/18]

441—7.7(17A) Notice of intent to approve, deny, terminate, reduce, or suspend assistance or deny reinstatement of assistance.**7.7(1) Notification.**

a. Whenever the department proposes to cancel or reduce assistance or services or to revoke a license, certification, approval, registration, or accreditation, it shall give timely and adequate notice of the pending action, except:

(1) When a service is deleted from the state's comprehensive annual service plan in the social services block grant program at the onset of a new program year, or

(2) As provided in subrule 7.7(2).

b. For the purpose of this subrule, "assistance" includes food assistance, medical assistance, the family investment program, refugee cash assistance, child care assistance, emergency assistance, the family planning program, family or community self-sufficiency grant, PROMISE JOBS, state supplementary assistance, healthy and well kids in Iowa (HAWK-I) program, foster care, adoption, aftercare services, or other programs or services provided by the department.

c. The department shall give adequate notice of the approval or denial of assistance or services; the approval or denial of a license, certification, approval, registration, or accreditation; and pending action for a state or federal tax or debtor offset.

d. "Timely" means that the notice is sent at least ten calendar days before the date the action would become effective. The timely notice period shall begin on the day after the notice is sent.

e. "Adequate" means a written notice that includes:

- (1) A statement of what action is being taken,
- (2) The effective date of such action,
- (3) A clear statement of the specific reasons supporting the intended action,
- (4) The corresponding rule reference,
- (5) An explanation of the appellant's right to appeal, and
- (6) The circumstances under which assistance is continued when an appeal is filed.

7.7(2) Dispensing with timely notice. Timely notice may be dispensed with, but adequate notice shall be sent no later than the date benefits would have been issued when:

a. There is factual information confirming the death of a recipient or of the family investment program payee when there is no relative available to serve as a new payee.

b. The recipient provides a clear written, signed statement that the recipient no longer wishes assistance, or gives information which requires termination or reduction of assistance, and the recipient has indicated, in writing, that the recipient understands this must be the consequence of supplying the information.

c. The recipient has been admitted or committed to an institution that does not qualify for payment under an assistance program.

d. The recipient has been placed in skilled nursing care, intermediate care, or long-term hospitalization.

e. The recipient's whereabouts are unknown and mail directed to the recipient has been returned by the post office indicating no known forwarding address. When the recipient's whereabouts become known during the payment period covered by the returned warrant, the warrant shall be made available to the recipient.

f. The agency establishes that the recipient has been accepted for assistance in another state.

g. Cash assistance or food assistance is changed because a child is removed from the home as a result of a judicial determination or is voluntarily placed in foster care.

h. A change in the level of medical care is prescribed by the recipient's physician.

i. A special allowance or service granted for a specific period is terminated and the recipient has been informed in writing at the time of initiation that the allowance or service shall terminate at the end of the specified period.

j. The notice involves an adverse determination made with regard to the preadmission screening requirements.

k. The department terminates or reduces benefits or makes changes based on a completed Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS), Review/Recertification Eligibility Document, as described at 441—subrule 40.27(3) or rule 441—75.52(249A).

l. The agency terminates benefits for failure to return a completed report form, as described in paragraph “*k.*”

m. The agency approves or denies an application for assistance.

n. The agency implements a mass change based on law or rule changes that affect a group of recipients.

7.7(3) Action due to probable fraud. When the agency obtains facts indicating that assistance should be canceled, suspended, or reduced because of the probable fraud of the recipient, and, where possible, the facts have been verified through collateral sources, notice of the action shall be timely when sent at least five calendar days before the action would become effective. The notice shall be sent by certified mail, return receipt requested.

7.7(4) Conference during the timely notice period. Rescinded IAB 7/10/13, effective 9/1/13.

7.7(5) Notification not required. Notification is not required in the following instances:

a. When services in the social service block grant preexpenditure report are changed from one plan year to the next, or when the plan is amended because funds are no longer available.

b. When service has been time-limited in the social service block grant preexpenditure report, and as a result the service is no longer available.

c. When the placement of a person(s) in foster care is changed.

d. When payment has been in accordance with the Medicaid payment schedule for the service billed because there is no adverse action.

7.7(6) Reinstatement.

a. Whenever the department determines that a previously canceled case must remain canceled for a reason other than that covered by the original notice, timely and adequate notice shall be sent except as specified in subrule 7.7(2).

b. Whenever the department determines that a previously canceled case is eligible for reinstatement at a lower level of benefits, for a reason other than that covered by the original notice, timely and adequate notice shall be sent except as specified in subrule 7.7(2).

c. Food assistance cases are eligible for reinstatement only in circumstances found in rule 441—65.44(234). FIP cases are eligible for reinstatement only in circumstances found in 441—subrule 40.22(5).

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09; **ARC 0819C**, IAB 7/10/13, effective 9/1/13; **ARC 1261C**, IAB 1/8/14, effective 3/1/14; **ARC 3093C**, IAB 6/7/17, effective 7/12/17; **ARC 3199C**, IAB 7/19/17, effective 7/1/17; **ARC 3389C**, IAB 10/11/17, effective 11/15/17]

441—7.8(17A) Opportunity for hearing.

7.8(1) Initiating an appeal. To initiate an appeal, a person, the person’s authorized representative or an individual or organization recognized by the department as acting responsibly for the person pursuant to policy governing a particular program must state in writing that the person disagrees with a decision, action, or failure to act on the person’s case.

a. Food assistance, medical assistance, child care assistance, family planning program and family investment program appeals may be made in person, by telephone or in writing as specified in subrule 7.8(2).

b. All other appeals, subject to paragraph 7.8(1)“*a.*,” shall be made in writing.

c. A written request may be submitted via the appeals section’s website or may be delivered by mail, electronic mail, facsimile transmission or personal delivery to the appeals section, to the local office, or to the department office that took the adverse action.

d. A request by telephone or in person may be made to the appeals section or to the department office that took the adverse action.

e. A Medicaid provider or an authorized representative requesting a hearing on behalf of the member regarding an adverse benefit determination made by a managed care organization must have the prior express written consent of the member or the member’s lawfully appointed guardian on Form

470-5526, Authorized Representative for Managed Care Appeals. Legal documentation of authority to act on behalf of a person, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a signed designation by the person. No hearing will be granted unless the provider submits a document providing the member's consent to the request for a hearing.

7.8(2) *Filing the appeal.* The appellant shall be encouraged, but not required, to make written appeal on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, and the worker shall provide any instructions or assistance required in completing the form. When the appellant is unwilling to complete or sign this form, nothing in this rule shall be construed to preclude the right to perfect the appeal, as long as the appeal is in writing (except for food assistance, medical assistance, child care assistance, family planning program and family investment program appeals) and has been communicated to the department by the appellant or appellant's representative.

A written appeal submitted by mail is filed on the date postmarked on the envelope sent to the department or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency. When an appeal is submitted through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile, the appeal is filed on the date it is submitted. The electronic delivery method shall record the date and time the appeal request was submitted. If there is no date recorded by the electronic delivery method, the date of filing is the date the appeal is stamped received by the agency. Receipt date of all appeals shall be documented by the office where the appeal is received.

7.8(3) *Informal conference.* When requested by the appellant, an informal conference with a representative of the department or one of its contracted partners, including a managed care organization, shall be held as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the informal conference, unless precluded by federal rule or state statute.

An informal conference need not be requested for the appellant to examine the contents of the case record, including any electronic case record, as provided in subrule 7.13(1) and 441—Chapter 9.

7.8(4) *Prehearing conference.* When requested, a prehearing conference may be held with the appellant, a representative of the department and a presiding officer as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the prehearing conference, unless precluded by federal rule or state statute.

7.8(5) *Interference.* Neither an informal conference nor a prehearing conference shall be used to discourage appellants from proceeding with their appeals. The right of appeal shall not be limited or interfered with in any way, even though the person's complaint may be without basis in fact, or because of the person's own misinterpretation of law, agency policy, or methods of implementing policy.

7.8(6) *Right to deny or dismiss an appeal.* The appeals section or the department of inspections and appeals has the right to deny or dismiss the appeal when:

- a. It has been withdrawn by the appellant pursuant to subrule 7.8(8).
- b. The sole issue is one of state or federal law requiring automatic grant adjustments for classes of recipients.
- c. It has been abandoned.
- d. The agency, by written notice, withdraws the action appealed and restores the appellant's status that existed before the action appealed was taken.
- e. The agency implements action and issues a notice of decision or notice of action to correct an error made by the agency which resulted in the appeal.
- f. An individual has waived the individual's right to an administrative disqualification hearing, agreed to repay any overpayment and agreed to be disqualified from the food assistance program for the period specified by signing and returning Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing.

Abandonment may be deemed to have occurred when the appellant, the appellant's authorized representative, or the department fails, without good cause, to appear at the prehearing or hearing.

7.8(7) *Denial of due process.* Facts of harassing, threats of prosecution, denial of pertinent information needed by the appellant in preparing the appeal, as a result of the appellant's communicated

desire to proceed with the appeal shall be taken into consideration by the administrative law judge in reaching a proposed decision.

7.8(8) *Withdrawal.* When the appellant desires to voluntarily withdraw an appeal, the worker, the presiding officer, or the appeals section shall accept a request from the appellant to withdraw the appeal by telephone, in writing or in person. A written request may be submitted in person, by mail or through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile. The appellant may use Form 470-0492 or 470-0492(S), Request for Withdrawal of Appeal, for this purpose. For child abuse and dependent adult abuse appeals, the request to withdraw an appeal must be made on the record before an administrative law judge or in writing and signed by the appellant or the appellant's legal counsel.

7.8(9) *Department's responsibilities.* Unless the appeal is voluntarily withdrawn, the department worker or agent responsible for representing the department at the hearing shall:

a. Within one working day of receipt of an appeal request, forward Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, the written appeal, the postmarked envelope, if there is one, and a copy of the notification of the proposed adverse action to the appeals section.

b. Forward a summary and supporting documentation of the worker's or agent's factual basis for the proposed action to the appeals section within ten days of the receipt of the appeal.

c. Provide the appellant and the appellant's representative copies of all materials sent to the appeals section or the presiding officer to be considered in reaching a decision on the appeal at the same time as the materials are sent to the appeals section or the presiding officer.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 0819C, IAB 7/10/13, effective 9/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 3093C, IAB 6/7/17, effective 7/12/17; ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17; ARC 3871C, IAB 7/4/18, effective 8/8/18; ARC 4064C, IAB 10/10/18, effective 12/1/18]

441—7.9(17A) Continuation of assistance pending a final decision on appeal.

7.9(1) *General standards for when assistance continues.*

a. Assistance, subject to paragraph 7.9(1)“*b*,” shall not be suspended, reduced, restricted, or canceled, nor shall a license, registration, certification, approval, or accreditation be revoked or other proposed adverse action be taken pending a final decision on an appeal when:

(1) An appeal is filed before the effective date of the intended action; or

(2) The appellant requests a hearing within ten days from receipt of a notice suspending, reducing, restricting, or canceling benefits or services.

The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. If it is determined at a hearing that the issue involves only federal or state law or policy, assistance will be immediately discontinued.

c. Assistance shall be continued on the basis authorized immediately prior to the notice of adverse action, subject to paragraph 7.9(2)“*c*.”

d. The appellant may ask to have the appellant's benefits continue on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing. If the form does not positively indicate that the appellant has waived continuation of benefits, the department shall assume that continuation of benefits is desired.

e. Once benefits are continued or reinstated, the department will not reduce or terminate benefits while the appeal is pending, subject to subrule 7.9(2).

7.9(2) *General standards for when assistance does not continue.* Assistance shall be suspended, reduced, restricted, or canceled; a license, registration, certification, approval, or accreditation shall be revoked; and other proposed action shall be taken pending a final decision on appeal when:

a. An appeal is not filed before the effective date of the intended action or within ten days from the date notice is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. Benefits or services were time-limited through a certification period or prior authorization for which notice was given when established or for which adequate notice was provided.

- c. The appellant directs the worker in writing to proceed with the intended action.
- d. Adverse action was taken because the appellant failed to return a complete review form.

7.9(3) *When assistance continues for food assistance.*

a. Assistance, subject to paragraph 7.9(3)“b,” shall not be suspended, reduced, restricted, or canceled or other proposed adverse action taken pending a final decision on an appeal when the appellant requests a hearing within ten days from receipt of a notice suspending, reducing, restricting, or canceling benefits.

The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. If it is determined at a hearing that the issue involves only federal or state law or policy, assistance will be immediately discontinued.

c. Assistance shall be continued on the basis authorized immediately prior to the notice of adverse action, subject to paragraph 7.9(4)“c.”

d. The appellant may ask to have the appellant’s benefits continue on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing. If the form does not positively indicate that the appellant has waived continuation of benefits, the department shall assume that continuation of benefits is desired.

e. Once benefits are continued or reinstated, the department must not reduce or terminate benefits while the appeal is pending, subject to subrule 7.9(4).

7.9(4) *When assistance does not continue for food assistance.* Assistance shall be suspended, reduced, restricted, or canceled or other proposed action shall be taken pending a final decision on appeal when:

a. An appeal is not filed within ten days from the date notice is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. Benefits or services were time-limited through a certification period or for which adequate notice was provided.

c. The appellant directs the worker in writing to proceed with the intended action.

d. Adverse action was taken because the appellant failed to return a complete review form.

7.9(5) *When assistance continues for managed care organization health care services.*

a. Health care services may not be reduced, limited, suspended, canceled or other proposed adverse action taken pending a final decision on an appeal when:

(1) An appeal is filed timely. “Timely” means the appeal is filed on or before the effective date of the adverse benefit determination or within ten calendar days of the date the managed care organization sent the notice of adverse benefit determination. The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period;

(2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(3) The services were ordered by an authorized provider;

(4) The period covered by the original authorization has not expired; and

(5) The appellant requests that health care services be continued.

b. If, at the appellant’s request, the managed care organization continues or reinstates the member’s health care services while the appeal is pending, the benefits must continue until one of the following occurs:

(1) The appellant withdraws the appeal.

(2) The appellant fails to request an appeal within ten calendar days from the date the managed care organization mails the notice of action.

(3) A hearing decision is issued that is adverse to the appellant.

7.9(6) *When assistance does not continue for health care services managed by a managed care organization.* Health care services may be reduced, limited, suspended, canceled or other proposed adverse action taken pending a final decision on an appeal when:

a. An appeal is not filed timely. “Timely” means the appeal is filed on or before the effective date of the adverse benefit determination or within ten calendar days of the date the managed care organization sent the notice of adverse benefit determination. The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period;

b. The appeal does not involve the termination, suspension, or reduction of a previously authorized course of treatment;

c. The services were not ordered by an authorized provider;

d. The period covered by the original authorization has expired; or

e. The appellant fails to request that health care services be continued.

7.9(7) *Recovery of excess assistance paid pending a final decision on appeal.* Continued assistance is subject to recovery by the department if the department’s action is affirmed, except as specified at subrule 7.9(9).

When the department’s action is sustained, excess assistance paid pending a final decision shall be recovered to the date of the decision. This recovery is not an appealable issue. However, appeals may be heard on the computation of excess assistance paid pending a final decision.

7.9(8) *Recovery of excess assistance paid when the appellant’s benefits are changed prior to a final decision.* Recovery of excess assistance paid will be made to the date of change which affects the improper payment. The recovery shall be made when the appellant’s benefits are changed due to one of the following reasons:

a. A determination is made at the hearing that the sole issue is one of state or federal law or policy or change in state or federal law or policy and not one of incorrect grant computation, and the grant is adjusted.

b. A change affecting the appellant’s grant occurs while the final decision is pending and the appellant fails to request a hearing after notice of the change.

7.9(9) *Recovery of assistance when a new limited benefit plan is established.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new limited benefit plan period is established. A new limited benefit plan period shall be established when the department is affirmed in a timely appeal of the establishment of the limited benefit plan. All of the following conditions shall exist:

a. The appeal is filed either:

(1) Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the limited benefit plan, or

(2) Within ten days from the date on which a notice establishing the beginning date of the limited benefit plan is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. Assistance is continued pending the final decision of the appeal.

c. The department’s action is affirmed.

7.9(10) *Recovery of assistance when a new ineligibility period is established for the use of an electronic access card at a prohibited location.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new ineligibility period is established for the use of an electronic access card at a prohibited location. A new ineligibility period pursuant to 441—paragraph 41.25(11)“e” shall be established when the department is affirmed in an appeal of the establishment of an ineligibility period for the use of an electronic access card at a prohibited location. All of the following conditions shall exist:

a. The appeal is filed either:

(1) Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the ineligibility period, or

(2) Within ten days from the date on which a notice establishing the beginning date of the ineligibility period is received. The date on which notice is received is considered to be five days after

the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. Assistance is continued pending the final decision of the appeal.

c. The department's action is affirmed.

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441—7.10(17A) Procedural considerations.

7.10(1) Registration. Upon receipt of the notice of appeal, the appeals section shall register the appeal.

7.10(2) Acknowledgment.

a. Upon receipt of the notice of appeal, the appeals section shall send an acknowledgment of receipt of the appeal to the appellant, representative, or both. A copy of the acknowledgment of receipt of appeal will be sent to the appropriate departmental office.

b. For an appeal regarding child abuse, all subjects other than the person alleged responsible (appellant) will be notified of the opportunity to file a motion to intervene as provided in Iowa Code section 235A.19.

c. The department shall advise the person of any legal services which may be available and that the person may be represented by counsel at the person's own expense.

7.10(3) Granting a hearing. The appeals section shall determine whether an appellant may be granted a hearing and the issues to be discussed at that hearing in accordance with the applicable rules, state statutes, or federal regulations.

a. The appeals of those appellants who are granted a hearing shall be certified to the department of inspections and appeals for the hearing to be conducted. The appeals section shall indicate at the time of certification the issues to be discussed at that hearing.

b. The appeals of those appellants who are denied a hearing shall not be closed until issuance of a letter to the appellant and the appellant's representative, advising of the denial of hearing and the basis upon which that denial is made. Any appellant who disagrees with a denial of hearing may present additional information relative to the reason for denial and request reconsideration by the appeals section or a hearing over the denial within 30 calendar days of the date on the denial letter.

7.10(4) Hearing scheduled. For those records certified for hearing, the department of inspections and appeals shall establish the date, time, method and place of the hearing, with due regard for the convenience of the appellant as set forth in 481—Chapter 10 of the department of inspections and appeals' rules unless otherwise designated by federal or state statute or regulation.

a. In cases involving individual appellants, the hearing shall be held by teleconference call or in the appropriate department office.

b. In cases of appeals by agencies, the hearing shall be scheduled by teleconference call or at the most appropriate department office.

c. In cases involving the determination of the community spouse resource allowance, the hearing shall be held within 30 days of the date of the appeal request.

d. In cases involving an appeal of a sex offender risk assessment, the hearing or administrative review shall be held within 30 days of the date of the appeal request.

e. Emergency assistance appeals shall be expedited.

f. In cases involving appellants who indicate that their lives, physical or mental health, or ability to attain, maintain or regain maximum function could seriously be jeopardized if they wait for standard resolution of their appeals, the hearing shall be held within three working days of the date on the appeal request if:

(1) The managed care organization handled the first-level review expeditiously; and

(2) The appellant or a provider acting on the appellant's behalf requested an expedited appeal hearing.

7.10(5) Method of hearing. The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties

to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if the appellant requests one. Upon advance request, a witness shall be permitted to appear by teleconference unless the administrative law judge determines that the physical presence of the witness is necessary for the administration of justice and does not impose an undue burden on the witness. All parties shall be granted the same rights during a teleconference hearing as specified in rule 441—7.13(17A). The appellant may request to have a presiding officer render a decision for attribution appeals through an administrative hearing.

7.10(6) Reschedule requests. Requests by the appellant or the department to set another date, time, method or place of hearing shall be made to the department of inspections and appeals directly except as otherwise noted. The granting of the requests will be at the discretion of the department of inspections and appeals.

a. The appellant may request that the teleconference hearing be rescheduled as an in-person hearing. All requests made to the appeals section or to the department of inspections and appeals for a teleconference hearing to be rescheduled as an in-person hearing shall be granted. Any appellant request for an in-person hearing made to the appeals section shall be communicated to the department of inspections and appeals immediately.

b. For food assistance appeals, the hearing may be rescheduled if requested by the appellant; however, the postponement shall not exceed 30 days.

c. For intentional program violation appeals, the hearing may be rescheduled provided that the request for postponement is made at least ten days in advance of the date of the scheduled hearing. The hearing shall not be postponed for more than a total of 30 days.

d. Reschedule requests made by the department shall only be granted in instances of inclement weather when the department office is closed. The department's representative shall arrange coverage by a coworker in instances including, but not limited to, when inclement weather is present, but the department office remains open or when a family emergency, sudden illness or death occurs.

e. All other requests, subject to paragraph 7.10(6) "a," concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.

7.10(7) Notification. For those appeals certified for hearing, the department of inspections and appeals shall send a notice to the appellant at least ten calendar days in advance of the hearing date.

a. The notice, as prescribed in Iowa Code section 17A.12(2), shall set forth:

(1) The date, time, method and place of the hearing;

(2) That evidence may be presented orally or documented to establish pertinent facts; and

(3) That the appellant may question or refute any testimony, may bring witnesses of the appellant's choice and may be represented by others, including an attorney, subject to federal law and state statute. The department will not pay for the cost of legal representation.

b. A copy of this notice shall be forwarded to the department employee who took the action and to other persons when circumstances peculiar to the case indicate that the notification may be desirable.

c. Notices of hearing regarding an intentional program violation shall be served upon the appellant by first-class mail, postage prepaid, addressed to the appellant at the last-known address at least 30 days in advance of the date the hearing is scheduled. All other notices of hearing shall be mailed by first-class mail, postage prepaid, addressed to the appellant at the appellant's last-known address.

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441—7.11(17A) Information and referral for legal services. The local office shall advise persons appealing any agency decision of legal services in the community that are willing to assist them.

441—7.12(17A) Subpoenas. The department shall have all subpoena power conferred upon it by statute. Departmental subpoenas shall be issued to a party on request or will be served by the department when requested at least one week in advance of the hearing date.

441—7.13(17A) Rights of appellants during hearings.

7.13(1) Examination of the evidence. The department shall provide the appellant, or representative, opportunity prior to, as well as during, the hearing, to examine all materials permitted under rule 441—9.1(17A,22) or to be offered as evidence. Off the record, or confidential information which the appellant or representative does not have the opportunity to examine shall not be included in the record of the proceedings or considered in reaching a decision.

7.13(2) Conduct of hearing.

a. The hearing shall be conducted by an administrative law judge designated by the department of inspections and appeals. It shall be an informal rather than a formal judicial procedure and shall be designed to serve the best interest of the appellant. The appellant shall have the right to introduce any evidence on points at issue believed necessary, to challenge and cross-examine any statement made by others, and to present evidence in rebuttal. A verbatim record shall be kept of the evidence presented.

b. For an appeal hearing regarding child abuse, the administrative law judge, upon request of any party to the hearing, may stay the hearing until the conclusion of the adjudicatory phase of a pending juvenile or district court case relating to the data or findings as provided in Iowa Code section 235A.19.

7.13(3) Opportunity for response. Opportunity shall be afforded all parties to respond and present evidence and arguments on all issues involved and to be represented by counsel at their own expense.

7.13(4) Default. If a party to the appeal fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing pursuant to subrules 7.13(1), 7.13(2) and 7.13(3) and render a proposed decision on the merits in the absence of the defaulting party.

a. Where appropriate and not contrary to law, any party may move for a default decision against a party who has failed to file a required pleading or has failed to appear after proper service for a hearing. A proposed decision on the merits may be issued in the absence of a defaulting party.

b. A default decision or a proposed decision rendered on the merits in the absence of the defaulting party may award any relief against the defaulting party consistent with the relief requested before the default, but the relief awarded against the defaulting party may not exceed the requested relief before the default.

c. Proceedings after a default decision are specified in subrule 7.13(5).

d. Proceedings after a hearing and a proposed decision on the merits in the absence of a defaulting party are specified in subrule 7.13(6).

7.13(5) Proceedings after default decision.

a. Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final agency action unless a motion to vacate the decision is filed within the time allowed for an appeal of a proposed decision by subrule 7.16(5).

b. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding. A party must file the motion with the Department of Human Services, Appeals Section, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. The department or its representative shall file a motion to vacate as specified in subrule 7.16(6). Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact. Each affidavit must be attached to the motion. In lieu of submitting an affidavit, the moving party may submit business records or other acceptable documentation from a disinterested third party that substantiates the claim of good cause.

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the appeals section to respond to the motion to vacate. All parties to the appeal shall be allowed to conduct discovery as to the issue of good cause and shall be allowed to present evidence on the issue before a decision on the motion, if a request to do so is included in that party's response. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the appeals section.

(2) The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists to set aside the default.

c. Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

d. "Good cause" for purposes of this rule is defined as an emergency circumstance that is beyond the control of the party and that prevents the party from being able to participate in the hearing.

(1) Examples of good cause include, but are not limited to:

1. Sudden, severe illness or accident involving the party or the party's immediate family (spouse, partner, children, parents, sibling).

2. Death or serious illness in the party's immediate family.

3. Other circumstances evidencing an emergency situation which was beyond the party's control and was not reasonably foreseeable.

(2) Examples of circumstances that do not constitute good cause include, but are not limited to:

1. A lost or misplaced notice of hearing.

2. Confusion as to the date and time for the hearing.

3. Failure to follow the directions on the notice of hearing.

4. Oversleeping.

5. Other acts demonstrating a lack of due care by the party.

e. Upon determining whether good cause exists, the presiding officer shall issue a proposed decision on the motion to vacate, which shall be subject to review by the director pursuant to rule 441—7.16(17A).

f. Once the time limit to appeal a proposed decision has expired, the contested case hearing shall proceed accordingly, after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.

g. Upon a final decision denying a motion to vacate, the default decision becomes final agency action.

7.13(6) *Proceedings after hearing and proposed decision on the merits in the absence of a defaulting party.*

a. Proposed decisions on the merits after a party has failed to appear or participate in a contested case become final agency action unless:

(1) A motion to vacate the proposed decision is filed by the defaulting party based on good cause for the failure to appear or participate, within the time allowed for an appeal of a proposed decision by subrule 7.16(5); or

(2) Any party requests review on the merits by the director pursuant to rule 441—7.16(17A).

b. If a motion to vacate and a request for review on the merits are both made in a timely manner after a proposed decision on the merits in the absence of a defaulting party, the review by the director on the merits of the appeal shall be stayed pending the outcome of the motion to vacate.

c. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding. A party must file a motion with the Department of Human Services, Appeals Section, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the appeals section to respond to the motion to vacate. All parties to the appeal shall be allowed to conduct discovery as to the issue of good cause and shall be allowed to present evidence on the issue before a decision on the motion, if a request to do so is included in that party's response. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the appeals section.

(2) The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists to set aside the default.

d. Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

e. “Good cause” for purposes of this rule is defined as an emergency circumstance that is beyond the control of the party and that prevents the party from being able to participate in the hearing.

(1) Examples of good cause include, but are not limited to:

1. Sudden, severe illness or accident involving the party or the party’s immediate family (spouse, partner, children, parents, sibling).

2. Death or serious illness in the party’s immediate family.

3. Other circumstances evidencing an emergency situation which was beyond the party’s control and was not reasonably foreseeable.

(2) Examples of circumstances that do not constitute good cause include, but are not limited to:

1. A lost or misplaced notice of hearing.

2. Confusion as to the date and time for the hearing.

3. Failure to follow the directions on the notice of hearing.

4. Oversleeping.

5. Other acts demonstrating a lack of due care by the party.

f. Upon determining whether good cause exists, the presiding officer shall issue a proposed decision on the motion to vacate, which shall be subject to review by the director pursuant to rule 441—7.16(17A).

g. Once the time limit to appeal a proposed decision has expired, a new contested case hearing shall be held after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.

h. Upon a final decision denying a motion to vacate, the proposed decision on the merits in the absence of a defaulting party becomes final unless there is request for review on the merits by the director made pursuant to paragraph 7.13(6) “a” or “j.”

i. Any review on the merits by the director requested pursuant to paragraph 7.13(6) “a” and stayed pursuant to paragraph 7.13(6) “b” pending a decision on a motion to vacate shall be conducted upon a final decision denying the motion to vacate.

j. Upon a final decision denying a motion to vacate a proposed decision issued in the absence of a defaulting party, any party to the contested case proceeding may request a review on the merits by the director pursuant to rule 441—7.16(17A), treating the date that the denial of the motion to vacate became final as the date of the proposed decision.

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441—7.14(17A) Limitation of persons attending.

7.14(1) The hearing shall be limited in attendance to the following persons, unless otherwise specified by statute or federal regulations: appellant, appellant’s representative, agency employees, agency’s legal representatives, other persons present for the purpose of offering testimony pertinent to the issues in controversy, and others upon mutual agreement of the parties. The administrative law judge may sequester witnesses during the hearing. Nothing in this rule shall be construed to allow members of the press, news media, or any other citizens’ group to attend the hearing without the written consent of the appellant.

7.14(2) For an appeal hearing regarding child abuse:

a. Subjects who file a motion to intervene, as provided in Iowa Code section 235A.19, will have the opportunity to appear at the prehearing conference. Any motion to intervene shall be considered by the administrative law judge at the prehearing conference.

b. The department shall not be considered to be a party who can adequately represent the interests of any other subject.

c. Subjects allowed to intervene as specified in subrule 7.5(4) will be considered parties to the hearing and will be allowed to attend the proceedings as provided in Iowa Code section 235A.19.

[ARC 0487C, IAB 12/12/12, effective 2/1/13]

441—7.15(17A) Medical examination. When the hearing involves medical issues, a medical assessment or examination by a person or physician other than the one involved in the decision under question shall be obtained and the report made a part of the hearing record when the administrative law judge or appellant considers it necessary. Any medical examination required shall be performed by a physician satisfactory to the appellant and the department at agency expense.

Forms 470-0502, Authorization for Examination and Claim for Payment, and 470-0447, Report on Incapacity, shall be utilized in obtaining medical information to be used in the appeal and to authorize payment for the examination.

441—7.16(17A) The appeal decision.

7.16(1) Record. The record in a contested case shall include, in addition to those materials specified in Iowa Code section 17A.12(6):

a. The notice of appeal.

b. All evidence received or considered and all other submissions, including the verbatim record of the hearing.

7.16(2) Findings of fact. Any party may submit proposed findings of fact. The presiding officer will rule on the proposed findings of fact. Findings of fact shall be based solely on the evidence in the record and on matters officially noticed in the record. The findings of fact and conclusions of law in the proposed or final decision shall be limited to contested issues of fact, policy, or law.

7.16(3) Proposed decision. Following the reception of evidence, the presiding officer shall issue a proposed decision, consisting of the issues of the appeal, the decision, the findings of fact and the conclusions of law. Each item shall be separately stated under individual headings. The proposed decision shall be sent by first-class mail, postage prepaid, addressed to the appellant at the appellant's last-known address.

7.16(4) Appeal of the proposed decision. After issuing a proposed decision, the administrative law judge shall submit it to the appeals section with copies to the appeals advisory committee.

a. The appellant, appellant's representative, a subject allowed to intervene as specified in subrule 7.5(4), the representative of a subject allowed to intervene as specified in subrule 7.5(4), or the department may appeal for the director's review of the proposed decision.

b. When the appellant, a subject allowed to intervene as specified in subrule 7.5(4), or the department has not appealed the proposed decision or when an appeal for the director's review of the proposed decision is not granted, the proposed decision shall become the final decision.

c. The director's review on appeal of the proposed decision shall be on the basis of the record as defined in subrule 7.16(1), except that the director need not listen to the verbatim record of the hearing in a review or appeal. The review or appeal shall be limited to issues raised prior to that time and specified by the party requesting the appeal or review. The director may designate another to act on the director's behalf in making final decisions.

7.16(5) Time limit for appeal of a proposed decision. Appeal for the director's review of the proposed decision must be made in writing to the director. The written request must be mailed or submitted in person or through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile. The request must be postmarked or received within ten calendar days of the date on which the proposed decision was sent. The day after the proposed decision is sent is the first day of the time period within which a request for review must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

7.16(6) Appeal of the proposed decision by the department. The appeals advisory committee acts as an initial screening device for the director and may recommend that the director review a proposed decision. That recommendation is not binding upon the director, and the director may decide to review a proposed decision without that committee's recommendation.

A request by the department for director's review of the proposed decision must be made in writing. The written request must be submitted to the appeals advisory committee in person or submitted through an electronic delivery method, such as electronic mail or facsimile, within ten calendar days of the date on which the proposed decision was sent. The day after the proposed decision is sent is the first day of

the time period within which a request for director's review must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

When the director grants a review of a proposed decision on the department's request, the appeals section shall notify all other parties to the appeal of the review and send a copy of the request to all other parties. All other parties shall be provided ten calendar days from the date of notification to submit further written arguments or objections for consideration upon review.

Written arguments or objections must be mailed or submitted in person to the appeals section or submitted through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile.

The day after the notification is sent is the first day of the time period within which a response to the department's request for review must be filed. When the time limit for responding falls on a holiday or a weekend, the time will be extended to the next workday.

7.16(7) *Appeal of the proposed decision by the managed care organization.* The appeals advisory committee acts as an initial screening device for the director and may recommend that the director review a proposed decision. That recommendation is not binding upon the director, and the director may decide to review a proposed decision without that committee's recommendation.

A request by the managed care organization for director's review of the proposed decision must be made in writing. The written request must be submitted to the appeals advisory committee in person or submitted through an electronic delivery method, such as electronic mail or facsimile, within 72 hours of the date on which the proposed decision was sent. The day after the proposed decision is sent is the first day of the time period within which a request for director's review must be filed.

When the director grants a review of a proposed decision on the managed care organization's request, the appeals section shall notify all other parties to the appeal of the review and send a copy of the request to all other parties. All other parties shall be provided ten calendar days from the date of notification to submit further written arguments or objections for consideration upon review.

Written arguments or objections must be mailed or submitted in person to the appeals section or submitted through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile.

The day after the notification is sent is the first day of the time period within which a response to the department's request for review must be filed. When the time limit for responding falls on a holiday or a weekend, the time will be extended to the next workday.

7.16(8) *Appeal of the proposed decision by the appellant.* When the director grants a review of a proposed decision, all other parties shall be so notified.

7.16(9) *Opportunity for oral presentation of appeal of the proposed decision.* In cases where there is an appeal of a proposed decision, each party shall be afforded an opportunity to present oral arguments with the consent of the director. Any party wishing oral argument shall specifically request it. When oral argument is granted, all parties shall be notified of the time and place.

7.16(10) *Time limits.*

a. A final decision on the appeal shall be issued within the following time frames:

(1) Appeals for all programs, except food assistance and intentional program violations, shall be rendered within 90 days from the date of the appeal.

(2) Food assistance-only decisions shall be rendered within 60 days.

(3) PROMISE JOBS displacement grievance decisions shall be rendered within 90 days from the date the displacement grievance was filed with the PROMISE JOBS contractee.

(4) Intentional program violation decisions shall be rendered within 90 days of the date the individual is notified in writing that a hearing initiated by the department has been scheduled. If the hearing was postponed pursuant to paragraph 7.21(4) "b," the 90-day period for notifying the individual of the final decision shall be extended for as many days as the hearing is postponed.

b. Failure to reach a decision within the time frames set forth in paragraph 7.16(10) "a" shall not affect the merits of the appellant's appeal.

c. Time frames may be extended based on continuances or additional time frames as approved by the presiding officer. Should the appellant request a delay in the hearing in order to prepare the case

or for other essential reasons, reasonable time, not to exceed 30 days except with the approval of the administrative law judge, shall be granted and the extra time shall be added to the maximum for final administrative action.

d. For an appeal regarding child abuse, if the proposed decision is not appealed within 10 days from the date of the proposed decision, the proposed decision shall be the final agency action. If a party files an appeal within 10 days from the date of the proposed decision, the director has 45 days from the date of the proposed decision to issue a ruling. If the director does not rule within that 45-day period, the proposed decision becomes the final decision as provided in Iowa Code section 235A.19.

e. The department shall take prompt, definite and final administrative action to carry out the decision rendered within seven calendar days of receipt of a copy of the final decision for all programs, except as provided in paragraph 7.6(10) “*f.*”

f. If the administrative law judge reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the managed care organization must authorize or provide the disputed services promptly and as expeditiously as the appellant’s health condition requires but no later than 72 hours from the date on the proposed decision.

If the administrative law judge reverses a decision to deny authorization of services and the appellant received the disputed services while the appeal was pending, the managed care organization must pay for those services pursuant to subrules 7.9(5) and 7.9(6).

g. When the final decision is favorable to the appellant or when the department decides in favor of the appellant before the hearing, the department shall make any additional corrective payments due, retroactive to the date of the incorrect action.

7.16(11) Final decision. The department shall mail the final decision to the appellant at the appellant’s last-known address by first-class mail, postage prepaid.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 1611C, IAB 9/3/14, effective 11/1/14; ARC 3093C, IAB 6/7/17, effective 7/12/17; ARC 3787C, IAB 5/9/18, effective 7/1/18; ARC 4064C, IAB 10/10/18, effective 12/1/18]

441—7.17(17A) Exhausting administrative remedies. To have exhausted all adequate administrative remedies, a party need not request a rehearing under Iowa Code section 17A.16(2) where the party accepts the findings of fact as prepared by the administrative law judge, but wishes to challenge the conclusions of law, or departmental policy.

441—7.18(17A) Ex parte communication.

7.18(1) Prohibited communication. There shall be no written, oral, or other type of communication between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in the case while an appeal is pending, without all parties being notified of an opportunity to participate, unless specifically authorized by statute or rule.

a. This provision does not prevent the presiding officer from communicating with members of the agency or seeking the advice or help of persons other than those defined in paragraph “*c.*”

b. Persons described in paragraph “*c.*” shall not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

c. For purposes of this rule:

(1) People with a direct or indirect interest in a case include any member of the appeals advisory committee and any person engaged in personally investigating, prosecuting, or advocating in either the case under appeal or a pending factually related case involving the same parties.

(2) The term “personally investigating” means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person’s investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other agency functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case.

7.18(2) *Commencement of prohibition.* Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

7.18(3) *When communication is ex parte.* Rescinded IAB 4/30/03, effective 7/1/03.

7.18(4) *Avoidance of ex parte communication.* To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Written communications shall be provided to all parties to the appeal.

7.18(5) *Communications not prohibited.* Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines.

7.18(6) *Disclosure of prohibited communications.* A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified from the case. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be disclosed. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of communication.

7.18(7) *Disclosure of prior receipt of information through ex parte communication.* Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

7.18(8) *Imposition of sanctions.* The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule, including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the agency. Violation of ex parte communication prohibitions by department personnel shall be reported to the department for possible sanctions, including censure, suspension, dismissal, or other disciplinary action.

441—7.19(17A) Accessibility of hearing decisions. Summary reports of all hearing decisions shall be made available to local offices and the public upon request. The information shall be presented in a manner consistent with requirements for safeguarding personal information concerning applicants and recipients.

[ARC 3093C, IAB 6/7/17, effective 7/12/17]

441—7.20(17A) Right of judicial review and stays of agency action.

7.20(1) *Right of judicial review.* If a director's review is requested, the final decision shall advise the appellant or the appellant's representative of the right to judicial review by the district court. When the appellant or the appellant's representative is dissatisfied with the final decision and requests judicial review of the decision to the district court, the department shall furnish copies of the documents or supporting papers to district court, including a written transcript of the hearing. An appeal of the final decision to district court does not itself stay execution or enforcement of an agency action.

7.20(2) *Stays of agency action.*

a. Any party to a contested case proceeding may petition the director for a stay or other temporary remedies pending judicial review, of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy.

b. In determining whether to grant a stay pending judicial review, the director shall consider the factors listed in Iowa Code section 17A.19(5)“c.”

c. A stay may be vacated by the director pending judicial review upon application of the department or any other party.

441—7.21(17A) Food assistance hearings and appeals.

7.21(1) Appeal hearings. All appeal hearings in the food assistance program shall be conducted in accordance with 7 CFR 273.15.

7.21(2) Food assistance administrative disqualification hearings. All food assistance administrative disqualification hearings shall be conducted in accordance with 7 CFR 273.16.

7.21(3) Waiver of right to an administrative disqualification hearing. An individual accused of an intentional program violation may waive the individual’s right to a food assistance administrative disqualification hearing.

a. When a case is referred for an administrative disqualification hearing, the appeals section shall advise the individual that the individual may waive the individual’s right to an administrative disqualification hearing by signing and returning Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing.

b. By signing the waiver, the individual gives up the right to an administrative disqualification hearing, agrees to repay any overpayment and agrees to be disqualified from the food assistance program for the period specified.

c. If the individual does not sign and return Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, within ten days of the date of the written notification, an administrative disqualification hearing shall be initiated.

d. Even after the administrative disqualification hearing is scheduled, the individual may sign and return Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, prior to or during the administrative disqualification hearing. The presiding officer shall dismiss the administrative disqualification hearing since the individual has agreed to repay any overpayment and agreed to be disqualified from the food assistance program.

e. The signed waiver shall carry the same penalties as the penalties for an individual found guilty in an administrative disqualification hearing.

f. No further administrative appeal procedure exists after an individual waives the individual’s right to an administrative disqualification hearing and a disqualification penalty has been imposed. The disqualification penalty shall not be changed by a subsequent fair hearing decision. The individual is entitled to seek relief in a court having appropriate jurisdiction. The period of disqualification may be subject to stay by a court of appropriate jurisdiction or other injunctive remedy.

7.21(4) Conduct of a food assistance administrative disqualification hearing. Hearings over disqualification of a household member for an intentional program violation shall be conducted by a presiding officer.

a. The department of inspections and appeals shall serve an Intentional Program Violation Hearing Notice upon the household member by first-class mail, postage prepaid, addressed to household member at the last-known address 30 calendar days before the initial hearing date.

b. The household member or that person’s representative may request to postpone the hearing for up to 30 days, provided the request is made at least 10 calendar days before the scheduled hearing date.

c. At the hearing, the presiding officer shall advise the household member or that person’s representative that the household member has the right to refuse to answer questions during the hearing and that the state or federal government may use the information in a civil or criminal action.

7.21(5) Consolidating hearings. Appeal hearings and food assistance administrative disqualification hearings may be consolidated if the issues arise out of the same or related circumstances and the household member has been provided with notice of the consolidation by the department of inspections and appeals.

a. If the hearings are combined, the time frames for conducting a food assistance administrative disqualification hearing shall apply.

b. If the hearings are combined for the purpose of setting the amount of the overpayment at the same time as determining whether or not an intentional program violation has occurred, the household shall lose its right to a subsequent hearing on the amount of the overpayment.

7.21(6) Attendance at hearing. The household member shall be allowed ten days from the scheduled hearing to present reasons indicating good cause for not attending the hearing.

a. The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists for the default as specified in subrule 7.13(5). Timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

b. Unless good cause is determined, when the household member or that person's representative cannot be located or fails to appear at the scheduled hearing, the hearing shall be conducted without that person. In that instance, the presiding officer shall consider the evidence and determine if the evidence is clear and convincing that an intentional program violation was committed.

c. If the household member who failed to appear at the hearing is found to have committed an intentional program violation, but the presiding officer later determines that this person or the person's representative had good cause for not appearing, the previous hearing decision shall no longer be valid. A new hearing shall be conducted.

d. When good cause for failure to appear is based upon a showing of nonreceipt of the hearing notice, the household member has 30 days after the date of the proposed decision to claim good cause for failure to appear.

e. "Good cause" for purposes of this rule is defined as an emergency circumstance that is beyond the control of the party and that prevents the party from being able to participate in the hearing.

(1) Examples of good cause include, but are not limited to:

1. Sudden, severe illness or accident involving the party or the party's immediate family (spouse, partner, children, parents, sibling).

2. Death or serious illness in the party's immediate family.

3. Other circumstances evidencing an emergency situation which was beyond the party's control and was not reasonably foreseeable.

(2) Examples of circumstances that do not constitute good cause include, but are not limited to:

1. A lost or misplaced notice of hearing.

2. Confusion as to the date and time for the hearing.

3. Failure to follow the directions on the notice of hearing.

4. Oversleeping.

5. Other acts demonstrating a lack of due care by the party.

7.21(7) Food assistance administrative disqualification hearing decisions. The presiding officer shall base the determination of an intentional program violation on clear and convincing evidence that demonstrates the person committed, and intended to commit, an intentional program violation.

a. The proposed and final hearing decisions shall be made in accordance with rule 441—7.16(17A) unless otherwise specified.

b. The appeals section shall notify the household member and the local office of the final decision within 90 days of the date the household member is notified in writing that the hearing has been scheduled. If the hearing was postponed pursuant to 7.21(4) "b," the 90-day period for notifying the household member of the final decision shall be extended for as many days as the hearing is postponed.

c. The department shall take no action to disqualify a person from receiving food assistance before receiving the final appeal decision finding that the person has committed an intentional program violation.

d. No further administrative appeal procedure shall exist after the final decision is issued. The determination of an intentional program violation shall not be reversed by a subsequent hearing decision. However, the person may appeal the case to the Iowa district court.

e. When a court decision reverses a determination of an intentional program violation, the appeals section shall notify the local office of the specifics of the court decision.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 3093C, IAB 6/7/17, effective 7/12/17; ARC 3787C, IAB 5/9/18, effective 7/1/18; ARC 4064C, IAB 10/10/18, effective 12/1/18]

441—7.22(17A) FIP disqualification hearings. Rescinded IAB 4/30/03, effective 7/1/03.

441—7.23(17A) Contested cases with no factual dispute. If the parties in a contested case agree that there is no dispute of material fact, the parties may present all admissible evidence either by stipulation, or as otherwise agreed, in lieu of an evidentiary hearing. If an agreement is reached, the parties shall jointly submit a schedule for submission of the record, briefs and oral arguments to the presiding officer for approval.

441—7.24(17A) Emergency adjudicative proceedings.

7.24(1) Necessary emergency action. To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the United States Constitution and the Iowa Constitution and other provisions of law, the department of inspections and appeals may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the agency by emergency adjudicative order. Before issuing an emergency adjudicative order, the department of inspections and appeals shall consider factors including, but not limited to, the following:

a. Whether there has been sufficient factual investigation to ensure that the agency is proceeding on the basis of reliable information.

b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing.

c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare.

d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare.

e. Whether the specific action contemplated by the agency is necessary to avoid the immediate danger.

7.24(2) Issuance of order.

a. An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger and the department's decision to take immediate action.

b. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by using one or more of the following procedures:

(1) Personal delivery.

(2) Certified mail, return receipt requested, to the last address on file with the department.

(3) Certified mail to the last address on file with the department.

(4) First-class mail to the last address on file with the department.

(5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that department orders be sent by fax and has provided a fax number for that purpose.

c. To the degree practicable, the agency shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

7.24(3) Oral notice. Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

7.24(4) Completion of proceedings. After the issuance of an emergency adjudicative order, the agency shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger. Issuance of a written emergency adjudicative order shall include notification of the date on which agency proceedings are scheduled for completion. After

issuance of an emergency adjudicative order, continuance of further agency proceedings to a later date will be granted only in compelling circumstances upon application in writing.
[ARC 3093C, IAB 6/7/17, effective 7/12/17]

441—7.25 to 7.40 Reserved.

DIVISION II
APPEALS BASED ON THE COMPETITIVE PROCUREMENT BID PROCESS

441—7.41(17A) Scope and applicability. The rules in Division II apply to appeals based on the department's competitive procurement bid process.
[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.42(17A) Requests for timely filing of an appeal. Any bidder that receives either a notice of disqualification or a notice of award, and has first exhausted the reconsideration process, is considered an aggrieved party and may file a written appeal with the department.

7.42(1) An aggrieved party in a competitive procurement must seek reconsideration of a disqualification or a notice of award prior to filing any appeal. The request for reconsideration must be received by the department within five days of the date of either a disqualification notice or notice of award. The department will expeditiously address the request for reconsideration and issue a decision on the reconsideration. If the party seeking reconsideration continues to be an aggrieved party following receipt of the decision on reconsideration, the aggrieved party may file an appeal within five days of the date of the department's decision on reconsideration.

7.42(2) The written appeal shall state the grounds upon which the appellant challenges the department's decision.

7.42(3) The day after the department's decision on reconsideration is issued is the first day of the period in which the appeal may be filed. The mailing address is: Department of Human Services, Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Appeals may also be sent by fax, email, or in-person delivery.

When an appeal is submitted through an electronic delivery method, such as electronic mail or facsimile, the appeal is filed on the date it is submitted. The electronic delivery method shall record the date and time the appeal request was submitted. If there is no date recorded by the electronic delivery method or the appeal was filed via in-person delivery, the date of filing is the date the appeal is stamped received by the agency. Receipt date of all appeals shall be documented by the office where the appeal is received.

When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 3093C, IAB 6/7/17, effective 7/12/17]

441—7.43(17A) Bidder appeals. The bidder appeal shall be a contested case proceeding and shall be conducted in accordance with the provisions of Division II. Division I of this chapter does not apply to competitive procurement bid appeals, unless otherwise noted.

7.43(1) Hearing time frame. The presiding officer shall hold a hearing on the bidder appeal within 60 days of the date the notice of appeal was received by the department.

7.43(2) Registration. Upon receipt of the notice of appeal, the department shall register the appeal.

7.43(3) Acknowledgment. Upon receipt of the notice of appeal, the department shall send a written acknowledgment of receipt of the appeal to the appellant, representative, or both. The appropriate department staff will be notified of the appeal.

7.43(4) Granting a hearing. The department shall determine whether an appellant may be granted a hearing and the issues to be discussed at the hearing in accordance with the applicable rules, statutes or federal regulations or request for proposal.

a. The appeals of those appellants who are granted a hearing shall be certified to the department of inspections and appeals for the hearing to be conducted. The department shall indicate at the time of certification the issues to be discussed at the hearing.

b. Appeals of those appellants that are denied a hearing shall not be closed until a letter is sent to the appellant and the appellant's representative advising of the denial of the hearing and the basis upon which that denial is made. Any appellant that disagrees with a denial may present additional information relative to the reason for denial and request reconsideration by the department over the denial.

7.43(5) *Hearing scheduled.* For those records certified for hearing, the department of inspections and appeals shall establish the date, time, method and place of the hearing, with due regard for the convenience of the appellant as set forth in the department of inspections and appeals rules in 481—Chapter 10 unless otherwise designated by federal or state statute or regulation.

7.43(6) *Method of hearing.* The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if the appellant requests one. All parties shall be granted the same rights during a teleconference hearing as specified in rule 441—7.13(17A).

7.43(7) *Reschedule requests.* Requests made by the appellant or the department to set another date, time, method or place of hearing shall be made to the department of inspections and appeals, except as otherwise noted. The granting of the requests will be at the discretion of the department of inspections and appeals. All requests concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.

7.43(8) *Notification.* For those appeals certified for hearing, the department of inspections and appeals shall send a notice to the appellant at least ten calendar days in advance of the hearing date.

a. The notice shall comply with Iowa Code section 17A.12(2), and include a statement that opportunity shall be afforded to all parties to respond and present evidence on all issues involved and to be represented by counsel at their own expense.

b. A copy of this notice shall be made available to the department employee who took the action and to any other parties to the appeal.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.44(17A) Procedures for bidder appeal.

7.44(1) *Discovery.* The parties shall serve any discovery requests upon other parties at least 30 days prior to the date set for the hearing. The parties must serve responses to discovery at least 15 days prior to the date set for the hearing.

7.44(2) *Witnesses and exhibits.* The parties shall contact each other regarding witnesses and exhibits at least ten days prior to the date set for the hearing. The parties must meet prior to the hearing regarding the evidence to be presented in order to avoid duplication or the submission of extraneous materials.

7.44(3) *Amendments to notice of appeal.* The aggrieved bidder may amend the grounds upon which the bidder challenges the department's award no later than 15 days prior to the date set for the hearing.

7.44(4) *If the hearing is not conducted in person, the parties must deliver all exhibits to the office of the presiding officer at least three days prior to the time the hearing is conducted.*

7.44(5) *The presiding officer shall issue a proposed decision in writing that includes findings of fact and conclusions of law stated separately. The decision shall be based on the record of the contested case and shall conform to Iowa Code chapter 17A. The presiding officer shall send the proposed decision to the appellant and representative by mail.*

7.44(6) *The record of the contested case shall include all materials specified in Iowa Code subsection 17A.12(6).*

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.45(17A) Stay of agency action for bidder appeal.

7.45(1) *When a stay may be requested.*

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

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

7.45(2) *When a stay is granted.* In determining whether to grant a stay, the director shall consider the factors listed in Iowa Code section 17A.19(5)“c.”

7.45(3) *Vacation.* A stay may be vacated by the issuing authority upon application of the department or any other party.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.46(17A) Request for review of the proposed decision. A request for review of the proposed decision shall follow the provisions outlined in subrules 7.16(5) to 7.16(8).

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 3787C, IAB 5/9/18, effective 7/1/18]

441—7.47(17A) Other procedural considerations.

7.47(1) *Consolidation—severance.*

a. Consolidation. The presiding officer may, upon motion by any party or the presiding officer’s own motion, consolidate any or all matters at issue in two or more contested case proceedings where:

- (1) The matters at issue involve common parties or common questions of fact or law;
- (2) Consolidation would expedite and simplify consideration of the issues; and
- (3) Consolidation would not adversely affect the rights of parties to those proceedings.

At any time prior to the hearing, any party may on motion request that the matters not be consolidated, and the motion shall be granted for good cause shown.

b. Severance. The presiding officer may, upon motion by any party or upon the presiding officer’s own motion, for good cause shown, order any proceeding or portion thereof severed.

7.47(2) *Presiding officer.* Appeal hearings shall be conducted by an administrative law judge appointed by the department of inspections and appeals pursuant to rule 441—7.3(17A).

7.47(3) *Rights of appellants during hearings.* All rights afforded appellants at rule 441—7.13(17A) shall apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.48(17A) Appeal record.

7.48(1) The appeal record shall consist of all items specified in subrule 7.16(1).

7.48(2) The party that requests a transcription of the proceedings shall bear the cost.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.49(17A) Pleadings.

7.49(1) Pleadings may be required by rule, by the notice of hearing or by order of the presiding officer.

7.49(2) *Petition.* When an action of the department is appealed and pleadings are required under subrule 7.49(1), the aggrieved party shall file the petition.

a. Any required petition shall be filed within 20 days of delivery of the notice of hearing, unless otherwise ordered.

b. The petition shall state in separately numbered paragraphs the following:

- (1) On whose behalf the petition is filed;
- (2) The particular provisions of the statutes and rules involved;
- (3) The relief demanded and the facts and law relied upon for relief; and
- (4) The name, address and telephone number of the petitioner and the petitioner’s attorney, if any.

7.49(3) *Answer.* If pleadings are required, the answer shall be filed within 20 days of service of the petition or notice of hearing, unless otherwise ordered.

a. Any party may move to dismiss or apply for a more definite, detailed statement when appropriate.

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

c. The answer shall state the name, address and telephone number of the person filing the answer and of the attorney representing that person, if any.

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

7.49(4) Amendment. Any notice of hearing, petition or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed and to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.50(17A) Ex parte communications. The rules regarding ex parte communications listed at 441—7.18(17A) apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.51(17A) Right of judicial review. The rules regarding right of judicial review listed at 441—7.20(17A) apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

These rules are intended to implement Iowa Code chapter 17A.

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◊ Two or more ARCs

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF
MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

For purposes of this chapter, "managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

79.1(1) Types of reimbursement.

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's website at: dhs.iowa.gov/ime/providers/csrp/fee-schedule.

d. Fee for service with cost settlement. Rescinded IAB 10/10/18, effective 12/1/18.

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1) "e"(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5) "aa" and 79.1(16) "h."

h. Indian health facilities.

(1) Indian health facilities enrolled pursuant to rule 441—77.45(249A) are paid for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible at the current daily visit rates approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register. For services provided to American Indians or Alaskan natives, Indian health facilities may bill for one visit per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all medical services provided on that day, except as follows:

1. For services provided to American Indians and Alaskan natives, Indian health facilities may bill for multiple visits per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)") only if medical services are provided for different diagnoses or if distinctly different medical services from different categories of services are provided for the same diagnoses in different units of the facility. For this purpose, the categories of medical services are vision services; dental services; mental health and addiction services; early and periodic screening, diagnosis, and treatment services for children; other outpatient services; and other inpatient services. A visit is a face-to-face contact between a patient and a health professional at or through the facility.

2. For services provided to American Indians or Alaskan natives, Indian health facilities may also bill for one visit per patient per calendar day for outpatient prescribed drugs provided by the facility (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all outpatient prescribed drugs provided on that day.

(2) Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the reimbursement rate otherwise allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form or through pharmacy point of sale. Claims for nonpharmacy services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

<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	Fee schedule in effect 7/1/13.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community-based neurobehavioral rehabilitation services	Fee schedule, see 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: \$21.11 per 15-minute unit.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Crisis response services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization community-based services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization residential services	Fee schedule	Fee schedule in effect 2/1/18.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Federally qualified health centers	Retrospective cost-related. See 441—Chapter 73	<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 FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Fee schedule	Effective 7/1/16, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider’s rate in effect 6/30/16 plus 1%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/16 rate: Veterans Administration contract rate or \$1.47 per 15-minute unit, \$23.47 per half day, \$46.72 per full day, or \$70.06 per extended day if no Veterans Administration contract.
	For intellectual disability waiver: Fee schedule for the member’s acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17, for intellectual disability waiver: The provider’s rate in effect 6/30/16 plus 1%, converted to a 15-minute or half-day rate. If no 6/30/16 rate, \$1.96 per 15-minute unit or \$31.27 per half day. For daily services, the fee schedule rate published on the department’s website, pursuant to 79.1(1)“c,” for the member’s acuity tier, determined pursuant to 79.1(30).
2. Emergency response system: Personal response system	Fee schedule	Effective 7/1/13, provider’s rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Portable locator system	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: One equipment purchase: \$323.26. Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%. For intellectual disability waiver effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.20 per 15-minute unit.
5. Nursing care	Fee schedule	For AIDS/HIV, health and disability, elderly and intellectual disability waiver effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$87.99 per visit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed \$315.09 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.96 per 15-minute unit, not to exceed \$315.09 per day.
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$4.78 per 15-minute unit, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.96 per 15-minute unit, not to exceed \$315.09 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$4.78 per 15-minute unit, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Adult day care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed contractual daily rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Foster group care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.05 per 15-minute unit.
8. Home-delivered meals	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$8.10 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/13: \$1,061.11 lifetime maximum. For intellectual disability waiver effective 7/1/13: \$5,305.53 lifetime maximum. For brain injury, health and disability, and physical disability waivers effective 7/1/13: \$6,366.64 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Effective 10/1/13: The provider's nonemergency medical transportation contract rate or, in the absence of a nonemergency medical transportation contract rate, the median nonemergency medical transportation contract rate paid per mile or per trip within the member's DHS region.
12. Nutritional counseling	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.76 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/13: \$115.62 per unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
14. Senior companion	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$1.89 per 15-minute unit.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$5.35 per 15-minute unit, not to exceed \$123.85 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$5.35 per 15-minute unit, not to exceed \$123.85 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/16, \$3.58 per 15-minute unit, not to exceed \$83.36 per day. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.45 per 15-minute unit.
Group	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.44 per 15-minute unit. 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 schedule	For brain injury and elderly waivers: Fee schedule in effect 7/1/18.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
18. Supported community living	For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15)	For brain injury waiver effective 7/1/16: \$9.28 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3.927%.
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30). Retrospectively limited prospective rate for SCL 15-minute unit. See 79.1(15)	For intellectual disability waiver effective 7/1/17: \$9.28 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
19. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/16. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$11.45 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.44 per 15-minute unit.
23. Prevocational services, including career exploration	Fee schedule	Fee schedule in effect 7/1/16.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit.
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$9.28 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 3.927%.
25. Residential-based supported community living	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17: The fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
26. Day habilitation	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.51 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$9.28 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$24.85 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$68.97 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$16.07 per hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider	\$26.08 per day.
Health home services provider	Fee schedule based on the member's qualifying health condition(s).	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule. See 79.1(24) "d"	Fee schedule in effect 7/1/18.
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.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
3. Day habilitation	See 79.1(24) "d"	Effective 7/1/13: \$3.30 per 15-minute unit or \$64.29 per day.
4. Prevocational habilitation Career exploration	Fee schedule	Fee schedule in effect May 4, 2016.
5. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect May 4, 2016. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.
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 7/1/18: Medicare LUPA rates in effect on 6/30/18 plus a 3% increase.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14) "d")
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1) "g" and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/13 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16) "c"	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 6/30/13 plus 1%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health facilities	1. Daily visit rate approved by the U.S. Indian Health Service (IHS) for services provided to American Indian and Alaskan native members. See 79.1(1) "h"	1. IHS-approved rate published in the Federal Register as outpatient per visit rate (excluding Medicare).

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/13 plus 1%.
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. See 79.1(7) “d”	Fee schedule in effect 7/1/17. See 79.1(7) “d.”
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Qualified primary care services	See 79.1(7) “c”	Rate provided by 79.1(7) “c”

<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	Fee schedule	Effective 7/1/14: non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
State-operated institutions	Retrospective cost-related	
Subacute mental health facility	Fee schedule	Fee schedule in effect 2/1/18.
Targeted case management providers	Fee schedule	Fee schedule in effect 7/1/18.

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 website. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)“c”). This payment is made directly to the physician or dentist.

79.1(4) *Durable medical equipment, prosthetic devices, medical supply dealers.* Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5)“n.”

79.1(5) *Reimbursement for hospitals.*

a. *Definitions.*

“*Adolescent*” shall mean a Medicaid patient 17 years or younger.

“*Adult*” shall mean a Medicaid patient 18 years or older.

“*Average daily rate*” shall mean the hospital’s final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

“*Base year cost report*” means the hospital’s cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5)“x.” Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“*Blended base amount*” shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Blended capital costs*” shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Capital costs*” shall mean an add-on to the blended base amount, which shall compensate for Medicaid’s portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital’s base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“Case-mix adjusted” shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“Case-mix index” shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“Children’s hospitals” shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children’s hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children’s Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children’s Hospitals and Related Institutions for dates of service on or after October 1, 2014.

“Cost outlier” shall mean cases which have an extraordinarily high cost as established in 79.1(5) “f,” so as to be eligible for additional payments above and beyond the initial DRG payment.

“Critical access hospital” or *“CAH”* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

“Diagnosis-related group (DRG)” shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

“Direct medical education costs” shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Direct medical education rate” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital’s case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Disproportionate share payment” shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

“Disproportionate share percentage” shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital’s own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5) “y”(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Disproportionate share rate” shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

“DRG weight” shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

“Final payment rate” shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider’s reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

“Full DRG transfer” shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

“Indirect medical education rate” shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns’ and residents’ program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Inlier” shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

“Long stay outlier” shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5) “f.”

“Low-income utilization rate” shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

"Medicaid inpatient utilization rate" shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" shall mean a designated level II or level III neonatal unit.

"Net discharges" shall mean total discharges minus transfers and short stay outliers.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rate table listing" shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

"Rebasing" shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Rebasing implementation year" means 2008 and every three years thereafter.

"Recalibration" shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5) "f."

b. *Determination of final payment rate amount.* The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5) "r." Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5) "r." Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating

neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.
4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs,

direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$75,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within 30 days for same condition. Effective for dates of service on or after July 1, 2015, when an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays. The readmission policy does not apply to the following:

1. Scheduled readmissions that are part of repetitive or periodic treatments; and
2. Critical access hospitals.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)“r,” and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)“r,” which are paid per diem, as specified in paragraph 79.1(5)“i.”

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)“r” and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)“r” is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital’s base-year cost report pursuant to paragraph 79.1(5)“a.” No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)“j.”

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state’s fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare’s approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital’s reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)“y”(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph 79.1(5)“y,” for dates of service prior to October 1, 2014. Out-of-state hospitals do not qualify for disproportionate share payments for dates of service on or after October 1, 2014.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5)“y.”

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph "f."

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)"b"(1), a neonatal intensive care unit under subparagraph 79.1(5)"b"(2), a psychiatric unit under paragraph 79.1(5)"i," or a physical rehabilitation hospital or unit under paragraph 79.1(5)"i" shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)"b"(1) if the unit's program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital

must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)“b”(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit’s certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)“i” if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5)“i” if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital's fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state's fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is \$26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. Non-state-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5) "y" and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity.

Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

- (1) Advertising.
- (2) Promotional items.
- (3) Feasibility studies.
- (4) Administrative travel and entertainment.
- (5) Dues, subscriptions, or membership costs.
- (6) Contributions made to other organizations.
- (7) Home office costs.
- (8) Public relations items.
- (9) Any patient convenience items.
- (10) Management fees for administrative services.
- (11) Luxury employee benefits (i.e., country club dues).
- (12) Motor vehicles for other than patient care.
- (13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals in Iowa qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is \$7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is \$13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services

to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term “obstetrician” includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency’s calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital’s own state Medicaid inpatient utilization rate exceeds the hospital’s own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility’s status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is \$6,959,868.59. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital’s low-income utilization rate and Medicaid utilization rate (or for children’s hospitals, during the preceding state fiscal year) by each hospital’s disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children’s hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital’s dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital’s percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5) “u” or 79.1(5) “v” cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children’s hospital. A licensed hospital qualifies for disproportionate share payments as a children’s hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age. In addition, the hospital must be a voting member of the National Association of Children’s Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children’s Hospitals and Related Institutions for dates of service on or after October 1, 2014.

A hospital wishing to qualify for disproportionate share payments as a children’s hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audit and rate setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5) "a" to "z" are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5) "a" to "z." Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5) "k."

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code Explanation

- | | |
|---|--|
| Y | The condition was present or developing at the time of the order for inpatient admission. |
| N | The condition was not present or developing at the time of the order for inpatient admission. |
| U | Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission. |
| W | Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission. |

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

ac. Rural hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) “y,” payment shall be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) Qualifying criteria. A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5) “y” and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) Source of nonfederal share. The required nonfederal share shall be funds generated from tax levy collections of the county or city in which the hospital is located, and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year shall apply.

(3) Amount of payment. The total amount of disproportionate share payments made pursuant to paragraph 79.1(5) “y” and the rural hospital disproportionate share payments shall not exceed the amount of the state’s allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department, for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666.

79.1(6) Independent laboratories. The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician’s Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) Physicians.

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician’s Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2) “e” for the guidelines for immunization replacement.

b. Payment reduction for services rendered in facility settings. The fee schedule amount paid to physicians based on paragraph 79.1(7) “a” shall be reduced by an adjustment factor, as determined by the department and published with the Iowa Medicaid fee schedule, to reflect the lower cost of providing physician services in a facility setting, as opposed to the physician’s office. For the purpose of this provision, a “facility” place of service (POS) is defined as any of the following (consistent with “POS” definitions under Medicare, per the Medicare Claims Processing Manual, Chapter 12, Section 20.4.2, revised as of May 2017):

- (1) Telehealth (POS 02).
- (2) Outpatient hospital-off campus (POS 19).
- (3) Inpatient hospital (POS 21).
- (4) Outpatient hospital-on campus (POS 22).
- (5) Emergency room-hospital (POS 23).

- (6) Ambulatory surgical center (POS 24).
- (7) Military treatment center (POS 26).
- (8) Skilled nursing facility (POS 31).
- (9) Hospice-for inpatient care (POS 34).
- (10) Ambulance-land (POS 41).
- (11) Ambulance-air or water (POS 42).
- (12) Inpatient psychiatric facility (POS 51).
- (13) Psychiatric facility-partial hospitalization (POS 52).
- (14) Community mental health center (POS 53).
- (15) Psychiatric residential treatment center (POS 56).
- (16) Comprehensive inpatient rehabilitation (POS 61).

c. Payment for primary care services. To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar year 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (4) and (6) of this paragraph (79.1(7) "c"). Primary care services furnished January 1, 2015, through June 30, 2017, by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (3), (5), and (7) of this paragraph (79.1(7) "c").

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7) "c") include:

1. Evaluation and management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7) "c"), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7) "c") equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7) "c"), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

(4) Primary care services rendered in calendar year 2013 or 2014. Primary care services rendered in calendar year 2013 or 2014 that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1).

(5) Primary care services rendered on or after January 1, 2015. Primary care services rendered on or after January 1, 2015, that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;
2. The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;
3. The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1), and in effect on June 30, 2014.

(6) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program in calendar year 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program; or

2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

(7) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program on or after January 1, 2015, shall be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or

2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

d. Payment for anesthesia services. Anesthesia services are paid pursuant to this paragraph and the Iowa Medicaid fee schedule published by the department pursuant to paragraph 79.1(1)“c.” Anesthesia procedures listed in the fee schedule with a factor code of “F” are paid at the dollar amount of the factor listed for the procedure in the fee schedule. Anesthesia procedures listed in the fee schedule with a factor code of “A” are paid a dollar amount equal to the Iowa Medicaid anesthesia conversion factor multiplied by the sum of the minutes of service provided and the factor listed for the procedure in the fee schedule. Beginning July 1, 2017, the Iowa Medicaid anesthesia conversion factor is the current Medicare anesthesia conversion factor for Iowa, converted to a per-minute amount. For 2017, that amount is \$1.40, which will be updated annually on January 1.

79.1(8) Drugs.

a. Except as provided below in paragraphs 79.1(8)“d” through “i,” all providers are reimbursed for covered drugs as follows:

(1) Reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c.”

2. The federal upper limit (FUL), defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514(a)-(c), plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c.”

3. The total submitted charge.

4. Providers’ usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state AAC, determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c.”

2. The total submitted charge.

3. Providers’ usual and customary charge to the general public.

b. For purposes of this subrule, average state AAC is defined as retail pharmacies’ average prices paid to acquire drug products. Average state AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department’s discretion. The average state AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average state AAC determined by the department shall be published on the Iowa Medicaid enterprise website. If no current average state AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average state AAC.

c. For purposes of this subrule, the professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers’ costs of dispensing drugs to Medicaid beneficiaries. The survey shall be conducted every two years beginning in state fiscal year 2014-2015.

d. For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose shall be added to reimbursement based on acquisition cost or FUL.

e. 340B-purchased drugs.

- (1) Notwithstanding paragraph 79.1(8)“a” above, reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. The submitted 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price) plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

2. The average state AAC determined pursuant to paragraph 79.1(8)“b” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

3. For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“a”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

4. The total submitted charge; or

5. Providers’ usual and customary charge to the general public.

- (2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4), will be according to paragraph 79.1(8)“a” because covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

f. Federal supply schedule (FSS) drugs. Notwithstanding paragraph 79.1(8)“a” above, reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

- (1) The provider’s actual acquisition cost, not to exceed the FSS price, plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

- (2) The average state AAC determined pursuant to paragraph 79.1(8)“b” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

- (3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“a”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

- (4) The total submitted charge; or

- (5) Providers’ usual and customary charge to the general public.

g. Nominal-price drugs. Notwithstanding paragraph 79.1(8)“a” above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug’s “best price” pursuant to 42 CFR 447.508 will be the lowest of:

- (1) The provider’s actual acquisition cost (not to exceed the nominal price paid) plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

(2) The average state AAC determined pursuant to paragraph 79.1(8)“b” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“a”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

(4) The total submitted charge; or

(5) Providers’ usual and customary charge to the general public.

h. Indian health facilities enrolled pursuant to rule 441—77.45(249A). For all drugs provided to American Indians or Alaskan natives by Indian health facilities enrolled pursuant to rule 441—77.45(249A), reimbursement is one pharmacy encounter payment per date of service, notwithstanding paragraphs 79.1(8)“a” through “f.” The pharmacy encounter rate is the current “outpatient per visit rate (excluding Medicare)” approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, and includes reimbursement for the dispensing fees, ingredient cost, and any necessary counseling by the pharmacist.

i. Vaccines for Children Program. All providers administering vaccines available through the Vaccines for Children Program to Medicaid members shall enroll in the Vaccines for Children Program. In lieu of payment, vaccines available through the Vaccines for Children Program shall be accessed from the department of public health for Medicaid members. Providers may receive Medicaid reimbursement for the administration of vaccines to Medicaid members through the otherwise applicable reimbursement for inpatient or outpatient services.

j. Physician-administered drugs. Notwithstanding paragraphs 79.1(8)“a” through “f,” payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II “J” codes, as a physician service, shall be pursuant to the physician payment policy under subrule 79.1(2).

k. Under this subrule, no payment shall be made for sales tax.

l. For purposes of this subrule, the Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

79.1(9) HCBS consumer choices financial management.

a. Monthly allocation. A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer’s individual budget amount as determined under 441—paragraph 78.34(13)“b,” 78.37(16)“b,” 78.38(9)“b,” 78.41(15)“b,” 78.43(15)“b,” or 78.46(6)“b.”

b. Cost settlement. The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

c. Start-up grants. A qualifying financial management service provider may be reimbursed up to \$10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under Part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the Part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) *Copayment by member.* A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment of \$1 for each covered prescription or refill of any covered drug.

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 brain injury waiver supported community living; HCBS intellectual disability waiver supported community living for 15-minute services; HCBS family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed \$1,570 per consumer per year for supported community living services in the brain injury waiver.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed \$1,500 per child per year for family and community support services.

(9) The reasonable costs of direct care staff training shall be treated as direct care costs, rather than as indirect administrative costs.

c. Prospective rates for new providers.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph "e."

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph "d."

d. Prospective rates for established providers.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph "f."

e. Prospective rates for respite. Rescinded IAB 5/1/13, effective 7/1/13.

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) For services provided from July 1, 2015, through June 30, 2016, revenues exceeding adjusted actual costs by more than 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) For services provided from July 1, 2015, through June 30, 2016, providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 percent of the actual costs deducted from future payments.

(4) For services provided on or after July 1, 2016, revenues exceeding adjusted actual costs by more than 5.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(5) For services provided on or after July 1, 2016, providers who do not reimburse revenues exceeding 105.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 105.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) Outpatient reimbursement for hospitals.*a. Definitions.*

“*Allowable costs*” means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

“*Ambulatory payment classification*” or “*APC*” means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

“*Ambulatory payment classification relative weight*” or “*APC relative weight*” means the relative value assigned to each APC.

“*Ancillary service*” means a supplemental service that supports the diagnosis or treatment of the patient’s condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

“*APC service*” means a service that is priced and paid using the APC system.

“*Base year cost report,*” for rates effective January 1, 2009, means the hospital’s cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“*Blended base APC rate*” shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

“*Case-mix index*” shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

“*Cost outlier*” shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph “g” and are therefore eligible for additional payments above and beyond the base APC payment.

“*Current procedural terminology—fourth edition (CPT-4)*” is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

“*Diagnostic service*” means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

“*Direct medical education costs*” shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

“*Direct medical education rate*” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

“*Discount factor*” means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

“*GME/DSH fund apportionment claim set*” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

“*GME/DSH fund implementation year*” means 2009.

“*Graduate medical education and disproportionate share fund*” or “*GME/DSH fund*” means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

“*Healthcare common procedures coding system*” or “*HCPCS*” means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

“*Hospital-based clinic*” means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

“*Medicaid claim set*” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“*Modifier*” means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

“*Multiple significant procedure discounting*” means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

“*Observation services*” means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

“*Outpatient hospital services*” means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

“*Outpatient prospective payment system*” or “*OPPS*” means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

“*Outpatient visit*” shall mean those hospital-based outpatient services which are billed on a single claim form.

“*Packaged service*” means a service that is secondary to other services but is considered an integral part of another service.

“*Pass-through*” means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

“*Quality improvement organization*” or “*QIO*” shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“*Rebasing*” shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

“*Significant procedure*” shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

“*Status indicator*” or “*SI*” means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. *Outpatient hospital services.* Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)"c."

(2) Except as provided in paragraph 79.1(16)"h," outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)"j."

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)"e."
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as:</p> <ul style="list-style-type: none"> ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital. 	<p>For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)"c."</p> <p>For 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).</p>
B	Codes that are not paid by Medicare on an outpatient hospital basis	<p>Not paid under OPPS APC.</p> <ul style="list-style-type: none"> ● May be paid when submitted on a different bill type other than outpatient hospital (13x).

Indicator	Item, Code, or Service	OPPS Payment Status
		<ul style="list-style-type: none"> ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	<p>Items, codes, and services:</p> <ul style="list-style-type: none"> ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid. 	<p>If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: <ul style="list-style-type: none"> ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “S,” “T,” “V,” or “X.” ● In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.” ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	<p>If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.</p>
R	Blood and blood products	<p>If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
S	Significant procedure, not discounted when multiple	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
T	Significant procedure, multiple reduction applies	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
U	Brachytherapy sources	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.”</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
Y	Nonimplantable durable medical equipment	<p>For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital’s base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital’s total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital’s total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital’s base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n.”

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.
2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n,” for all hospitals.
3. The total calculated Medicaid cost for ambulance services for all hospitals.
4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital’s cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)“a” shall be the hospital’s line-item charge multiplied by the hospital’s Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital’s annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)“j.”

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

- (1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

- (2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

- (3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

- (1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

- (2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

- (3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

- (4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16) "v"(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

- (1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

- (2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16) "v."

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

- (1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

- (2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)“d”(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room.

1. For members who were referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Rescinded IAB 6/30/10, effective 7/1/10.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) Reimbursement for home- and community-based services home and vehicle modification and equipment. Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) Pharmaceutical case management services reimbursement. Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

<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. Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for Medicare crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicaid-allowed amount*” means the Medicaid reimbursement for the service(s) rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

“*Medicare-allowed amount*” means the total reimbursement allowed by Medicare for the service(s) rendered, for a participating Medicare provider who has accepted Medicare assignment of claims for services rendered, including any portion to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Medicare cost sharing*” means the Medicare member's responsibility to pay for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Medicare crossover claim*” means a claim for Medicaid payment for services covered by Medicare Part A or Part B rendered to a Medicare beneficiary who is also eligible for Medicaid. Medicare crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

“*Medicare deductible and coinsurance amounts*” means the portion of the Medicare-allowed amount to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Medicare provider reimbursement*” means the Medicare-allowed amount less any portion thereof to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual’s Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

“*Third-party payment*” means payment from any source other than Medicaid, Medicare, or the Medicaid and Medicare beneficiary.

b. Reimbursement of Medicare crossover claims. Covered Medicare crossover claims shall be paid by Medicaid at the lesser of:

(1) Applicable Medicare deductible and coinsurance amounts, less any third-party payment available to the provider for the Medicare deductible and coinsurance amounts and any Medicaid copayment or spenddown; or

(2) Either:

1. For Medicaid-covered services: the Medicaid-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown; or

2. For non-Medicaid-covered services: 50 percent of the Medicare-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown.

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1). The unit of service may be a quarter hour, a half hour, an hour, a half day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year’s retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider’s fiscal year that are consistent with Medicaid’s obligation to reimburse that provider’s reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider’s financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider’s Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider’s fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) Reimbursement for home- and community-based habilitation services. Reimbursement for all home- and community-based habilitation services provided on or after January 1, 2016, shall be as provided in paragraph 79.1(24) "d." All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

1. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.

2. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

(3) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

(4) A unit of supported employment habilitation supports to maintain employment is a 15-minute unit.

b. Submission of cost reports. For services provided prior to July 1, 2013, the department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed \$1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report for services provided through June 30, 2013, that meets the requirements of this paragraph, the Iowa Medicaid enterprise or the Iowa Plan for Behavioral Health contractor shall reduce the provider's rate to 76 percent of the current rate. The reduced rate shall be paid until the provider's cost report has been received by the Iowa Medicaid enterprise's provider cost audit and rate setting unit pursuant to subparagraph 79.1(24) "b"(4) but for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. For services provided prior to July 1, 2013, reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

d. Reimbursement for services provided on or after January 1, 2016.

(1) For dates of services on or after January 1, 2016, habilitation services, except for case management, shall be reimbursed by fee schedule. Case management will continue to be reimbursed by retrospective cost settlement.

(2) For dates of services on or after July 1, 2018, case management services shall be reimbursed by fee schedule.

79.1(25) Reimbursement for community mental health centers (CMHCs) and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).

a. Reimbursement methodology for providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3). Effective for services rendered on or after October 1, 2006, providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles.

b. Reimbursement methodology for community mental health centers. Effective for services rendered on or after July 1, 2014, community mental health centers may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology approved by the department of human services. Once a community mental health center chooses the alternative reimbursement rate methodology, the community mental health center may not change its elected reimbursement methodology to 100 percent of reasonable costs.

c. Cost-based reimbursement. For providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) and CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following.

(1) Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

d. Reporting requirements. All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using Form 470-4419, Financial and Statistical Report. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552-96. The following requirements apply to all required cost reports.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

79.1(26) Home health services.

a. Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

79.1(27) Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.

a. *Rate determination based on cost reports.* Reimbursement shall be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and the Iowa Medicaid enterprise (IME) may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review or audit or both by the Iowa Medicaid enterprise to determine the actual cost of services in accordance with generally accepted accounting principles, Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, subject to the exceptions and limitations in the department's administrative rules.

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. *Financial and statistical report submission and reporting requirements.*

(1) The provider shall submit the complete Financial and Statistical Report, Form 1728-94, in an electronic format approved by the department to the IME provider cost audit and rate setting unit within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to the IME provider cost audit and rate setting unit. The extension request must be received by the IME provider cost audit and rate setting unit before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to the IME provider cost audit and rate setting unit in an electronic format that can be opened using the extension xls or xlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be emailed to costaudit@dhs.state.ia.us on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27) "b"(4), the department shall reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

2. The reduced rate(s) shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items which had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify the Iowa Medicaid enterprise when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

c. Terminated home health agencies.

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department of human services with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27) "b."

(2) For facilities that terminate activity with the Iowa Medicaid enterprise, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27) "a" shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, the Iowa Medicaid enterprise will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

79.1(28) Reimbursement for community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.

a. New providers. Providers who are newly enrolled shall be paid prospective rates based on projected reasonable and proper costs of operation based on the statewide average rate paid to community-based neurobehavioral rehabilitation service providers in effect June 30 each fiscal year.

b. Established providers. After establishment of the initial rate for a provider, the rate will be adjusted annually, effective July 1 each year. The provider's new rate shall be the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, not to exceed the limit in effect June 30.

79.1(29) *Reimbursement for health insurance premium payment (HIPP) program providers.* Reimbursement for HIPP program providers shall be provided only when such provider is enrolled with Iowa Medicaid for the sole purpose of billing HIPP-eligible in-network coinsurance, copayments, and deductibles.

a. Definitions. For purposes of this subrule:

"*Coinsurance*" means a percentage of costs of a covered health care service that has to be paid.

"*Copayment*" means a fixed amount a member pays for a covered health care service.

"*Deductible*" means the amount paid for covered health care services before the insurance plan starts to pay.

"*Eligible member*" means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

"*Health insurance premium payment (HIPP) program*" or "*HIPP program*" has the same meaning as provided in rule 441—75.21(249A).

b. Claim submission. To submit a claim for reimbursement, a HIPP provider shall use Form 470-5475, Health Insurance Premium Payment (HIPP) Provider Invoice.

(1) Payment shall be made to eligible providers for a HIPP-eligible member's coinsurance, copayment, and deductible, when the HIPP-eligible member is active on the date of service.

(2) Member responsibility. The eligible member may be responsible for a copayment pursuant to subrule 79.1(13).

79.1(30) *Tiered rates.* For supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the intellectual disability waiver, the fee schedule published by the department pursuant to paragraph 79.1(1) "*c*" provides rates based on the acuity tier of the member, as determined pursuant to this subrule.

a. Acuity tiers are based on the results of the Supports Intensity Scale® (SIS) core standardized assessment. The SIS assessment tool and scoring criteria are available on request from the Iowa Medicaid enterprise, bureau of long-term care.

b. The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the SIS scores.

c. For supported community living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services a member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:

(1) Members who receive an average of 40 hours or more of day services per month.

(2) Members who receive an average of less than 40 hours of day services per month.

d. For this purpose, the "SIS activities score" is the sum total of the subscale raw SIS scores converted to standard scores on the following subsections:

(1) Subsection 2A: Home Living Activities;

(2) Subsection 2B: Community Living Activities;

(3) Subsection 2E: Health and Safety Activities; and

(4) Subsection 2F: Social Activities.

e. Also used in determining a member's acuity tier, as provided in paragraphs 79.1(30) "*f*" and "*g*," are the subtotal scores on the following subsections:

(1) Subsection 1A: Exceptional Medical Support Needs, excluding questions 16 through 19; and

(2) Subsection 1B: Exceptional Behavioral Support Needs, excluding question 13.

f. Subject to adjustment pursuant to paragraph 79.1(30) "*g*," acuity tiers are the highest applicable tier pursuant to the following:

- (1) Tier 1: SIS activities score of 0 – 25.
- (2) Tier 2: SIS activities score of 26 – 40.
- (3) Tier 3: SIS activities score of 41 – 44 or SIS activities score of 0 – 40 and a SIS subsection 1B subtotal score of 6 or higher.
- (4) Tier 4: SIS activities score of 45 or higher.
- (5) Tier 5: SIS activities score of 41 or higher and a subsection 1B subtotal score of 7 or higher.
- (6) Tier 6: SIS subsection 1A or 1B subtotal score of 14 or higher.
- (7) RCF tier: Members residing in a residential care facility (RCF) licensed for six or more beds.
- (8) RBSCCL tier: Members residing in a residential-based supported community living (RBSCCL) facility.
- (9) Enhanced tier: An individual member rate negotiated between the department and the provider.
 - g. The tier determined pursuant to paragraph 79.1(30)“f” shall be adjusted as follows:
 - (1) For members with a subsection 1A subtotal score of 2 or 3, as provided in subparagraph 79.1(30)“e”(1), but with a response of “extensive support needed” (score = 2) in response to any prompt in subsection 1A, as provided in subparagraph 79.1(30)“e”(1) and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (2) For members with a subsection 1A subtotal score of 4 – 9, and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (3) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 1 to 3 pursuant to paragraph 79.1(30)“f,” the tier is increased by two tiers.
 - (4) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (5) Any member may receive an enhanced tier rate when approved by the department for fee-for-service members.
 - h. Tier redetermination. A member’s acuity tier may be changed in the following circumstances:
 - (1) There is a change in the member’s SIS activity scores as determined in the annual level of care redetermination process pursuant to rule 441—83.64(249A).
 - (2) A completed DHS Form 470-5486, Emergency Needs Assessment, indicates a change in the member’s support needs. A member’s case manager may request an emergency needs assessment when a significant change in the member’s needs is identified. When a completed emergency needs assessment indicates significant changes that are likely to continue in three of the five domains assessed, a full SIS core standardized assessment shall be conducted and any change in the SIS scores will be used to determine the member’s acuity tier.
 - i. New providers, provider acquisitions, mergers and change in ownership. Any change in provider enrollment status including, but not limited to, new providers, enrolled providers merging into one or more consolidated provider entities, acquisition or takeover of existing HCBS providers,

or change in the majority ownership of a provider on or after December 1, 2017, shall require the new provider entity to use the tiered rate fee schedule in accordance with paragraph 79.1(1) “c.”

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

[ARC 7835B, IAB 6/3/09, effective 7/8/09; ARC 7937B, IAB 7/1/09, effective 7/1/09; ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 8205B, IAB 10/7/09, effective 11/11/09; ARC 8206B, IAB 10/7/09, effective 11/11/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8647B, IAB 4/7/10, effective 3/11/10; ARC 8649B, IAB 4/7/10, effective 3/11/10; ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 8899B, IAB 6/30/10, effective 7/1/10; ARC 9046B, IAB 9/8/10, effective 8/12/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9134B, IAB 10/6/10, effective 10/1/10; ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9176B, IAB 11/3/10, effective 12/8/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 9706B, IAB 9/7/11, effective 8/17/11; ARC 9708B, IAB 9/7/11, effective 8/17/11; ARC 9710B, IAB 9/7/11, effective 8/17/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9712B, IAB 9/7/11, effective 9/1/11; ARC 9714B, IAB 9/7/11, effective 9/1/11; ARC 9719B, IAB 9/7/11, effective 9/1/11; ARC 9722B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 9886B, IAB 11/30/11, effective 1/4/12; ARC 9887B, IAB 11/30/11, effective 1/4/12; ARC 9958B, IAB 1/11/12, effective 2/15/12; ARC 9959B, IAB 1/11/12, effective 2/15/12; ARC 9960B, IAB 1/11/12, effective 2/15/12; ARC 9966B, IAB 2/8/12, effective 1/19/12; ARC 0028C, IAB 3/7/12, effective 4/11/12; ARC 0029C, IAB 3/7/12, effective 4/11/12; ARC 9959B nullified (See nullification note at end of chapter); ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0194C, IAB 7/11/12, effective 7/1/12; ARC 0196C, IAB 7/11/12, effective 7/1/12; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0355C, IAB 10/3/12, effective 12/1/12; ARC 0354C, IAB 10/3/12, effective 12/1/12; ARC 0360C, IAB 10/3/12, effective 12/1/12; ARC 0485C, IAB 12/12/12, effective 2/1/13; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0581C, IAB 2/6/13, effective 4/1/13; ARC 0585C, IAB 2/6/13, effective 1/9/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0708C, IAB 5/1/13, effective 7/1/13; ARC 0710C, IAB 5/1/13, effective 7/1/13; ARC 0713C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 0838C, IAB 7/24/13, effective 7/1/13; ARC 0840C, IAB 7/24/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 0864C, IAB 7/24/13, effective 7/1/13; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1057C, IAB 10/2/13, effective 11/6/13; ARC 1058C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1150C, IAB 10/30/13, effective 1/1/14; ARC 1152C, IAB 10/30/13, effective 1/1/14; ARC 1154C, IAB 10/30/13, effective 1/1/14; ARC 1481C, IAB 6/11/14, effective 8/1/14; ARC 1519C, IAB 7/9/14, effective 7/1/14; ARC 1521C, IAB 7/9/14, effective 7/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 1608C, IAB 9/3/14, effective 10/8/14; ARC 1609C, IAB 9/3/14, effective 10/8/14; ARC 1699C, IAB 10/29/14, effective 1/1/15; ARC 1697C, IAB 10/29/14, effective 1/1/15; ARC 1977C, IAB 4/29/15, effective 7/1/15; ARC 2026C, IAB 6/10/15, effective 8/1/15; ARC 2075C, IAB 8/5/15, effective 7/15/15; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2167C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2846C, IAB 12/7/16, effective 11/15/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2930C, IAB 2/1/17, effective 4/1/17; ARC 2932C, IAB 2/1/17, effective 3/8/17; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3158C, IAB 7/5/17, effective 7/1/17; ARC 3161C, IAB 7/5/17, effective 7/1/17; ARC 3162C, IAB 7/5/17, effective 7/1/17; ARC 3160C, IAB 7/5/17, effective 7/1/17; ARC 3159C, IAB 7/5/17, effective 7/1/17; ARC 3294C, IAB 8/30/17, effective 10/4/17; ARC 3295C, IAB 8/30/17, effective 10/4/17; ARC 3296C, IAB 8/30/17, effective 10/4/17; ARC 3292C, IAB 8/30/17, effective 10/4/17; ARC 3293C, IAB 8/30/17, effective 10/4/17; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3494C, IAB 12/6/17, effective 1/10/18; ARC 3551C, IAB 1/3/18, effective 2/7/18; ARC 3716C, IAB 3/28/18, effective 5/2/18; ARC 3790C, IAB 5/9/18, effective 6/13/18; ARC 4067C, IAB 10/10/18, effective 11/14/18; ARC 4065C, IAB 10/10/18, effective 12/1/18; ARC 4066C, IAB 10/10/18, effective 12/1/18; ARC 4068C, IAB 10/10/18, effective 12/1/18]

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. Service documentation shall include narrative documentation and may also include documentation in checkbox format. The service record 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.
 3. Other service documentation as applicable.
- (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.
 3. Other service documentation as applicable.
- (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.
 7. Other service documentation as applicable.
- (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.
 4. Other service documentation as applicable.
- (25) Behavioral health intervention:
1. Order for services.

2. Comprehensive treatment or service plan (initial and subsequent).
 3. Service notes or narratives.
 4. Other service documentation as applicable.
- (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).
 8. Other service documentation as applicable.
- (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.
 8. Other service documentation as applicable.
- (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.
 4. Other service documentation as applicable.
- (40) Health home services:
1. Comprehensive care management plan.
 2. Care coordination and health promotion plan.
 3. Comprehensive transitional care plan, including appropriate follow-up, from inpatient to other settings.
 4. Documentation of member and family support (including authorized representatives).
 5. Documentation of referral to community and social support services, if relevant.
- (41) Services of public health agencies:
1. Service or office notes or narratives.
 2. Immunization records.
 3. Results of communicable disease testing.
- (42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services:
1. Department-approved standardized neurobehavioral assessment tool.
 2. Community-based neurobehavioral treatment order.
 3. Treatment plan.
 4. Clinical records documenting diagnosis and treatment history.
 5. Progress or status notes.
 6. Service notes or narratives.
 7. Procedure, laboratory, or test orders and results.
 8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable.
 9. Medication administration records.
 10. Other service documentation as applicable.
- (43) Child care medical services:
1. Plan of care.
 2. Certification and recertification.
 3. Service notes or narratives.

4. Physician orders or medical orders.
5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).
6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).

(44) Subacute mental health services.

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. Medication administration records (residential services).

(45) Crisis response services, crisis stabilization community-based services and crisis stabilization residential services.

1. Assessment.
2. Individual stabilization plan.
3. Service notes or narratives (history and physical, therapy records, discharge summary).
4. Medication administration records (residential services).

e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) Maintenance requirement. The provider shall maintain records as required by this rule:

- a.* During the time the member is receiving services from the provider.
- b.* For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.
- c.* As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

79.3(4) Availability. Rescinded IAB 1/30/08, effective 4/1/08.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 8262B, IAB 11/4/09, effective 12/9/09; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0711C, IAB 5/1/13, effective 7/1/13; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 3358C, IAB 10/11/17, effective 10/1/17; ARC 3551C, IAB 1/3/18, effective 2/7/18; ARC 3554C, IAB 1/3/18, effective 2/7/18; ARC 3716C, IAB 3/28/18, effective 5/2/18]

441—79.4(249A) Reviews and audits.

79.4(1) Definitions.

“Authorized representative,” within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

“Claim” means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

“*Clinical record*” means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

“*Confidence level*” means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

“*Customary and prevailing fee*” means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

“*Extrapolation*” means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

“*Fiscal record*” means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

“*Overpayment*” means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

“*Procedure code*” means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

“*Random sample*” means a statistically valid random sample for which the probability of selection for every item in the universe is known.

“*Underpayment*” means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

“*Universe*” means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records to determine whether:

- (1) The department has correctly paid claims for goods or services.
- (2) The provider has furnished the services to Medicaid members.
- (3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.
- (4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise program integrity unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“d” to document the basis for services or activities provided.

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph “b.”

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider’s designee. The request must:

1. Establish good cause for the delay in submitting the records; and

2. Be received by the department before the date the records are due to be submitted.
- (2) For purposes of these rules, “good cause” has the same meaning as in Iowa Rule of Civil Procedure 1.977.
 - (3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.
 - (4) The provider may appeal the department’s denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.
- c.* The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.
- (1) For an announced on-site review or audit, the department’s employee or authorized agent may give as little as one day’s advance notice of the review or audit and the records and supporting documentation to be reviewed.
 - (2) Notice is not required for unannounced on-site reviews and audits.
 - (3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.
- d.* Audit or review procedures may include, but are not limited to, the following:
- (1) Comparing clinical and fiscal records with each claim.
 - (2) Interviewing members who received goods or services and employees of providers.
 - (3) Examining third-party payment records.
 - (4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.
 - (5) Examining all documents related to the services for which Medicaid was billed.
- e.* Use of statistical sampling techniques. The department’s procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.
- (1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.
 - (2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.
 - (3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.
 - (4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.
- f.* Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.
- 79.4(4) *Preliminary report of audit or review findings.*** If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.
- 79.4(5) *Disagreement with audit or review findings.*** If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.
- a. Reevaluation request.* A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.
- (1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph “a” of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph “c” of this subrule.

c. Disagreement with sampling results. When the department’s audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department’s sample. Any such audit or review must:

- (1) Be arranged and paid for by the provider.
- (2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.
- (3) Be conducted by a certified public accountant if the issues relate to fiscal records.
- (4) Demonstrate that bills and records that were not audited or reviewed in the department’s sample are in compliance with program regulations.
- (5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) Finding and order for repayment. Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) Appeal by provider of care. A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) shall not be admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

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

[ARC 0712C, IAB 5/1/13, effective 7/1/13; ARC 1155C, IAB 10/30/13, effective 1/1/14]

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

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

441—79.7(249A) Medical assistance advisory council.

79.7(1) Officers.

a. Definitions.

“Co-chairpersons” means the public health director co-chairperson and the public co-chairperson.

“Public co-chairperson” means the individual selected by the other publicly appointed members of the council to serve as a co-chairperson of the council.

“Public health director co-chairperson” means the director of the department of public health, who serves as a co-chairperson of the council.

b. The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

c. The public co-chairperson shall have the right to vote on any issue before the council. The public health director co-chairperson serves as a nonvoting member of the council.

d. The position of public co-chairperson shall be held by one of the ten publicly appointed council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by department of human services staff.

e. The co-chairpersons shall appoint members to other committees approved by the council.

f. The co-chairpersons shall also serve on the executive committee and will serve as the co-chairpersons of that committee.

g. Responsibilities.

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the full council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with the staff and director of human services, taking into consideration the following:

1. Workplans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the executive committee to receive the council's feedback and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.

2. Requests from the director of human services.

3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council and executive committee meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department of human services on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

79.7(2) Membership. The membership of the council and its executive committee shall be as prescribed at Iowa Code sections 249A.4B(2), 249A.4B(3), and 249A.4B(4a).

a. Council membership.

(1) Council membership of professional and business entities shall consist of those entities outlined in Iowa Code section 249A.4B(2). Professional and business entities shall identify their representatives and report information to the department of human services.

1. If an entity's representative does not attend more than three consecutive meetings, the department of human services will notify the entity and representative and verify whether an alternate contact is needed.

2. Professional and business entities shall determine the length of appointment of their representatives. The department of human services will confirm each representative's participation every two years, regardless of the representative's meeting attendance.

3. All professional and business entities will be voting members of the council.

(2) Council membership of public representatives shall consist of ten representatives which may include members of consumer groups, including recipients of medical assistance or their families, consumer organizations, and others, appointed by the governor for staggered terms of two years each, none of whom shall be members of, or practitioners of, or have a pecuniary interest in any of the professional or business entities specifically represented in Iowa Code sections 249A.4B(2) and 249A.4B(3) and a majority of whom shall be current or former recipients of medical assistance or members of the families of current or former recipients. All public representatives will be voting members of the council.

(3) A member of the HAWK-I board, created in Iowa Code section 514I.5, selected by the members of the HAWK-I board, shall be a member of the council. The HAWK-I board member representative will be a voting member of the council.

(4) Council membership shall also consist of state agency and medical school partners, including representatives from the department of public health, the department on aging, the office of the long-term care ombudsman, Des Moines University and the University of Iowa College of Medicine.

1. Partner agency and medical school representatives will be nonvoting members of the council.

2. If an agency's or school's representative does not attend more than three consecutive meetings, the department of human services will notify the agency or school.

3. Partner agencies and medical schools shall determine the length of appointment of their representatives. The department of human services will confirm each representative's participation every two years, regardless of the representative's meeting attendance.

(5) The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 69.16B. Members appointed from the general assembly will serve as nonvoting members of the council.

1. Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

2. Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate.

b. Executive committee membership. Executive committee membership shall consist of the following:

(1) Five professional and business entities identified in Iowa Code section 249A.4B(2). The entity, not the individual representative, is selected for membership on the executive committee. Each selected entity shall appoint its individual representative. Professional and business entities of the council vote to select the business and professional entities of the executive committee.

(2) Five individuals appointed to the council as public members, pursuant to Iowa Code section 249A.4B(2).

1. One of the five public member positions on the executive committee will be held by the co-chairperson identified in subrule 79.7(1).

2. At least one public member shall be a recipient of medical assistance.

3. Public members of the council vote to select the public members of the executive committee.

(3) The co-chairpersons identified in subrule 79.7(1), who shall serve as the co-chairpersons of the executive committee.

(4) The executive committee will be elected for two-year terms, beginning at the start of a state fiscal year.

1. All voting members of the council will be eligible for election to the executive committee, based on the criteria outlined in this paragraph.

2. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by department of human services staff.

3. Should any vacancy occur on the executive committee, a special election will be held following the standards outlined in this paragraph.

4. Ballots should include the professional and business entity name but omit the name of the representative of the entity.

79.7(3) Responsibilities, duties and meetings. The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department of human services through the executive committee of the council.

a. Recommendations. Recommendations made by the executive committee from the council shall be advisory and not binding upon the department of human services or the professional and business entities represented. The director of the department of human services shall consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

b. Council. The council shall be provided with information to deliberate and provide input on the medical assistance program. The executive committee will use that input in making final recommendations to the department of human services.

(1) Council meetings.

1. The council will meet no more than quarterly.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director of the department of human services.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be distributed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

(6) The council shall review the recommendations submitted by the executive committee regarding feedback received at the IA Health Link statewide public comment meetings outlined in 2016 Iowa Acts, chapter 1139, section 102.

c. Executive committee.

(1) Executive committee meetings.

1. The executive committee shall meet on a monthly basis.
2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of executive committee members; or by the director of the department of human services.
3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.
4. In a month when a council meeting is held, the executive committee shall meet after the council meeting, allowing committee members to discuss and make recommendations based on the topics discussed by council members.

(2) Based on the deliberations of the full council, the executive committee shall make recommendations to the director of human services regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

1. Recommendations on the reimbursement for medical services rendered by providers of services.
2. Identification of unmet medical needs and maintenance needs which affect health.
3. Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.
4. Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to program recipients.
5. Advice on such administrative and fiscal matters as the director of human services may request.

(3) Pursuant to 2016 Iowa Acts, chapter 1139, section 102, the executive committee shall review the compilation of the input and recommendations from the public meetings convened statewide and shall submit recommendations based upon the compilation to the director of human services on a quarterly basis through December 31, 2017.

79.7(4) Procedures.

- a. Procedures shall apply to both the council and the executive committee.
- b. A quorum shall consist of 50 percent of the current voting members.
- c. Where a quorum is present, a position is carried by two-thirds of the council members present.
- d. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the full council.
- e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(5) Expenses, staff support, and technical assistance. Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

- a. The department shall provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.
- b. The department shall present the annual budget for the medical assistance program for review and comment.
- c. The department shall permit staff members to appear before the council to review and discuss specific information and problems.
- d. The department shall maintain a current list of members on the council and executive committee.
- e. The department shall be responsible for the organization of all council and executive committee meetings and notice of meetings.
- f. As required in Iowa Code section 21.3, minutes of the meetings of the council and of the executive committee will be kept by the department. The co-chairpersons will review minutes before distribution.
- g. The department shall compile input and recommendations received at the public meetings established in 2016 Iowa Acts, chapter 1139, section 102, and submit the information to the executive committee for review.

441—79.8(249A) Requests for prior authorization. This rule governs requests for prior authorization for services not provided through a managed care organization. For services provided through a managed care organization, the prior authorization request is submitted, reviewed, and authorized by the managed care organization.

79.8(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

- (1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and
- (2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78.

a. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

- (1) The conditions for payment outlined in the provider manual with reference to coverage and duration.
- (2) The determination made by the Medicare program unless specifically stated differently in state law or rule.
- (3) The recommendation to the department from the appropriate advisory committee.
- (4) Whether there are other less expensive procedures which are covered and which would be as effective.
- (5) The advice of an appropriate professional consultant.

b. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

- a. Be consistent with the diagnosis and treatment of the patient's condition.
- b. Be in accordance with standards of good medical practice.
- c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
- d. Be the least costly type of service which would reasonably meet the medical need of the patient.
- e. Be eligible for federal financial participation unless specifically covered by state law or rule.
- f. Be within the scope of the licensure of the provider.
- g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.
- h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

79.9(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

79.9(7) Incorrect payment.

a. Except as provided in paragraph 79.9(7)“b,” medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7)“a,” medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, “legal representative” means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

79.9(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2014 Iowa Acts, Senate File 2320. [ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4. [ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—79.12(249A) Advance directives. “Advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person’s admission as an inpatient, a home health care provider in advance of a person’s coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person’s rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider’s policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person’s medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

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

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

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

441—79.14(249A) Provider enrollment.

79.14(1) Application request. Iowa Medicaid providers, including those enrolled with a managed care organization, shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise website. Managed care organizations and fiscal agents are exempt from completing an application.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.

c. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

d. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in 441—subrule 82.3(1).

f. Qualified Medicare beneficiary (QMB) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

g. Health insurance premium payment (HIPP) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

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 email, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

a. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

b. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C).

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under 2013 Iowa Acts, Senate File 357, section 12.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) Exempt providers. The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.

2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR § 455.460.

79.14(3) Program integrity information requirements.

a. All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required

to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

- (1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;
- (2) Has been or is subject to a payment suspension under a federally funded health care program;
- (3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;
- (4) Has had its billing privileges denied or revoked;
- (5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or
- (6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3)“a”(1), (2), (3), (4), or (5).

b. The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. The Iowa Medicaid enterprise shall deny enrollment to or shall immediately disenroll any person that the Iowa Medicaid enterprise, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and shall deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3)“c.” Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

c. For purposes of this rule, the term “direct or indirect affiliation” includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

- (1) A compensation arrangement;
- (2) An ownership arrangement;
- (3) Managerial authority over any member of the affiliation;
- (4) The ability of one member of the affiliation to control or influence any other; or
- (5) The ability of a third party to control or influence any member of the affiliation.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years, pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

79.14(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

a. For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

b. Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450.

c. Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state’s Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

79.14(5) Notification. A provider shall be notified of the decision on the provider’s application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.

79.14(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

79.14(7) Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by the Iowa Medicaid enterprise provider services unit.

79.14(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(9) No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise’s approval of an application.

79.14(10) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(11) An amendment to an application shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(13) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider’s Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

b. When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider’s failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

79.14(14) Provider termination or denial of enrollment. The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

79.14(15) Temporary moratoria. The Iowa Medicaid enterprise must impose any temporary moratorium pursuant to 2013 Iowa Acts, Senate File 357, section 12.

79.14(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.14(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

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

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0580C**, IAB 2/6/13, effective 4/1/13; **ARC 1153C**, IAB 10/30/13, effective 1/1/14; **ARC 1695C**, IAB 10/29/14, effective 1/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 3494C**, IAB 12/6/17, effective 1/10/18]

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 website, 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 website at www.imeincentives.com. The applicant shall use the website 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 website.

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]

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- ¹ Effective date of 79.1(2) and 79.1(5) “t” delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.
- ² Two ARCs
- ³ Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.
- ⁴ Two or more ARCs
- ⁵ Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.
- ⁶ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.
- ⁷ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.
- ⁸ Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.
- ⁹ Two ARCs
- ¹⁰ July 1, 2009, effective date of amendments to 79.1(1) “d,” 79.1(2), and 79.1(24) “a”(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- ¹¹ See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7) “b” (ARC 9959B, IAB 1/11/12).

CHAPTER 81
NURSING FACILITIES
[Prior to 7/1/83 Social Services[770] Ch 81]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
GENERAL POLICIES

441—81.1(249A) Definitions.

“*Abuse*” means any of the following which occurs as a result of the willful or negligent acts or omissions of a nursing facility employee:

1. Physical injury to, or injury which is at a variance with the history given of the injury, or unreasonable confinement or unreasonable punishment or assault as defined in Iowa Code section 708.1 of a resident.

2. The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 or 728.12, subsection 1, or sexual exploitation under Iowa Code chapter 235B, as a result of the acts or omissions of the facility employee responsible for the care of the resident with or against a resident.

3. Exploitation of a resident which means the act or process of taking unfair advantage of a resident or the resident’s physical or financial resources for one’s own personal or pecuniary profit without the informed consent of the resident, including theft, by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

4. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a resident’s life or health.

“*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 resident is incapacitated.

“*Allowable costs*” means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm’s-length transaction, not to exceed the limitations set out in rules.

“*Beginning eligibility date*” means date of an individual’s admission to the facility or date of eligibility for medical assistance, whichever is the later date.

“*Case mix*” means a measure of the intensity of care and services used by similar residents in a facility.

“*Case-mix index*” means a numeric score within a specific range that identifies the relative resources used by similar residents and represents the average resource consumption across a population or sample.

“*Civil penalty*” shall mean a civil money penalty not to exceed the amount authorized under Iowa Code section 135C.36 for health care facility violations.

“*Clinical experience*” means application or learned skills for direct resident care in a nursing facility.

“*Clock hour*” means 60 minutes.

“*Complete replacement*” means completed construction on a new nursing facility to replace an existing licensed and certified nursing facility. The replacement facility shall have no more licensed beds than the facility being replaced and shall be located either in the same county as the facility being replaced or within 30 miles from the facility being replaced.

“*Cost normalization*” refers to the process of removing cost variations associated with different levels of resident case mix. Normalized cost is determined by dividing a facility’s per diem direct care component costs by the facility cost report period case-mix index.

“*Denial of critical care*” is a pattern of care in which the resident’s basic needs are denied or ignored to such an extent that there is imminent or potential danger of the resident suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the resident’s serious social maladjustment, or is a gross failure of the facility employee to meet the emotional needs of the resident necessary for normal functioning, or is a failure of the facility employee to provide for the proper supervision of the resident.

“*Department*” means the Iowa department of human services.

“Direct care component” means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services. “Direct care component” also includes costs related to therapy services provided to residents during inpatient stays and not billed as an outpatient service.

“Discharged resident” means a resident whose accounts and records have been closed out and whose personal effects have been taken from the facility. When a resident is discharged, the facility shall notify the department via Form 470-0042, Case Activity Report.

“Facility” means a licensed nursing facility certified in accordance with the provisions of 42 CFR 483.5 as amended to December 4, 2017, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

“Facility-based nurse aide training program” means a nurse aide training program that is offered by a nursing facility and taught by facility employees or under the control of the licensee.

“Facility cost report period case-mix index” is the average of quarterly facilitywide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2000-12/31/2000 financial and statistical reporting period would use the facilitywide average case-mix indices for quarters ending 03/31/00, 06/30/00, 09/30/00 and 12/31/00.

“Facilitywide average case-mix index” is the simple average, carried to four decimal places, of all resident case-mix indices based on the last day of each calendar quarter.

“Informed consent” means a resident’s agreement to allow something to happen that is based on a full disclosure of known facts and circumstances needed to make the decision intelligently, i.e., with knowledge of the risks involved or alternatives.

“Iowa Medicaid enterprise” means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

“Laboratory experience” means practicing care-giving skills prior to contact in the clinical setting.

“Level I review” means screening to identify persons suspected of having mental illness or intellectual disability as defined in 42 CFR 483.102 as amended to July 1, 2014.

“Level II review” means the evaluation of a person identified in a Level I review to determine whether nursing facility services and specialized services are needed.

“Major renovations” means new construction or facility improvements to an existing licensed and certified nursing facility in which the total depreciable asset value of the new construction or facility improvements exceeds \$1.5 million. The \$1.5 million threshold shall be calculated based on the total depreciable asset value of new construction or facility improvements placed into service during a two-year period ending on the date the last asset was placed into service. When the property costs of an asset have been included in a facility’s financial and statistical report that has already been used in a biennial rebasing, the costs of that asset shall not be considered in determining whether the facility meets the \$1.5 million threshold.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medicaid average case-mix index” is the simple average, carried to four decimal places, of all resident case-mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

“Minimum data set” or *“MDS”* refers to a federally required resident assessment tool. Information from the MDS is used by the department to determine the facility’s case-mix index for purposes of normalizing per diem allowable direct care costs as provided by paragraph 81.6(16) “b,” for determining the Medicaid average case-mix index to adjust the direct care component pursuant to paragraphs 81.6(16) “c” and “e,” the excess payment allowance pursuant to paragraph 81.6(16) “d,” and the limits on reimbursement components pursuant to paragraph 81.6(16) “f.” MDS is described in subrule 81.13(9).

“Minimum food, shelter, clothing, supervision, physical or mental health care, or other care” means that food, shelter, clothing, supervision, physical or mental health care, or other care which, if not provided, would constitute denial of critical care.

“Mistreatment” means any intentional act, or threat of an act, coupled with the apparent ability to execute the act, which causes or puts another person in fear of mental anguish, humiliation, deprivation or physical contact which is or will be painful, insulting or offensive. Actions utilized in providing necessary treatment or care in accordance with accepted standards of practice are not considered mistreatment.

“New construction” means the construction of a new nursing facility that does not replace an existing licensed and certified facility and that requires the provider to obtain a certificate of need pursuant to Iowa Code chapter 135, division VI.

“Non-direct care component” means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

“Non-facility-based nurse aide training program” means a nurse aide training program that is offered by an organization that is not licensed to provide nursing facility services.

“Nurse aide” means any individual who is not a licensed health professional or volunteer providing nursing or nursing-related services to residents in a nursing facility.

“Nurse aide registry” means Nurse Aide Registry, Department of Inspections and Appeals, Third Floor, Lucas State Office Building, Des Moines, Iowa 50319.

“Nurse aide training and competency evaluation programs (NATCEP)” are educational programs approved by the department of inspections and appeals for nurse aide training as designated in subrule 81.16(3).

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“PASRR” means a Level I screening or a Level II evaluation for mental illness or intellectual disability for all persons who live in or seek entry to a Medicaid-certified nursing facility, as required by 42 CFR Part 483, Subpart C, as amended to July 1, 2014.

“Patient-day-weighted median cost” means the per diem cost of the nursing facility that is at the median per diem cost of all nursing facilities based on patient days provided when per diem allowable costs are ranked from low to high. A separate patient-day-weighted median cost amount shall be determined for the direct care and non-direct care components.

“Physical abuse” means any nonaccidental physical injury, or injury which is at variance with the history given of it, suffered by a resident as the result of the acts or omissions of a person responsible for the care of the resident.

“Physical injury” means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition, or damage to any bodily tissue which results in the death of the person who has sustained the damage.

“Poor performing facility (PPF)” is a facility designated by the department of inspections and appeals as a poor performing facility (PPF) based on surveys conducted by the department of inspections and appeals pursuant to subrule 81.13(1). A facility shall be designated a PPF if it has been cited for substandard quality of care on the current standard survey and it:

1. Has been cited for substandard quality of care or immediate jeopardy on at least one of the previous two standard surveys;
2. Has a history of substantiated complaints during the last two years;
3. Has a current deficiency for not having a quality assurance program; or
4. Does not have an effective quality assurance program as defined in paragraph 81.13(19)“o.”

“Primary instructor” means a registered nurse responsible for teaching a state-approved nurse aide training course.

“Program coordinator” means a registered nurse responsible for administrative aspects of a state-approved nurse aide training course.

“Rate determination letter” means the letter that is distributed quarterly by the Iowa Medicaid enterprise to each nursing facility notifying the facility of the facility’s Medicaid reimbursement rate calculated in accordance with this rule and of the effective date of the reimbursement rate.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that identifies support needs.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Skills performance record” means a record of major duties and skills taught which consists of, at a minimum:

1. A listing of the duties and skills expected to be learned in the program.
2. Space to record the date when the aide performs the duty or skill.
3. Space to note satisfactory or unsatisfactory performance.
4. The signature of the instructor supervising the performance.

“Special population nursing facility” refers to a nursing facility that serves the following populations:

1. One hundred percent of the residents served are aged 30 and under and require the skilled level of care.
2. Seventy percent of the residents served require the skilled level of care for neurological disorders.
3. One hundred percent of the residents require care from a facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness.
4. One hundred percent of the residents require care from a facility licensed by the department of inspections and appeals as an intermediate care facility for persons with medical complexity.

“Surgical or other invasive procedure” means an operative procedure in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Surgical or other invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multiorgan transplantation. Surgical or other invasive procedures include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) published by the American Medical Association and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. Surgical or other invasive procedures include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. “Surgical or other invasive procedure” does not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

“Terminated from the Medicare or Medicaid program” means a facility has lost the final appeal to which it is entitled.

“*Testing entity*” means a person, agency, institution, or facility approved by the department of inspections and appeals to take responsibility for obtaining, keeping secure and administering the competency test and reporting nurse aide scores to the nurse aide registry.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) “a,” and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3718C, IAB 3/28/18, effective 5/2/18; ARC 3717C, IAB 3/28/18, effective 7/1/18; ARC 4052C, IAB 10/10/18, effective 9/12/18]

441—81.2 Rescinded, effective 11/21/79.

441—81.3(249A) Initial approval for nursing facility care.

81.3(1) *Need for nursing facility care.* Residents of nursing facilities must be in need of either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department.

a. Decisions on level of care, subject to paragraph 81.3(1) “*b*,” shall be made for the department by the Iowa Medicaid enterprise (IME) medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

b. For residents subject to a Level II PASRR review pursuant to subrule 81.3(3), the level of care determination shall be made as part of the Level II PASRR review, based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

c. Adverse level of care decisions may be appealed to the department pursuant to 441—Chapter 7.

81.3(2) *Skilled nursing care level of need.* Rescinded IAB 7/11/01, effective 7/1/01.

81.3(3) *Preadmission review.* The department’s contractor for PASRR screening and evaluation shall complete a Level I review for all persons seeking admission to a Medicaid-certified nursing facility, regardless of the source of payment for the person’s care. When a Level I review identifies evidence for the presence of mental illness or intellectual disability, the department’s contractor for PASRR evaluations shall complete a Level II review before the person is admitted to the facility.

a. Exceptions to Level II review. Persons in the following circumstances may be exempted from Level II review based on a categorical determination that, in that circumstance, admission to or residence in a nursing facility is normally needed and the provision of specialized services for mental illness or intellectual disability is normally not needed.

(1) The person’s attending physician certifies that the person is terminally ill with death expected within six months, the person requires nursing care or supervision due to the person’s physical condition, and the person is not a danger to self or others. If the person’s nursing facility stay exceeds six months, a Level II review must be completed.

(2) The severity of the person’s illness results in impairment so severe that the person could not be expected to benefit from specialized services, and the person does not present a danger to self or others. This category includes persons who are comatose, who function at brain-stem level, who are ventilator-dependent, or who have diagnoses such as Parkinson’s disease, Huntington’s chorea, amyotrophic lateral sclerosis, chronic obstructive pulmonary disease (COPD), or congestive heart failure (CHF).

(3) The person is suffering from delirium. Exemptions made on a basis of delirium are valid until the delirium clears or for seven days, whichever is sooner.

(4) The person is in an emergency situation that requires protective services with placement in the nursing facility. A Level II review must be completed if the admission lasts more than seven days.

(5) The admission is for the purpose of providing respite to the person’s caregiver. If the nursing facility stay exceeds 30 days, a Level II review must be completed.

(6) The person has dementia in combination with an intellectual disability.

(7) The person has been approved for specialized services in another facility based on a previous Level II evaluation, the specialized services still meet the person's needs, and the receiving facility agrees to provide the specialized services.

(8) The person is transferring directly from receiving acute hospital inpatient care and requires nursing facility services for the same acute physical illness for which hospital care was received, and the person's attending physician certifies before the admission that the person is likely to require less than 30 days of nursing facility services. If the person is later found to require more than 30 days of nursing facility care, a Level II review must be completed within 40 calendar days of the person's admission date.

(9) The person:

1. Is transferring to a nursing facility directly from receiving acute hospital inpatient care, and
2. Requires nursing facility services for convalescence from the same acute physical illness for which the person received hospital care, and
3. Is clearly sufficiently psychiatrically and behaviorally stable enough for nursing facility admission, and
4. Before entering the facility, has been certified by the attending physician as likely to require less than 60 days of nursing facility services.

b. Outcome of Level II review. The Level II review shall determine:

(1) Whether nursing facility care or skilled nursing care is medically necessary and appropriate under 441—subrules 79.9(1) and 79.9(2) for the person seeking admission;

(2) Whether the person seeking admission needs specialized services for mental illness as defined in paragraph 81.13(14) "b," using the procedures set forth in 42 CFR 483.134 as amended to July 1, 2014; and

(3) Whether the person seeking admission needs specialized services for intellectual disability as defined in paragraph 81.13(14) "c," using the procedures set forth in 42 CFR 483.136 as amended to July 1, 2014.

c. The department's division of mental health and disability services or its designee shall review each Level II evaluation and plan for obtaining needed specialized services before the person's admission to a nursing facility to determine whether nursing facility care or skilled nursing care is medically necessary and whether the nursing facility is an appropriate placement.

d. Nursing facility payment under the Iowa Medicaid program will be made for Medicaid members residing in the nursing facility:

(1) Only if a Level I review was completed prior to admission;

(2) For persons with mental illness or intellectual disability, only if a Level II review has been completed, or an exception under paragraph 81.3(3) "a" has been approved, and it is determined by the division of mental health and disability services that nursing facility care or skilled nursing care is medically necessary and appropriate and that the person's treatment needs related to a mental illness or intellectual disability will be or are being met.

e. Adverse PASRR decisions may be appealed to the department pursuant to 441—Chapter 7.

f. A nursing facility requesting an administrative hearing regarding a PASRR determination must have the prior, express, signed, written consent of the resident or the resident's lawfully appointed guardian to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no hearing will be granted unless the nursing facility submits a document providing such resident's consent to the request for a state fair hearing. The document must specifically inform the resident 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 resident's knowledge of the potential for PHI to become public and that the resident knowingly, voluntarily, and intelligently consents to the nursing facility's bringing the state fair hearing on the resident's behalf.

81.3(4) *Special care level of need.* Rescinded IAB 3/20/91, effective 3/1/91.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) "a" and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15]

441—81.4(249A) Arrangements with residents.

81.4(1) *Resident care agreement.* Rescinded IAB 12/6/95, effective 2/1/96.

81.4(2) *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made. The state will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

81.4(3) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. (See subrule 81.13(5) "c.") The funds shall be deposited in a bank within the state of Iowa insured by FDIC. Expense for bank service charges for this account is an allowable expense under rule 441—81.6(249A) if the service cannot be obtained free of charge. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, dated receipt shall be required to be deposited in the resident's files.

d. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

e. Upon a patient's death, a receipt shall be obtained from the next of kin, the resident's guardian, or the representative handling the funeral before releasing the balance of the personal needs funds. In the event there is no next of kin or guardian available and there are no outstanding funeral expenses, any funds shall revert to the department. In the event that an estate is opened, the department shall turn the funds over to the estate.

81.4(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that all mail is delivered unopened to the resident to whom it is addressed, except in those cases where the resident is too confused, as documented in the person's permanent medical record, to receive it, in which case the mail is held unopened for the resident's conservator or relatives. Mail

may be opened by the facility in cases where the resident or relatives or guardian have given permission in writing for mail to be opened and read to the resident.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) “a,” and 249A.4.

441—81.5(249A) Discharge and transfer. (See paragraph 81.13(6) “c.”)

81.5(1) Notice. When a Medicaid member requests transfer or discharge, or another person requests this for the member, the administrator shall promptly notify the department. This shall be done in sufficient time to permit a social service worker or case manager to assist in the planning for the transfer or discharge.

81.5(2) Case activity report. A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, or is discharged from the facility.

81.5(3) Plan. The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

81.5(4) Transfer records. When a resident is transferred to another facility, transfer information shall be summarized from the facility’s records in a copy to accompany the resident. This information shall include:

- a. A transfer form of diagnosis.
- b. Aid to daily living information.
- c. Transfer orders.
- d. Nursing care plan.
- e. Physician’s orders for care.
- f. The resident’s personal records.
- g. When applicable, the personal needs fund record.
- h. Resident care review team assessment.

81.5(5) Unused client participation. When a resident leaves the facility during the month, any unused portion of the resident’s client participation shall be refunded.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) “a,” and 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.6(249A) Financial and statistical report and determination of payment rate. With the exception of hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care, herein referred to as Medicare-certified hospital-based nursing facilities, all facilities in Iowa wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the Iowa Medicaid enterprise provider cost audit and rate setting unit. All Medicare-certified hospital-based nursing facilities shall submit a copy of their Medicare cost report. These reports shall be based on the following rules.

81.6(1) Failure to maintain records. Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility may result in the penalties specified in subrule 81.14(1).

81.6(2) Accounting procedures. Financial information shall be based on that appearing in the audited financial statements of the facility. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases.

a. Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. A schedule shall be required when necessary for a fair presentation of expense attributable to nursing facility patients.

b. Costs for patient care services shall be divided into the subcategories of “direct patient care costs” and “support care costs.” Costs associated with food and dietary wages shall be included in the “support care costs” subcategory.

81.6(3) *Submission of reports.* All nursing facilities, except the Iowa Veterans Home, shall submit reports electronically, in a format approved by the department, to the Iowa Medicaid enterprise provider cost audit and rate setting unit not later than the last day of the fifth calendar month after the close of the provider's reporting year. The Iowa Veterans Home shall submit the report electronically, in a format approved by the department, no later than three months after the close of each six-month period of the facility's established fiscal year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within 60 days after the initial certification of a provider. The option to change the reporting period may be exercised only one time by a provider, and the reporting period shall coincide with the fiscal year end for Medicare cost-reporting purposes. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

a. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a copy of their Medicare cost report that covers their most recently completed historical reporting period as submitted to the Medicare fiscal intermediary.

b. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the Iowa Medicaid enterprise provider cost audit and rate setting unit to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the nursing facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 81.6(3) "e."

c. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report as set forth in subrule 81.6(2).

d. For nursing facilities, except the Iowa Veterans Home, an extension of the five-month filing period shall not be granted unless one is granted for the filing of the Medicare cost report. If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, the Medicaid cost report and all required forms shall be submitted on the date Medicare requires submission of its report. Notice of the extension shall be presented to the department within ten days of a decision by Medicare.

e. A complete submission shall include all of the items identified in this subrule. Failure to submit a complete report that meets the requirements of this rule within the stated time shall reduce payment to 75 percent of the current rate.

(1) The reduced rate 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 Iowa Medicaid enterprise provider cost audit and rate setting unit.

(2) The reduced rate 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 Iowa Medicaid enterprise provider cost audit and rate setting unit.

f. When a nursing facility continues to include in the total costs an item or items which had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the provider may include the cost, but must include sufficient detail so that the Iowa Medicaid enterprise provider cost audit and rate setting unit can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

g. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost

report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

h. A facility may change its fiscal year one time in any two-year period. If the facility changes its fiscal year, the facility shall notify the Iowa Medicaid enterprise cost audit and rate setting unit 60 days prior to the first date of the change.

81.6(4) *Payment at new rate.*

a. Except for state-operated nursing facilities and special population nursing facilities, payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted quarterly to account for changes in the Medicaid average case-mix index. For nursing facilities receiving both an ICF and SNF Medicaid rate effective June 30, 2001, the June 30, 2001, Medicaid rate referenced in subparagraphs (1) and (2) below shall be the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

(1) The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, shall be 66.67 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed \$94, and 33.33 percent of the July 1, 2001, modified price-based rate pursuant to subrule 81.6(16). In no case shall the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

(2) Payment rates for services rendered from July 1, 2002, through June 30, 2003, shall be 33.33 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the CMS/SNF Total Market Basket Index. However, the current system rate to be used effective July 1, 2002, shall not exceed \$94, times an inflation factor pursuant to subrule 81.6(18), and 66.67 percent of the July 1, 2002, modified price-based rate. In no case shall the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor pursuant to subrule 81.6(18) projected for the following 12 months.

(3) Payment rates for services rendered from July 1, 2003, and thereafter will be 100 percent of the modified price-based rate.

(4) Rescinded IAB 9/8/10, effective 8/12/10.

b. The Medicaid payment rate for special population nursing facilities shall be updated annually without a quarterly adjustment.

c. The Medicaid payment rate for state-operated nursing facilities shall be updated annually without a quarterly adjustment.

81.6(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

81.6(6) *Census of public assistance recipients.* Census figures of public assistance recipients shall be obtained on the last day of the month ending the reporting period.

81.6(7) *Patient days.* In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

81.6(8) *Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

81.6(9) *Calculating patient days.* When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient's status at midnight at the end of each day.

b. When a recipient is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

81.6(10) Revenues. Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services include room, board, nursing services, therapies, and such services as supervision, feeding, pharmaceutical consulting, over-the-counter drugs, incontinency, and similar services, for which the associated costs are in nursing service. Routine daily services shall not include:

(1) Laboratory or diagnostic radiology services, unless the service is provided by facility staff using facility equipment, and

(2) Prescription (legend) drugs.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private pay residents of items or services which are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

81.6(11) Limitation of expenses. Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs.

b. Fees paid directors and nonworking officers' salaries are not allowed as reimbursable costs.

c. Bad debts are not an allowable expense.

d. Charity allowances and courtesy allowances are not an allowable expense.

e. Personal travel and entertainment are not allowable as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal costs shall be prorated. Amounts which appear to be excessive may be limited after consideration of the specific circumstances. Records shall be maintained to substantiate the indicated charges.

(1) Commuter travel by the owner(s), owner-administrator(s), administrator, nursing director or any other employee is not an allowable cost (from private residence to facility and return to residence).

(2) The expense of one car or one van or both designated for use in transporting patients shall be an allowable cost. All expenses shall be documented by a sales slip, invoice or other document setting forth the designated vehicle as well as the charges incurred for the expenses to be allowable.

(3) At the time of annual contract renewal with the Iowa department of transportation, each facility which supplies transportation services as defined in Iowa Code section 324A.1 shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code section 324A.5 and 761—Chapter 910 of the Iowa department of transportation's rules. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation shall result in disallowance of vehicle costs and other costs associated with transporting residents.

(4) Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings which provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.

(5) Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.

(6) Travel for which a patient must pay is not an allowable expense.

(7) Allowable expenses in subparagraphs (2) through (5) above are limited to 6 percent of total administrative expense.

f. Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.

g. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

h. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including, but not limited to, salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include, but are not limited to, costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the Iowa Medicaid enterprise provider cost audit and rate setting unit. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the Iowa Medicaid enterprise provider cost audit and rate setting unit with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 81.6(3) "e."

(2) Reasonableness requires that the compensation allowance be the same amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) Effective July 1, 2001, the base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$3,296 per month plus \$35.16 per month per licensed bed capacity for each bed over 60, not to exceed \$4,884 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by an annual inflation factor as specified by subrule 81.6(18).

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional

services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership or a relative as are maintained for any other employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for anyone working for another entity (e.g., home office) that allocates cost to the nursing facility and is involved in ownership of the facility or allocating entity or who is an immediate relative of an owner of the facility or allocating entity is 60 percent of the amount allowed for the administrator. An employee working for another entity that allocates cost to the nursing facility is considered to be involved in ownership of a facility when that individual has ownership interest of 5 percent or more of the home office or the nursing facility.

(8) The maximum allowed compensation for employees as set forth in subparagraphs 81.6(11) "h"(4) to 81.6(11) "h"(7) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the nursing facility for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. In the case that an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the nursing facility. In no case shall the amount of salary for one employee allocated to multiple nursing facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

i. Management fees paid to a related party shall be limited on the same basis as the owner administrator's salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.

j. Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide, 1983 edition, may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made. For change of ownership, refer to subrule 81.6(12).

k. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) "Necessary" requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) "Proper" requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

l. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for the services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

m. When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be based on the cost of the facility as identified in subrule 81.6(12), paragraph “a,” plus the landlord’s other expenses and a reasonable rate of return, not to exceed actual rent payments.

When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be no more than the amortized cost of the facility as identified in subrule 81.6(12), paragraph “a,” plus the landlord’s other expenses.

The landlord must be willing to provide documentation of these costs for rental arrangements.

n. Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

o. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are unallowable:

- (1) Any fees or portion of fees used or designated for lobbying.
- (2) Nonrefundable and unused retainers.
- (3) Fees paid by the facility for the benefit of employees.

(4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. EXCEPTION: Facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the conditions below are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,
2. The costs are reasonable expenditures for the services obtained,
3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and
4. The facility prevails on the disputed issue.

p. The nursing facility quality assurance assessment paid pursuant to 441—Chapter 36, Division II, shall not be an allowable cost for cost reporting and audit purposes but shall be reimbursed pursuant to paragraph 81.6(21) “a.”

q. Prescription (legend) drug costs are excluded from services covered as part of the nursing facility per diem rate as set forth in paragraph 81.10(5) “d.” The Iowa Medicaid program will provide direct payment for drugs covered pursuant to 441—subrule 78.1(2) to relieve the facility of payment responsibility. As Medicaid reimburses pharmacy providers only for the cost and dispensation of legend

drugs included on the Medicaid preferred drug list, no drug costs will be recognized for other payor sources.

r. Inpatient therapy services provided by nursing facilities are included in the established rate as a direct care cost and subject to the normalization process and quarterly case-mix index adjustments.

(1) Under no circumstances shall therapies for Medicaid members residing in a nursing facility be billed to Medicaid through any provider other than the nursing facility. Therapy services for nursing facility residents that are reimbursed by other payment sources shall not be reimbursed by Medicaid.

(2) For purposes of determining allowable therapy costs, the Iowa Medicaid enterprise provider cost audit and rate setting unit shall adjust each provider's reported cost of therapy services, including any employee benefits prorated based on total salaries and wages, to account for nonfacility patients including patients with costs paid by Medicare. Such adjustments shall be applied to each cost report in order to remove reported costs attributable to outpatient therapy services reimbursed for non-inpatient services. When the costs of the services are not determinable, an adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification.

s. Penalties or fines imposed by federal, state or local agencies are not allowable expenses.

t. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

u. Laboratory costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

v. Diagnostic radiology costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

81.6(12) Termination or change of owner.

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department of human services with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. The new owner shall be responsible for all Medicaid debts incurred by the previous owner, including those incurred due to changes in rates, fines, penalties and quality assurance fees, from the first day of the quarter until the date the change occurs. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing facility is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of

reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

81.6(13) Amended reports. The department, in its sole discretion, may 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 submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem summary and adjustments following a review of a financial and statistical report. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

81.6(14) Payment to new facility. The payment to a new facility shall be the sum of the patient-day-weighted median cost for the direct care and non-direct care components pursuant to paragraph 81.6(16)“c.” After the first full calendar quarter of operation, the patient-day-weighted median cost for the direct care component shall be adjusted by the facility’s average Medicaid case-mix index pursuant to subrule 81.6(19). A financial and statistical report shall be submitted from the beginning day of operation to the end of the fiscal year. Following the completion of the new facility’s first fiscal year, rates will be established in accordance with subrule 81.6(16). Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility’s fiscal year.

81.6(15) Payment to new owner. An existing facility with a new owner shall continue to be reimbursed using the previous owner’s per diem rate adjusted quarterly for changes in the Medicaid average case-mix index. The facility shall submit a financial and statistical report for the period from beginning of actual operation under new ownership to the end of the facility’s fiscal year. Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility’s fiscal year. The facility shall notify the Iowa Medicaid enterprise provider cost audit and rate setting unit of the date the facility’s fiscal year will end.

81.6(16) Establishment of the direct care and non-direct care patient-day-weighted medians and modified price-based reimbursement rate. This subrule provides for the establishment of the modified price-based reimbursement rate. The first step in the rate calculation (paragraph “a”) determines the per diem direct care and non-direct care component costs. The second step (paragraph “b”) normalizes the per diem direct care component costs to remove cost variations associated with different levels of resident case mix. The third step (paragraph “c”) calculates the patient-day-weighted medians for the direct care and non-direct care components that are used in subsequent steps to establish rate component limits and excess payment allowances, if any. The fourth step (paragraph “d”) calculates the potential excess payment allowance. The fifth step (paragraph “e”) calculates the reimbursement rate, including any applicable capital cost per diem instant relief add-on described in paragraph “h,” that is further subjected to the rate component limits, including any applicable enhanced non-direct care rate component limit described in paragraph “h,” in step six (paragraph “f”). The seventh step (paragraph “g”) calculates the additional reimbursement based on accountability measures available beginning July 1, 2002.

a. Calculation of per diem cost. For purposes of calculating the non-state-owned nursing facility Medicaid reimbursement rate and the Medicare-certified hospital-based nursing facility Medicaid

reimbursement rate, the costs shall be divided into two components, the direct care component and non-direct care component as defined in rule 441—81.1(249A). Each nursing facility's per diem allowable direct care and non-direct care cost shall be established. Effective July 1, 2001, and every second year thereafter, the per diem allowable cost shall be arrived at by dividing total reported allowable costs by total inpatient days during the reporting period. On July 1, 2001, July 1, 2003, July 1, 2004, July 1, 2005, and every second year thereafter, total reported allowable costs shall be adjusted using the inflation factor specified in subrule 81.6(18) from the midpoint of the cost report period to the beginning of the state fiscal year rate period.

(1) Non-state-owned nursing facilities. Effective December 1, 2009, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state-owned facilities shall be inpatient days as determined in subrule 81.6(7) or 85 percent of the licensed capacity of the facility, whichever is greater. Patient days for purposes of the computation of all other expenses shall be inpatient days as determined in subrule 81.6(7).

(2) Medicare-certified hospital-based nursing facilities. Patient days for purposes of the computation of all expenses shall be inpatient days as determined by subrule 81.6(7).

b. Cost normalization. The per diem allowable direct care costs are normalized by dividing a facility's per diem direct care costs by the facility's cost report period case-mix index as defined in rule 441—81.1(249A) and subrule 81.6(19).

c. Calculation of patient-day-weighted medians. For each of the rate components, a patient-day-weighted median shall be established for both the non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities, hereinafter referred to as the non-state-owned nursing facility patient-day-weighted medians and the Medicare-certified hospital-based nursing facility patient-day-weighted medians.

The per diem normalized direct care cost for each facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. An array and patient-day-weighted median for each cost component is determined separately for both non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities.

(1) For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001, using the inflation factor specified in subrule 81.6(18).

(2) Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated. The non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest completed cost report with a fiscal year end of the preceding December 31 or earlier. When patient-day-weighted medians are recalculated, inflation is applied from the midpoint of the cost report period to the first day of the state fiscal year rate period using the inflation factor specified in subrule 81.6(18).

(3) For the fiscal period beginning July 1, 2004, and ending June 30, 2005, the non-state-owned and Medicare-certified hospital-based nursing facility direct care and the non-direct care patient-day-weighted medians calculated July 1, 2003, shall be inflated to July 1, 2004, using the inflation factor specified in subrule 81.6(18).

d. Excess payment allowance.

(1) For non-state-operated nursing facilities not located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

(2) For non-state-operated nursing facilities located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the wage index factor specified below times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to paragraph 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

The wage index factor applied July 1, 2001, through June 30, 2002, shall be 11.46 percent. Beginning July 1, 2002, and thereafter, the wage index factor shall be determined annually by calculating the average difference between the Iowa hospital-based rural wage index and all Iowa hospital-based Metropolitan Statistical Area wage indices as published by the Centers for Medicare and Medicaid Services (CMS) each July. The geographic wage index adjustment shall not exceed \$8 per patient day.

A nursing facility may request an exception to application of the geographic wage index based upon a reasonable demonstration of wages, locations, and total cost. The nursing facility shall request the exception within 30 days of receipt of notification to the nursing facility of the new reimbursement rate using the department's procedures for requesting exceptions at rule 441—1.8(17A,217).

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

(3) For Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's normalized allowable per patient day direct care costs pursuant to paragraph 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the

percentage specified in 441—subrule 79.1(2) times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

e. Reimbursement rate. The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter, as specified in subparagraphs (1) and (2) below, plus a potential excess payment allowance determined by the methodology in paragraph "d," not to exceed the rate component limits determined by the methodology in paragraph "f."

(1) For non-state-owned nursing facilities and Medicare-certified hospital-based nursing facilities, direct care and non-direct care rate components are calculated as follows:

1. The direct care component is equal to the provider's normalized allowable per patient day costs times the Medicaid average case-mix index pursuant to subrule 81.6(19), plus the allowed excess payment allowance as determined by the methodology in paragraph "d."

2. The non-direct care component is equal to the provider's allowable per patient day costs, plus the allowed excess payment allowance as determined by the methodology in paragraph "d" and the allowable capital cost per diem instant relief add-on as determined by the methodology in paragraph "h."

(2) The reimbursement rate for state-operated nursing facilities and special population nursing facilities shall be the facility's average allowable per diem costs, adjusted for inflation pursuant to subrule 81.6(18), based on the most current financial and statistical report.

f. Notwithstanding paragraphs "d" and "e," in no instance shall a rate component exceed the rate component limit defined as follows:

(1) For non-state-operated nursing facilities not located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph "h."

(2) For non-state-operated nursing facilities located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the wage factor specified in paragraph "d" times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph "h."

(3) For Medicare-certified hospital-based nursing facilities, the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(4) For special population nursing facilities enrolled on or after June 1, 1993, the upper limit on their rate is equal to the sum of the following:

1. The direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2).

2. The non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

g. Pay-for-performance program. Effective July 1, 2010, additional reimbursement based on the nursing facility pay-for-performance program is available for non-state-owned facilities as provided in this paragraph in state fiscal years for which funding is appropriated by the legislature. The pay-for-performance program provides additional reimbursement based upon a nursing facility’s achievement of multiple favorable outcomes as determined by established benchmarks. The reimbursement is issued as an add-on payment after the end of any state fiscal year (which is referred to in this paragraph as the “payment period”) for which there is funding appropriated by the legislature.

(1) Scope. Additional reimbursement for the nursing facility pay-for-performance program is not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities. Therefore, data from these facility types shall not be used when determining eligibility for or the amount of additional reimbursement based on the nursing facility pay-for-performance program.

(2) Benchmarks. The pay-for-performance benchmarks include characteristics in four domains: quality of life, quality of care, access, and efficiency. These characteristics are objective and measurable and when considered in combination with each other are deemed to have a correlation to a resident’s quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing facility’s achievement of multiple measures suggests that quality is an essential element in the facility’s delivery of resident care.

(3) Definition of direct care. For the purposes of the nursing facility pay-for-performance program, “direct care staff” is defined to include registered nurses (RNs), licensed practical nurses (LPNs), certified nurse assistants (CNAs), rehabilitation nursing, and other contracted nursing services. “Direct care staff” does not include the director of nursing (DON) or minimum data set (MDS) coordinator.

(4) Qualifying for additional reimbursement. The Iowa Medicaid enterprise shall annually award points based on the measures achieved in each of the four domains, as described in subparagraphs (5) through (8). The maximum available points are 100. To qualify for additional Medicaid reimbursement under the nursing facility pay-for-performance program, a facility must achieve a minimum score of 51 points. The relationship of the score achieved to additional payments is described in subparagraph (10). Payments are subject to reduction or forfeiture as described in subparagraphs (12) and (13).

(5) Domain 1: Quality of life.

Standard	Measurement Period	Value	Source
Subcategory: Person-Directed Care			
Enhanced Dining A: The facility makes available menu options and alternative selections for all meals.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification

Standard	Measurement Period	Value	Source
Enhanced Dining B: The facility provides residents with access to food and beverages 24 hours per day and 7 days per week and empowers staff to honor resident choices.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Enhanced Dining C: The facility offers at least one meal per day for an extended period to give residents the choice of what time to eat.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	2 points	Self-certification
Resident Activities A: The facility employs a certified activity coordinator for at least 38 minutes per week per licensed bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Activities B: The facility either has activity staff that exceed the required minimum set by law or has direct care staff who are trained to plan and conduct activities and carry out both planned and spontaneous activities on a daily basis.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Activities C: The facility's residents report that activities meet their social, emotional and spiritual needs.	For SFY 2010, 10/1/09 to 3/31/10; thereafter, July through March of payment period	2 points	Self-certification
Resident Choice A: The facility allows residents to set their own schedules, including what time to get up and what time to go to bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Choice B: The facility allows residents to have a choice of whether to take a bath or shower and on which days and at what time the bath or shower will be taken.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Consistent Staffing: The facility has all direct care staff members caring for the same residents at least 70% of their shifts..	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	3 points	Self-certification
National Accreditation: The facility has CARF or another nationally recognized accreditation for the provision of person-directed care.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	13 points NOTE: A facility that receives points for this measure does not receive points for any other measures in this subcategory.	Self-certification

Standard	Measurement Period	Value	Source
Subcategory: Resident Satisfaction			
<p>Resident/Family Satisfaction Survey: The facility administers an anonymous resident/family satisfaction survey annually. The survey tool must be developed, recognized, and standardized by an entity external to the facility. Results must be tabulated by an entity external to the facility.</p> <p>To qualify for the measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.</p>	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
<p>Long-Term Care Ombudsman: The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman.</p>	Calendar year ending December 31 of the payment period	5 points if resolution 70% to 74% 7 points if resolution 75% or greater	LTC ombudsman's list of facilities meeting the standard

(6) Domain 2: Quality of care.

Standard	Measurement Period	Value	Source
Subcategory: Survey			
<p>Deficiency-Free Survey: The facility is deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations.</p> <p>If a facility's only scope and severity deficiencies are an A level pursuant to 42 CFR Part 483, Subparts B and C, as amended to July 30, 1999, the facility shall be deemed to have a deficiency-free survey for purposes of this measure. Surveys are considered complete when all appeal rights have been exhausted.</p>	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisit, or complaint investigations	10 points	DIA list of facilities meeting the standard
<p>Regulatory Compliance with Survey: No on-site revisit to the facility is required for recertification surveys or for any substantiated complaint investigations during the measurement period.</p>	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisits, or complaint investigations	5 points NOTE: A facility that receives points for a deficiency-free survey does not receive points for this measure.	DIA list of facilities meeting the standard

Standard	Measurement Period	Value	Source
Subcategory: Staffing			
<p>Nursing Hours Provided: The facility's per-resident-day nursing hours are at or above one-half standard deviation above the mean of per-resident-day nursing hours for all facilities.</p> <p>Nursing hours include those of RNs, LPNs, CNAs, rehabilitation nurses, and other contracted nursing services. Nursing hours shall be normalized to remove variations in staff hours associated with different levels of resident case mix.</p>	Facility fiscal year ending on or before December 31 of the payment period	<p>5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation</p> <p>10 points if case-mix adjusted nursing hours are greater than mean plus one standard deviation</p>	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit. The facility cost report period case-mix index shall be used to normalize nursing hours.
<p>Employee Turnover: The facility has overall employee turnover of 50% or less and CNA turnover of 55% or less.</p>	Facility fiscal year ending on or before December 31 of the payment period	<p>5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55%</p> <p>10 points if overall turnover is less than or equal to 40% and CNA turnover is less than or equal to 45%</p>	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit
<p>Staff Education, Training and Development: The facility provides staff education, training, and development at 25% above the basic requirements for each position that requires continuing education. The number of hours for these programs must apply to at least 75% of all staff of the facility, based upon administrator or officer certification.</p>	Calendar year ending December 31 of the payment period	5 points	Self-certification
<p>Staff Satisfaction Survey: The facility annually administers an anonymous staff satisfaction survey. The survey tool must be developed, recognized, and standardized by an entity external to the facility and must identify worker job classification. Results must be tabulated by an entity external to the facility.</p> <p>To qualify for this measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.</p>	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results

Standard	Measurement Period	Value	Source
Subcategory: Nationally Reported Quality Measures			
High-Risk Pressure Ulcer: The facility has occurrences of high-risk pressure ulcers at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean percentage of occurrences 5 points if one standard deviation or more below the mean percentage of occurrences	IME medical services unit report based on MDS data as reported by CMS
Physical Restraints: The facility has a physical restraint rate of 0% based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	5 points	IME medical services unit report based on MDS data as reported by CMS
Chronic Care Pain: The facility has occurrences of chronic care pain at rates one-half standard deviation or more below the mean rate of occurrences for all facilities based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean rate of occurrences 5 points if one standard deviation or more below the mean rate of occurrences	IME medical services unit report based on MDS data as reported by CMS
High Achievement of Nationally Reported Quality Measures: The facility received at least 9 points from a combination of the measures listed in this subcategory.	12-month period ending September 30 of the payment period	2 points if the facility receives 9 to 12 points in the subcategory of nationally reported quality measures 4 points if the facility receives 13 to 15 points in this subcategory	IME medical services unit report based on MDS data as reported by CMS

(7) Domain 3: Access.

Standard	Measurement Period	Value	Source
Special Licensure Classification: The facility has a unit licensed for the care of residents with chronic confusion or a dementing illness (CCDI unit).	Status on December 31 of the payment period	4 points	DIA list of facilities meeting the standard

Standard	Measurement Period	Value	Source
High Medicaid Utilization: The facility has Medicaid utilization at or above the statewide median plus 10%. Medicaid utilization is determined by dividing total nursing facility Medicaid days by total nursing facility patient days.	Facility fiscal year ending on or before December 31 of the payment period	3 points if Medicaid utilization is more than the median plus 10% 4 points if Medicaid utilization is more than the median plus 20%	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

(8) Domain 4: Efficiency.

Standard	Measurement Period	Value	Source
High Occupancy Rate: The facility has an occupancy rate at or above 95%. "Occupancy rate" is defined as the percentage derived when dividing total patient days based on census logs by total bed days available based on the number of authorized licensed beds within the facility.	Facility fiscal year ending on or before December 31 of the payment period	4 points	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit
Low Administrative Costs: The facility's percentage of administrative costs to total allowable costs is one-half standard deviation or more below the mean percentage of administrative costs for all Iowa facilities.	Facility fiscal year ending on or before December 31 of the payment period	3 points if administrative costs percentage is less than the mean less one-half standard deviation 4 points if administrative costs percentage is less than the mean less one standard deviation	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

(9) Source of measurements. Source reports are due to the department by May 1 of each year. For those measures whose source is self-certification, the data shall be drawn from Form 470-4828, Nursing Facility Medicaid Pay-for-Performance Self-Certification Report, submitted by the facility to IME. The independent party that collects and compiles the results of the resident/family survey shall communicate the results to IME on Form 470-3891, Nursing Facility Opinion Survey Transmittal. The department shall request required source reports from the long-term care ombudsman and the department of inspections and appeals (DIA).

(10) Calculation of potential add-on payment. The number of points awarded shall be determined annually, for each state fiscal year for which funding is appropriated by the legislature. A determination is made on whether a facility qualifies for an add-on payment at the end of the payment period. Based upon the number of points awarded, a retroactive add-on payment is made effective beginning the first day of the payment period as follows, contingent upon legislative funding for the state fiscal year, and subject to subparagraph (11):

<u>Score</u>	<u>Amount of Add-on Payment</u>
0-50 points	No additional reimbursement
51-60 points	1 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
61-70 points	2 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
71-80 points	3 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
81-90 points	4 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
91-100 points	5 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

(11) Monitoring for reduction or forfeiture of reimbursement. The department shall request the department of inspections and appeals to furnish by September 1, December 1, March 1, and August 1 of each year a list of nursing facilities subject to a reduction or forfeiture of the additional reimbursement pursuant to the criteria in subparagraph (12) or (13).

(12) Forfeiture of additional reimbursement. A nursing facility shall not be eligible for any additional reimbursement under this program if during the payment period the nursing facility is cited for a deficiency resulting in actual harm or immediate jeopardy pursuant to the federal certification guidelines at a scope and severity level of H or higher, regardless of the amount of fines assessed.

(13) Reduction of additional reimbursement. The additional reimbursement for the nursing facility pay-for-performance program calculated according to subparagraph (10) shall be subject to reduction based on survey compliance as follows:

1. The add-on payment shall be suspended for any month in which the nursing facility has received denial of payment for new admission status that was enforced by CMS.

2. A facility's add-on payment shall be reduced by 25 percent for each citation received during the year for a deficiency resulting in actual harm at a scope and severity level of G pursuant to the federal certification guidelines.

3. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections and appeals, the add-on payment shall be forfeited, and the facility shall not receive any nursing facility pay-for-performance program payment for the payment period.

(14) Application of additional payments. The additional reimbursement for the nursing facility pay-for-performance program shall be paid to qualifying facilities at the end of the state fiscal year. At the end of each state fiscal year, the Iowa Medicaid enterprise shall:

1. Retroactively adjust each qualifying facility's quarterly rates from the first day of the state fiscal year to include the amount of additional reimbursement for the nursing facility pay-for-performance program calculated according to paragraph 81.6(16) "g"; and

2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for the nursing facility pay-for-performance program is effective to reflect the adjusted reimbursement rate.

(15) Use of additional payments. As a condition of eligibility for such payments, any additional payments received by a nursing facility for the pay-for-performance program must be:

1. Used to support direct care staff through increased wages, enhanced benefits, and expanded training opportunities; and

2. Used in a manner that improves and enhances quality of care for residents.

(16) Monitoring facility compliance on the use of payments. Each nursing facility shall complete Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, to report the use of any additional payments received for the nursing facility pay-for-performance program. Form 470-4829 is due to the department each year by May 1, beginning May 1, 2011. Failure to submit the report by the due date shall result in disqualification for add-on payment for the next pay-for-performance payment period.

(17) Reporting results of the program. The department shall publish the results of the nursing facility pay-for-performance program annually.

h. Capital cost per diem instant relief add-on and enhanced non-direct care rate component limit. Contingent upon approval from the Centers for Medicare and Medicaid Services (CMS) and to the extent that funding is appropriated by the Iowa general assembly, additional reimbursement is available for nursing facilities that have completed a complete replacement, new construction, or major renovations. Additional reimbursement under this paragraph is available for services rendered beginning on October 1, 2007, or beginning on the effective date of CMS approval if CMS approval is effective on a later date.

(1) Types of additional reimbursement. Two types of additional reimbursement are available:

1. The capital cost per diem instant relief add-on is an amount per patient day to be added to the non-direct care component of the reimbursement rate and is subject to the non-direct care rate component limit as determined in paragraph “*f.*”

2. The enhanced non-direct care rate component limit provides an increase in the percentage of the median that is applied when calculating the non-direct care rate component limit as defined in paragraph “*f.*” The percentage of the median is increased to 120 percent when the enhanced non-direct care rate component limit is granted.

(2) Eligible projects. To qualify for either the capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit, a facility must have undertaken a complete replacement, new construction, or major renovations for the purpose of:

1. Rectification of a violation of Life Safety Code requirements; or
2. Development of home- and community-based waiver program services.

(3) Additional requirements for all requests. To qualify for additional reimbursement, a facility with an eligible project must also meet the following requirements:

1. The facility has Medicaid utilization at or above 40 percent for the two-month period before the request for additional reimbursement is submitted. Medicaid utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total licensed bed capacity as reported on the facility’s most current financial and statistical report.

2. The facility meets the accountability measure criteria set forth in paragraph “*g.*” subparagraph (1), deficiency-free survey, or subparagraph (2), regulatory compliance with survey, based on the most current information available when the request for additional reimbursement is submitted.

3. The facility has documented active participation in a quality of care program.

4. The facility has documented plans to facilitate person-directed care, dementia units, or specialty post-acute services.

(4) Additional requirements for waiver services. To qualify for additional reimbursement for the development of home- and community-based waiver services, the facility shall also meet the following requirements:

1. Services shall be provided in an underserved area, which may include a rural area.
2. Services shall be provided on the direct site of the facility but not as a nursing facility service.
3. Services shall meet all federal and state requirements for Medicaid reimbursement.
4. Services shall include one or more of the following: adult day care as defined by 441—subrule 78.37(1), consumer-directed attendant care as defined by 441—subrule 78.37(15) provided in an assisted living setting, day habilitation as defined by 441—subrule 78.41(14), home-delivered meals as defined by 441—subrule 78.37(8), emergency response system as defined by 441—subrule 78.37(2), and respite care as defined by 441—subrule 78.37(6).

(5) Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on, the enhanced non-direct care rate component limit, or a preliminary evaluation of whether a project may qualify for additional reimbursement to the Iowa Medicaid Enterprise, Provider

Cost Audit and Rate Setting Unit, 100 Army Post Road, Des Moines, Iowa 50315. A qualifying facility may request one or both types of additional reimbursement.

1. A request for the capital cost per diem instant relief add-on may be submitted no earlier than 30 days before the complete replacement, new construction, or major renovations are placed in service.

2. A request for the enhanced non-direct care rate component limit may be submitted with a request for a capital cost per diem instant relief add-on or within 60 days after the release of a rate determination letter reflecting a change in the non-direct care rate component limit.

3. A request for a preliminary evaluation may be submitted when a facility is preparing a feasibility projection for a construction or renovation project. A preliminary evaluation does not guarantee approval of the capital cost per diem instant relief add-on or enhanced non-direct care rate component limit upon submission of a formal request.

(6) Content of request for add-on. A facility's request for the capital cost per diem instant relief add-on shall include:

1. A description of the project for which the add-on is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. The period during which the add-on is requested (no more than two years).

4. Whether the facility is also requesting the enhanced non-direct care rate component limit. (See subparagraph (7) for requirements.)

5. A copy of the facility's most current depreciation schedule which clearly identifies the cost of the project for which the add-on is requested if assets placed in service by that project are included on the schedule. Any removal of assets shall be clearly identifiable either on the depreciation schedule or on a separate detailed schedule, and that schedule shall include the amount of depreciation expense for removed assets that is included in the current reimbursement rate.

6. If the cost of the project is not reported on the submitted depreciation schedule, a detailed schedule of the assets to be placed in service by the project, including:

- The estimated date the assets will be placed into service;
- The total estimated depreciable value of the assets;
- The estimated useful life of the assets based upon existing Medicaid and Medicare provisions;

and

- The estimated annual depreciation expense of the assets using the straight-line method in accordance with generally accepted accounting principles.

7. The facility's estimated annual licensed bed capacity and estimated annual total patient days. If this information is not provided, estimated annual total patient days shall be determined using the most current submitted financial and statistical report.

8. If interest expense has been or will be incurred and is related to the project for which the add-on is requested, a copy of the general terms of the debt service and the estimated annual amount of interest expense shall be submitted.

9. If any debt service has been retired, a copy of the general terms of the debt service and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

(7) Content of request for enhanced limit. A facility's request for the enhanced non-direct care rate component limit shall include:

1. A description of the project for which the enhanced non-direct care rate component limit is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.

(8) Content of request for preliminary evaluation. A facility's request for a preliminary evaluation of a proposed project shall include:

1. The estimated completion date of the project.
2. The estimated date when a formal request for an add-on or enhanced limit will be submitted.
3. For a preliminary evaluation for a capital cost per diem instant relief add-on, all information required in subparagraph (6).
4. For a preliminary evaluation for the enhanced non-direct care rate component limit, all information required in subparagraph (7).

(9) Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual total patient days.

1. Effective December 1, 2009, total patient days shall be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of calculating the add-on, total patient days shall be the greater of the estimated annual total patient days or 85 percent of the facility's estimated licensed capacity.

2. The annual estimated property costs for the project are calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

3. A reconciliation between the estimated amounts and actual amounts shall be completed as described in subparagraph (12).

(10) Effective date of capital cost per diem instant relief add-on. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, a capital cost per diem instant relief add-on shall be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit as determined in paragraph "f."

(11) Term of capital cost per diem instant relief add-on. The period for which a facility may be granted the capital cost per diem instant relief add-on shall not exceed two years. The capital cost per diem instant relief add-on shall terminate at the time of the subsequent biennial rebasing. If the facility's submitted annual financial and statistical report used in the subsequent biennial rebasing does not include 12 months of property costs for the assets with which the capital cost per diem instant relief add-on is associated, including interest expense, if applicable, the facility may submit a new request for the capital cost per diem instant relief add-on.

(12) Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the Iowa Medicaid enterprise shall recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual financial and statistical report. A separate reconciliation shall be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. Effective December 1, 2009, for purposes of recalculating the capital cost per diem instant relief add-on, total patient days shall be based on the greater of the number of actual patient days during the period in which the add-on was paid or 85 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid.

2. The recalculated capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit as determined in paragraph "f." The facility's quarterly rates for the relevant period shall be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement

rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid shall be repriced to reflect the recalculated capital cost per diem instant relief add-on.

(13) Effective date of enhanced non-direct care rate component limit. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, an enhanced non-direct care rate component limit shall be effective:

1. With a capital cost per diem instant relief add-on (if requested at the same time); or
2. Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date shall be repriced.

(14) Term of enhanced non-direct care rate component limit. The period for which a facility may be granted an enhanced non-direct care rate component limit without reapplication shall not exceed two years. The total period for which a facility may be granted enhanced non-direct care rate component limits shall not exceed ten years. If the amount of the non-direct care rate component limit is revised during the period for which a facility is granted the enhanced limit, the approval shall be terminated effective the first day of the quarter in which the revised non-direct care rate component limit is effective. The facility may submit a new request for the enhanced non-direct care rate component limit.

(15) Ongoing conditions. Any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit granted by the Iowa Medicaid enterprise is temporary. Additional reimbursement shall be immediately terminated if:

1. The facility does not continue to meet all of the initial qualifications for additional reimbursement; or
2. The facility does not make reasonable progress on any plans required for initial qualification; or
3. The facility's medical assistance program or Medicare certification is revoked. A facility whose certification is revoked is not eligible to submit a subsequent request for a capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit.

(16) Change of ownership. Following a change in nursing facility ownership, any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit that was granted before the change in ownership shall continue under the new owner. Future reimbursement rates shall be determined pursuant to subrules 81.6(15) and 81.6(16).

81.6(17) Cost report documentation. All nursing facilities, except the Iowa Veterans Home, shall submit an annual cost report based on the closing date of the facility's fiscal year that incorporates documentation as set forth below. The Iowa Veterans Home shall submit semiannual cost reports based on the closing date of the facility's fiscal year and the midpoint of the facility's fiscal year that incorporate documentation as set forth below. The documentation incorporated in all cost reports shall include all of the following information:

- a. Information on staffing costs, including the number of hours of the following provided per resident per day by all the following: nursing services provided by registered nurses, licensed practical nurses, certified nurse aides, restorative aides, certified medication aides, and contracted nursing services; other care services; administrative functions; housekeeping and maintenance; and dietary services.
- b. The starting and average hourly wage for each class of employees for the period of the report.
- c. An itemization of expenses attributable to the home or principal office or headquarters of the nursing facility included in the administrative cost line item.

81.6(18) Inflation factor. The department shall consider an inflation factor in determining the reimbursement rate. The inflation factor shall be based on the CMS Total Skilled Nursing Facility (CMS/SNF) Market Basket Index published by Data Resources, Inc. The CMS/SNF index listed in the latest available quarterly publication prior to the July 1 rate setting shall be used to determine the inflation factor.

81.6(19) Case-mix index calculation.

- a. The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility pursuant to subrule 81.13(9). Standard Version 5.12b case-mix indices developed by CMS shall be the basis for calculating the average

case-mix index and shall be used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate pursuant to subrule 81.6(16).

b. Each resident in the facility on the last day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the last day of each calendar quarter. This RUG-III group shall be translated to the appropriate case-mix index referenced in paragraph "a." From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year based on the last day of each calendar quarter.

The facilitywide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payor source on the last day of the calendar quarter. Assessments that cannot be classified to a RUG-III group due to errors shall be excluded from both average case-mix index calculations.

81.6(20) Medicare crossover claims for nursing facility services.

a. Definitions. For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered nursing facility 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 reimbursement rate for the services rendered (including any portion to be paid by the Medicaid beneficiary as client participation) multiplied by the number of Medicaid units of service included in a crossover claim, as determined under state and federal law and policies.

"Medicaid reimbursement" includes any amount to be paid by the Medicaid beneficiary as Medicaid client participation and any amount to be paid by the department after application of any applicable Medicaid client participation.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered multiplied by the number of Medicare units of service included in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Crossover claims. Crossover claims for services covered under Medicare Part A and under Medicaid are reimbursed as set out in this paragraph.

(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 will 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 is 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.

81.6(21) Nursing facility quality assurance payments.

a. Quality assurance assessment pass-through. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance assessment pass-through shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule. The quality assurance assessment pass-through shall equal the per-patient-day assessment determined pursuant to 441—subrule 36.6(2).

b. Quality assurance assessment rate add-on. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance add-on of \$10 per patient day shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule.

c. Use of the pass-through and add-on. As a condition for receipt of the pass-through and add-on, each nursing facility shall submit information to the department on Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, demonstrating compliance by the nursing facility with the requirements for use of the pass-through and add-on. If the sum of the quality assurance assessment

pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment:

(1) No less than 35 percent of the difference shall be used to increase compensation and costs of employment for direct care workers determined pursuant to 2009 Iowa Acts, Senate File 476.

(2) No less than 60 percent of the difference shall be used to increase compensation and costs of employment for all nursing facility staff, with increases in compensation and costs of employment determined pursuant to 2009 Iowa Acts, Senate File 476.

d. Effective date. Until federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, has been approved by the federal Centers for Medicare and Medicaid Services, none of the nursing facility rate-setting methodologies of this subrule shall become effective.

e. End date. If the federal Centers for Medicare and Medicaid Services determines that federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, is unavailable for any period, or if the department no longer has the authority to collect the assessment, then beginning on the effective date that such federal financial participation is not available or authority to collect the assessment is rescinded, none of the nursing facility rate-setting methodologies of this subrule shall be effective. If the period for which federal match money is unavailable or the authority to collect the assessment is rescinded includes a retroactive period, the department shall:

(1) Recalculate Medicaid rates in effect during that period without the rate-setting methodologies of this subrule;

(2) Recompute Medicaid payments due based on the recalculated Medicaid rates;

(3) Recoup any previous overpayments; and

(4) Determine for each nursing facility the amount of quality assurance assessment collected during that period and refund that amount to the facility.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.16, Iowa Code chapter 249K, and 2009 Iowa Code Supplement chapter 249L.

[ARC 8258B, IAB 11/4/09, effective 1/1/10; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 9046B, IAB 9/8/10, effective 8/12/10; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1806C, IAB 1/7/15, effective 3/1/15]

441—81.7(249A) Continued review.

81.7(1) Level of care. The IME medical services unit shall review Medicaid members' need for continued care in nursing facilities, pursuant to the standards and subject to the appeals process in subrule 81.3(1). For all members enrolled with a managed care organization, the managed care organization shall review a Medicaid member's need for continued care in a nursing facility at least annually. The managed care organization must submit documentation to the IME medical services unit for all reviews that indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reviews that indicate a change in the level of care.

81.7(2) PASRR. As a condition of payment for nursing facility care under the Medicaid program when there is a significant change in a resident's condition, the nursing facility shall, within 24 hours, initiate a PASRR review by the department's contractor for PASRR evaluations. For purposes of this subrule, "significant change in a resident's condition" means any admission or readmission to the facility immediately following an inpatient psychiatric hospitalization or any change that is likely to impact the resident's treatment needs related to a mental illness or intellectual disability. The evaluation shall determine:

a. Whether nursing facility care or skilled nursing care is medically necessary and appropriate for the resident under 441—subrules 79.9(1) and 79.9(2);

b. Whether nursing facility services continue to be appropriate for the resident, as opposed to care in a more specialized facility or in a community-based setting; and

c. Whether the resident needs specialized services for mental illness or intellectual disability, as described in paragraph 81.3(3) “b.”

This rule is intended to implement Iowa Code sections 249A.2(1), 249A.3(3), and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.8(249A) Quality of care review. Rescinded IAB 8/8/90, effective 10/1/90.

441—81.9(249A) Records.

81.9(1) Content. The facility shall as a minimum maintain the following records:

a. All records required by the department of public health and the department of inspections and appeals.

b. Records of all treatments, drugs, and services for which vendors’ payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

c. Documentation in each resident’s records which will enable the department to verify that each charge is due and proper prior to payment.

d. Financial records maintained in the standard, specified form including the facility’s most recent audited cost report.

e. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

f. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for all residents of the facility.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.

g. Resident accounts.

h. In-service education program records.

i. Inspection reports pertaining to conformity with federal, state and local laws.

j. Residents’ personal records.

k. Residents’ medical records.

l. Disaster preparedness reports.

81.9(2) Retention. Records identified in subrule 81.9(1) shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

81.9(3) Change of owner. All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) “a.”

441—81.10(249A) Payment procedures.

81.10(1) Method of payment. Except for Medicaid accountability measures payment established in paragraph 81.6(16) “g,” facilities shall be reimbursed under a modified price-based vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—81.6(249A). Effective July 1, 2002, the per diem rate shall include an amount for Medicaid accountability measures.

81.10(2) Authorization of payment. The department shall authorize payment for care in a facility. The authorization shall be obtained prior to admission of the resident, whenever possible. For a nursing facility to be eligible for Medicaid payment for a resident, the facility must, when applicable, exhaust all Medicare benefits.

81.10(3) Rescinded IAB 8/9/89, effective 10/1/89.

81.10(4) Periods authorized for payment.

- a. Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.
- b. Payment will be authorized as long as the resident is certified as needing care in a nursing facility.
- c. Payment will be approved for the day of admission but not the day of discharge or death.
- d. Payment will be approved for periods the resident is absent overnight for purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 18 days in any calendar year. Additional days shall be based upon a recommendation by the resident's physician in the plan of care that additional days would be rehabilitative.
- e. Payment will be approved for a period not to exceed 10 days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.
- f. Payment for periods when residents are absent for a visit, vacation, or hospitalization shall be made at zero percent of the nursing facility's rate, except for special population facilities and state-operated nursing facilities, which shall be paid for such periods at 42 percent of the facility's rate.
- g. Payment for residents determined by utilization review to require the residential level of care shall be made at the maximum state supplementary assistance rate. This rate is effective as of the date of final notice by utilization review that the lower level of care is required.
- h. In-state nursing facilities serving Medicaid eligible patients who require a ventilator at least six hours every day, are inappropriate for home care, and have medical needs that require skilled care as determined by the peer review organization shall receive reimbursement for the care of these patients equal to the sum of the Medicare-certified hospital-based nursing facility direct care rate component limit plus the Medicare-certified hospital-based nursing facility non-direct care rate component limit factor pursuant to subparagraph 81.6(16) "f"(3). Facilities may continue to receive reimbursement at this rate for 30 days for any person weaned from a respirator who continues to reside in the facility and continues to meet skilled care criteria for those 30 days.
- i. Payment for residents of a special population facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness will be made only when the resident is aged 65 or over. If a resident under the age of 65 is admitted with a payment source other than Medicaid, the facility shall notify the resident, or when applicable the resident's guardian or legal representative, that Iowa Medicaid may neither make payment to the facility nor make payment for any other services rendered by any provider while the person resides in the facility, until the resident attains the age of 65.
- j. Nonpayment for provider-preventable conditions. Reimbursement will not be made for patient days attributable to preventable conditions identified pursuant to this rule that develop in a nursing facility. Any patient days attributable to a provider-preventable condition must be billed as noncovered days. A provider-preventable condition is one in which any of the following occur:
 - (1) The wrong surgical or other invasive procedure is performed on a resident; or
 - (2) A surgical or other invasive procedure is performed on the wrong body part; or
 - (3) A surgical or other invasive procedure is performed on the wrong resident.

81.10(5) Supplementation. Only the amount of client participation may be billed to the resident for the cost of care, and the facility must accept the combination of client participation and payment made through the Iowa Medicaid program as payment in full for the care of a resident. No additional charges shall be made to residents or family members for any supplies or services required in the facility-developed plan of care for the resident.

Residents may choose to spend their personal funds on items of personal care such as professional beauty or barber services, but the facility shall not require this expenditure and shall not routinely obligate residents to any use of their personal funds.

- a. Supplies or services that the facility shall provide:

(1) Nursing services, social work services, activity programs, individual and group therapy, rehabilitation or habilitation programs provided by facility staff in order to carry out the plan of care for the resident.

(2) Services related to the nutrition, comfort, cleanliness and grooming of a resident as required under state licensure and Medicaid survey regulations.

(3) Medical equipment and supplies including wheelchairs except for customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2)“a”(4), medical supplies except for those listed in 441—paragraph 78.10(4)“b,” oxygen except under circumstances specified in 441—paragraph 78.10(2)“a,” and other items required in the facility-developed plan of care.

(4) Nonprescription drugs ordered by the physician except for those specified in 441—paragraph 78.1(2)“f.”

(5) Fees charged by medical professionals for services requested by the facility that do not meet criteria for direct Medicaid payment.

b. The facility shall arrange for nonemergency transportation for members to receive necessary medical services outside the facility.

(1) If a family member, friend, or volunteer is not available to provide the transportation at no charge, the facility shall arrange and pay for the medically necessary transportation within 30 miles of the facility (one way).

(2) For medically necessary transportation beyond 30 miles from the facility (one way), when no family member, friend, or volunteer is available to provide the transportation at no charge, the facility shall arrange for transportation through the broker designated by the department, with the cost to be paid by the broker pursuant to rule 441—78.13(249A).

c. The Medicaid program will provide direct payment to relieve the facility of payment responsibility for certain medical equipment and services that meet the Medicare definition of medical necessity and are provided by providers enrolled in the Medicaid programs including:

(1) Physician services.

(2) Ambulance services.

(3) Hospital services.

(4) Hearing aids, braces and prosthetic devices.

(5) Customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2)“a”(4).

d. Other supplies or services for which direct Medicaid payment may be available include:

(1) Drugs covered pursuant to 441—subrule 78.1(2).

(2) Dental services.

(3) Optician and optometrist services.

(4) Repair of medical equipment and appliances that belong to the resident.

(5) Transportation to receive medical services beyond 30 miles from the facility (one way), through the broker designated by the department pursuant to a contract between the department and the broker.

(6) Other medical services specified in 441—Chapter 78.

e. The following supplementation is permitted:

(1) The resident, the resident’s family, or friends may pay to hold the resident’s bed in cases where a resident who is not discharged from the facility is absent overnight. When the resident is discharged, the facility may handle the holding of the bed in the same manner as for a private paying resident.

(2) Payments made by the resident’s family toward cost of care of the resident shall not be considered as supplementation so long as the payments are included in client participation and are not over and above the payment made by the state for care of the resident.

(3) If a physician does not order a nonprescription drug by brand name, the facility may offer a generic. If a resident or family member requests a brand name, the resident or family member may pay for the brand-name nonprescription drug.

(4) Supplementation for provision of a private room not otherwise covered under the medical assistance program, subject to the following conditions, requirements, and limitations:

1. Supplementation for provision of a private room is not permitted for any time period during which the private room is therapeutically required pursuant to 42 CFR § 483.10(c)(8)(ii).

2. Supplementation for provision of a private room is not permitted for a calendar month if no room other than the private room was available as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

3. Supplementation for provision of a private room is not permitted for a calendar month if the facility's occupancy rate was less than 50 percent as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

4. Supplementation for provision of a private room is not permitted if the nursing facility only provides one type of room or all private rooms.

5. If a nursing facility provides for supplementation for provision of a private room, the facility may base the supplementation amount on the difference between the amount paid for a room covered under the medical assistance program and the private-pay rate for the private room identified for supplementation. However, the total payment for the private room from all sources for a calendar month shall not be greater than the aggregate average private room rate during that month for the type of rooms covered under the medical assistance program for which the resident would be eligible.

6. If a nursing facility provides for supplementation for provision of a private room, the facility shall inform all residents, prospective residents, and their legal representatives of the following:

- That if the resident desires a private room, the resident or resident's family may provide supplementation by directly paying the facility the amount of supplementation;
- The nursing facility's policy if a resident residing in a private room converts from private pay to payment under the medical assistance program but the resident or resident's family is not willing or able to pay supplementation for the private room;
- The private rooms for which supplementation is available, including a description and identification of such rooms; and
- The process for an individual to take legal responsibility for providing supplementation, including identification of the individual and the extent of the legal responsibility.

7. For a resident for whom the nursing facility receives supplementation, the nursing facility shall indicate in the resident's record all of the following:

- A description and identification of the private room for which the nursing facility is receiving supplementation;
- The identity of the individual making the supplemental payments;
- The private-pay charge for the private room for which the nursing facility is receiving supplementation; and
- The total charge to the resident for the private room for which the nursing facility is receiving supplementation, the portion of the total charge reimbursed under the medical assistance program, and the portion of the total charge reimbursed through supplementation.

8. Supplementation pursuant to this subparagraph shall not be required as a precondition of admission, expedited admission, or continued stay in a facility.

9. The nursing facility shall ensure that all appropriate care is provided to all residents notwithstanding the applicability or availability of supplementation.

10. A private room for which supplementation is required shall be retained for the resident consistent with bed-hold policies.

11. A nursing facility that utilizes the supplementation pursuant to this subparagraph during any calendar year shall report to the department annually by January 15 the following information for the preceding calendar year:

- The total number of nursing facility beds available at the nursing facility, the number of such beds available in private rooms, and the number of such beds available in other types of rooms.
- The average occupancy rate of the facility on a monthly basis.
- The total number of residents for whom supplementation was utilized.
- The average private pay charge for a private room in the nursing facility.

- For each resident for whom supplementation was utilized, the total charge to the resident for the private room, the portion of the total charge reimbursed under the Medicaid program, and the total charge reimbursed through supplementation.

f. Any medical equipment, supplies, appliances, or devices, personal care items, drugs, or other items of personal property that are paid for directly by the Medicaid program or are paid for by the resident or the resident's family, on a nonrental basis, are the personal property of the resident.

g. The facility shall not charge a resident for days that are not covered under Medicaid due to a provider-preventable condition pursuant to paragraph 81.10(4) "j" and shall not discharge a resident due to nonpayment for such days.

81.10(6) *Payment for out-of-state care.* Rescinded IAB 9/5/90, effective 11/1/90.

81.10(7) *Comparative charges between private pay and Medicaid residents.* Rescinded IAB 2/6/02, effective 4/1/02.

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

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 0714C, IAB 5/1/13, effective 7/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1806C, IAB 1/7/15, effective 3/1/15]

441—81.11(249A) Billing procedures.

81.11(1) *Claims.* Claims for service must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Claims must be submitted electronically through Iowa Medicaid's electronic clearinghouse. A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system. Adjustments to submitted claims may be made electronically as provided for by the Iowa Medicaid enterprise. A request for an adjustment to a paid claim must be received by the Iowa Medicaid enterprise within one year from the date the claim was paid in accordance with rule 441—80.4(249A).

81.11(2) Reserved.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

[ARC 1806C, IAB 1/7/15, effective 3/1/15]

441—81.12(249A) Closing of facility. When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving medical assistance shall be approved by the resident's managed care organization or by the IME medical services unit for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.13(249A) Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

81.13(1) *Procedures for establishing health care facilities as Medicaid facilities.* All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "State Operations Manual."

a. The facility shall obtain the applicable license from the department of inspections and appeals and must be recommended for certification by the department of inspections and appeals.

b. The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.

c. The Iowa Medicaid enterprise provider services unit shall transmit an application form and a copy of the nursing facility provider manual to the facility.

d. The facility shall complete its portion of the application form and submit it to the Iowa Medicaid enterprise provider services unit.

e. The Iowa Medicaid enterprise provider services unit shall review the application form and verify with the department of inspections and appeals that the facility is licensed and has been recommended for certification.

f. Prior to requesting enrollment, the facility shall contact the department of inspections and appeals to schedule a survey. The department of inspections and appeals shall schedule and complete a survey of the facility.

g. The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.

h. The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division department of inspections and appeals. This plan must be approved before the facility can be certified.

i. The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.

j. When certification is recommended, the department of inspections and appeals shall notify the department recommending a provider agreement.

k. Rescinded IAB 12/6/95, effective 2/1/96.

81.13(2) Medicaid provider agreements. The health care facility shall be recommended for certification by the department of inspections and appeals for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

a. Rescinded IAB 2/3/93, effective 4/1/93.

b. Rescinded IAB 2/3/93, effective 4/1/93.

c. Rescinded IAB 2/3/93, effective 4/1/93.

d. Rescinded IAB 2/3/93, effective 4/1/93.

e. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents.

f. Rescinded IAB 2/3/93, effective 4/1/93.

81.13(3) Distinct part requirement. All facilities which provide nursing facility care and also provide other types of care shall set aside a distinct or identifiable part for the provision of the nursing facility care.

a. The distinct part shall meet the following conditions:

(1) The distinct part shall meet all requirements for a nursing facility.

(2) The distinct part shall be identifiable as a unit such as a designated group of rooms, an entire ward or contiguous wards, wings, floor, or building. It shall consist of all beds and related facilities in the unit for whom payment is being made for nursing facility services. It shall be clearly identified and licensed by the department of inspections and appeals.

(3) The appropriate personnel shall be assigned to the identifiable unit and shall work regularly therein. Immediate supervision of staff shall be provided in the unit at all times by qualified personnel as required for licensure.

(4) The distinct part may share such central services and facilities as management services, dietary services, building maintenance and laundry with other units.

(5) When members of the staff share time between units of the facility, written records shall be maintained of the time assigned to each unit.

b. Hospitals participating as nursing facilities shall meet all of the same conditions applicable to freestanding nursing facilities.

c. Nothing herein shall be construed as requiring transfer of a resident within or between facilities when in the opinion of the attending physician the transfer might be harmful to the physical or mental health of the resident. The opinion of the physician shall be recorded on the resident's medical chart and stands as a continuing order unless the circumstances requiring the exception change.

81.13(4) Civil rights. The nursing facility shall comply with Title VI of the Civil Rights Act of 1964 in all areas of administration including admissions, records, services and physical facilities,

room assignments and transfers, attending physicians' privileges and referrals. Written statements of compliance shall be available to residents, employees, attending physicians and other members of the public.

81.13(5) Resident rights. The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility shall protect and promote the rights of each resident, including each of the following rights:

a. Exercise of rights.

(1) The resident has the right to exercise rights as a resident of the facility and as a citizen of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising those rights.

(3) In the case of a resident adjudged incompetent under the laws of a state, by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.

(4) In the case of a resident who has not been adjudged incompetent by the state court, any legal-surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law.

b. Notice of rights and services.

(1) The facility shall inform the resident, both orally and in writing in a language that the resident understands, of the resident's rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility shall also provide the resident with the pamphlet "Medicaid for People in Nursing Homes and Other Care Facilities," Comm. 52. This notification shall be made prior to or upon admission and during the resident's stay. Receipt of this information, and any amendments to it, must be acknowledged in writing.

(2) The resident or the resident's legal representative has the right, upon an oral or written request, to access all records pertaining to the resident including clinical records within 24 hours (excluding weekends and holidays); and after receipt of the records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days' advance notice to the facility.

(3) The resident has the right to be fully informed in language that the resident can understand of the resident's total health status, including, but not limited to, medical condition.

(4) The resident has the right to refuse treatment and to refuse to participate in experimental research.

(5) The facility shall:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid, of the items and services that are included in nursing facility services under the state plan and for which the resident may not be charged and of those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in number "1" of this subparagraph.

(6) The facility shall inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

(7) The facility shall furnish a written description of legal rights which includes:

1. A description of the manner of protecting personal funds.

2. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment which determines the extent of a couple's nonexempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in the resident's process of spending down to Medicaid eligibility levels.

3. A posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit.

4. A statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect and misappropriation of resident property in the facility.

(8) The facility shall inform each resident of the name, specialty and way of contacting the physician responsible for the resident's care.

(9) The facility shall prominently display in the facility written information and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by these benefits.

(10) Notification of changes.

1. A facility shall immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility.

2. The facility shall also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment or a change in resident rights under federal or state law or regulations.

3. The facility shall record and periodically update the address and telephone number of the resident's legal representative or interested family member.

c. Protection of resident funds.

(1) The resident has the right to manage the resident's financial affairs and the facility may not require residents to deposit their personal funds with the facility.

(2) Management of personal funds. Upon written authorization of a resident, the facility shall hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, as specified in subparagraphs (3) to (8) of this paragraph.

(3) Deposit of funds. The facility shall deposit any residents' personal funds in excess of \$50 in an interest-bearing account that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's funds to that account. In pooled accounts, there must be a separate accounting for each resident's share.

The facility shall maintain a resident's personal funds that do not exceed \$50 in a non-interest-bearing account, an interest-bearing account, or petty cash fund.

(4) Accounting and records. The facility shall establish and maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

1. The system shall preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

2. The individual financial record shall be available through quarterly statements and on request to the resident or the resident's legal representative.

(5) Notice of certain balances. The facility shall notify each resident that receives Medicaid benefits:

1. When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person.

2. That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(6) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility shall convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(7) Assurance of financial security. The facility shall purchase a surety bond, or otherwise provide assurance satisfactory to the department of inspections and appeals and the department of human services, to ensure the security of all personal funds of residents deposited with the facility.

(8) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

d. Free choice. The resident has the right to:

- (1) Choose a personal attending physician.
- (2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.
- (3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, participate in planning care and treatment or changes in care and treatment.

e. Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room.

(2) Except as provided in subparagraph (3) below, the resident may approve or refuse the release of personal and clinical records to any person outside the facility.

(3) The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution or record release is required by law.

f. Grievances. A resident has the right to:

- (1) Voice grievances without discrimination or reprisal for voicing the grievances. The grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.
- (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

g. Examination of survey results. A resident has the right to:

- (1) Examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability.
- (2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

h. Work. The resident has the right to:

- (1) Refuse to perform services for the facility.
- (2) Perform services for the facility if the resident chooses, when:
 1. The facility has documented the need or desire for work in the plan of care.
 2. The plan specifies the nature of the services performed and whether the services are voluntary or paid.
 3. Compensation for paid services is at or above prevailing rates.
 4. The resident agrees to the work arrangement described in the plan of care.
 5. Rescinded IAB 3/4/92, effective 4/8/92.

i. Mail. The resident has the right to privacy in written communications, including the right to send and receive mail promptly that is unopened and to have access to stationery, postage and writing implements at the resident's own expense.

j. Access and visitation rights.

(1) The resident has the right and the facility shall provide immediate access to any resident by the following:

1. Any representative of the secretary of the Department of Health and Human Services.
2. Any representative of the state.
3. The resident's individual physician.
4. The state long-term care ombudsman.
5. The agency responsible for the protection and advocacy system for developmentally disabled individuals.
6. The agency responsible for the protection and advocacy system for mentally ill individuals.
7. Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time.
8. Others who are visiting with the consent of the resident subject to reasonable restrictions and to the resident's right to deny or withdraw consent at any time.

(2) The facility shall provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(3) The facility shall allow representatives of the state ombudsman to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with state law.

k. Telephone. The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

l. Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

m. Married couples. The resident has the right to share a room with the resident's spouse when married residents live in the same facility and both spouses consent to the arrangement.

n. Self-administration of drugs. An individual resident has the right to self-administer drugs if the interdisciplinary team has determined that this practice is safe.

o. Refusal of certain transfers.

(1) A person has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a skilled nursing facility from the distinct part of the institution that is a skilled nursing facility to a part of the institution that is not a skilled nursing facility or, if a resident of a nursing facility, from the distinct part of the institution that is a nursing facility to a distinct part of the institution that is a skilled nursing facility.

(2) A resident's exercise of the right to refuse transfer under subparagraph (1) does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

p. Advance directives.

(1) The nursing facility, at the time of admission, shall provide written information to each resident which explains the resident'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 nursing facility's policies regarding the implementation of these rights.

(2) The nursing facility shall document in the resident's medical record whether or not the resident has executed an advance directive.

(3) The nursing facility shall not condition the provision of care or otherwise discriminate against a resident based on whether or not the resident has executed an advance directive.

(4) The nursing facility shall ensure compliance with requirements of state law regarding advance directives.

(5) The nursing facility shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this paragraph shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any nursing facility which as a matter of conscience cannot implement an advance directive.

81.13(6) *Admission, transfer and discharge rights.*

a. Transfer and discharge.

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) Transfer or discharge requirements. The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.

3. The safety of persons in the facility is endangered.

4. The health of persons in the facility would otherwise be endangered.

5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.

6. The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in subparagraph (2), numbers 1 through 5 above, the resident's clinical record shall be documented. The documentation shall be made by:

1. The resident's physician when transfer or discharge is necessary under subparagraph (2), number 1 or 2.

2. A physician when transfer or discharge is necessary under subparagraph (2), number 4.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility shall:

1. Notify the resident, the resident's case manager for those residents enrolled with a managed care organization and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

2. Record the reasons in the resident's clinical record.

3. Include in the notice the items in subparagraph (6) below.

(5) Timing of the notice. The notice of transfer or discharge shall be made by the facility at least 30 days before the resident is transferred or discharged except that notice shall be made as soon as practicable before transfer or discharge when:

1. The safety of persons in the facility would be endangered.

2. The health of persons in the facility would be endangered.

3. The resident's health improves sufficiently to allow a more immediate transfer or discharge.

4. An immediate transfer or discharge is required by the resident's urgent medical needs.

5. A resident has not resided in the facility for 30 days.

(6) Contents of the notice. The written notice shall include the following:

1. The reason for transfer or discharge.

2. The effective date of transfer or discharge.

3. The location to which the resident is transferred or discharged.

4. A statement that the resident has the right to appeal the action to the department.

5. The name, address, and telephone number of the state long-term care ombudsman.

6. The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals for residents with developmental disabilities.

7. The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals for residents who are mentally ill.

(7) Orientation for transfer or discharge. A facility shall provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

b. Notice of bed-hold policy and readmission.

(1) Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility shall provide written information to the resident and a family member or legal representative that specifies:

1. The duration of the bed-hold policy under the state plan during which the resident is permitted to return and resume residence in the facility.

2. The facility's policies regarding bed-hold periods, which shall be consistent with subparagraph (3) below, permitting a resident to return.

(2) Notice upon transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility shall provide written notice to the resident and a family member or legal representative, which specifies the duration of the bed-hold policy described in subparagraph (1) above.

(3) Permitting resident to return to facility. A nursing facility shall establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the state plan, is readmitted to the facility immediately upon the first availability of a bed in a semiprivate room if the resident requires the services provided by the facility and is eligible for Medicaid nursing facility services.

c. Equal access to quality care.

(1) A facility shall establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all persons regardless of source of payment.

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in 81.13(1)“a”(5).

(3) The state is not required to offer additional services on behalf of a resident other than services provided in the state plan.

d. Admissions policy.

(1) The facility shall not require residents or potential residents to:

1. Waive their rights to Medicare or Medicaid; or

2. Give oral or written assurance that they are not eligible for, or will not apply for, Medicare or Medicaid benefits. However, a continuing care retirement community or a life care community that is licensed, registered, certified, or the equivalent by the state, including a nursing facility that is part of such a community, may require in its contract for admission that before a resident applies for medical assistance, the resources that the resident declared for the purposes of admission must be spent on the resident's care, subject to 441—subrule 75.5(3), 441—paragraph 75.5(4)“a,” and 441—subrule 75.16(2).

(2) The facility shall not require a third-party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require a person who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the state plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However:

1. A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the state plan as included in the term “nursing facility services” so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of these additional services.

2. A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid-eligible resident.

(4) States or political subdivisions may apply stricter admission standards under state or local laws than are specified in these rules, to prohibit discrimination against persons entitled to Medicaid.

81.13(7) *Resident behavior and facility practices.*

a. Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

b. Abuse. The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

c. Staff treatment of residents. The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

* (1) Facility staff shall not use verbal, mental, sexual, or physical abuse, including corporal punishment, or involuntary seclusion of residents. The facility shall not employ persons who have been found guilty by a court of law of abusing, neglecting or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

The facility shall report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

*See Objection filed 8/25/92 published herein at end of 441—Chapter 81.

(2) The facility shall ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility or to other officials (including the department of inspections and appeals) in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations conducted by facility staff shall be reported to the administrator or the administrator's designated representative or to other officials (including the department of inspections and appeals) in accordance with state law within five working days of the incident and if the alleged violation is verified, take appropriate corrective action.

81.13(8) *Quality of life.* A facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

a. Dignity. The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of the resident's individuality.

b. Self-determination and participation. The resident has the right to:

(1) Choose activities, schedules, and health care consistent with the resident's interests, assessments and plans of care.

(2) Interact with members of the community both inside and outside the facility.

(3) Make choices about aspects of life in the facility that are significant to the resident.

c. Participation in resident and family groups.

(1) A resident has the right to organize and participate in resident groups in the facility.

(2) A resident's family has the right to meet in the facility with the families of other residents in the facility.

(3) The facility shall provide a resident or family group, if one exists, with private space.

(4) Staff or visitors may attend meetings at the group's invitation.

(5) The facility shall provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

(6) When a resident or family group exists, the facility shall listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

d. Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

e. Accommodation of needs. A resident has the right to:

(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

(2) Receive notice before the resident's room or roommate in the facility is changed.

f. Activities.

(1) The facility shall provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(2) The activities program shall be directed by a qualified professional who meets one of the following criteria:

1. Is a qualified therapeutic recreation specialist or an activities professional who is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990.

2. Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting.

3. Is a qualified occupational therapist or occupational therapy assistant.

4. Has completed a training course approved by the state.

g. Social services.

(1) The facility shall provide medically related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident.

(2) A facility with more than 120 beds shall employ a qualified social worker on a full-time basis.

(3) Qualifications of social worker. A qualified social worker is a person who meets both of the following criteria:

1. A bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation, counseling and psychology.

2. One year of supervised social work experience in a health care setting working directly with individuals.

h. Environment. The facility shall provide:

(1) A safe, clean, comfortable and homelike environment, allowing the resident to use personal belongings to the extent possible.

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.

(3) Clean bed and bath linens that are in good condition.

(4) Private closet space in each resident room.

(5) Adequate and comfortable lighting levels in all areas.

(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990, shall maintain a temperature range of 71 to 81 degrees Fahrenheit.

(7) For the maintenance of comfortable sound levels.

81.13(9) Resident assessment. The facility shall conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional ability.

a. Admission orders. At the time each resident is admitted, the facility shall have physician orders for the resident's immediate care.

b. Comprehensive assessments.

(1) The facility shall make a comprehensive assessment of a resident's needs which is based on the minimum data set (MDS) specified by the department of inspections and appeals, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

(2) The assessment process shall include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. The comprehensive assessment shall include at least the following information:

1. Identification and demographic information.

2. Customary routine.

3. Cognitive patterns.

4. Communication.
 5. Vision.
 6. Mood and behavior patterns.
 7. Psychosocial well-being.
 8. Physical functioning and structural problems.
 9. Continence.
 10. Disease diagnoses and health conditions.
 11. Dental and nutritional status.
 12. Skin condition.
 13. Activity pursuit.
 14. Medications.
 15. Special treatments and procedures.
 16. Discharge potential.
 17. Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
 18. Documentation of participation in assessment.
 19. Additional specification relating to resident status as required in Section S of the MDS.
- (3) Frequency. Assessments shall be conducted:
1. Within 14 calendar days after admission or readmission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. "Readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.
 2. Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. A "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and that requires either interdisciplinary review, revision of the care plan, or both.
 3. In no case less often than once every 12 months.
- (4) Review of assessments. The facility shall examine each resident no less than once every three months, and as appropriate, revise the resident's assessment to ensure the continued accuracy of the assessment.
- (5) Maintenance and use. A facility shall maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results to develop, review and revise the resident's comprehensive plan of care.
- (6) Coordination. The facility shall coordinate assessments with any state-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.
- (7) Automated data processing requirement.
1. Entering data. Within seven days after a facility completes a resident's assessment, a facility shall enter the following information for the resident into a computerized format that meets the specifications defined in numbered paragraphs "2" and "4" below.
 - Admission assessment.
 - Annual assessment updates.
 - Significant change in status assessments.
 - Quarterly review assessments.
 - A subset of items upon a resident's transfer, reentry, discharge, and death.
 - Background (face sheet) information, if there is no admission assessment.
 2. Transmitting data. Within seven days after a facility completes a resident's assessment, a facility shall be capable of transmitting to the state each resident's assessment information contained in the MDS in a format that conforms to standard record layouts and data dictionaries and that passes edits that ensure accurate and consistent coding of the MDS data as defined by the Centers for Medicare and Medicaid Services (CMS) and the department of human services or the department of inspections and appeals.

3. Monthly transmittal requirements. On at least a monthly basis, a facility shall input and electronically transmit accurate and complete MDS data for all assessments conducted during the previous month, including the following:

- Admission assessment.
- Annual assessment.
- Significant correction of prior full assessment.
- Significant correction of prior quarterly assessment.
- Quarterly review.
- A subset of items upon a resident's transfer, reentry, discharge, and death.
- Background (face sheet) information, for an initial transmission of MDS data on a resident who does not have an admission assessment.

4. The facility must transmit MDS data in the ASCII format specified by CMS.

(8) Resident-identifiable information. A facility shall not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

c. Accuracy of assessments. The assessment shall accurately reflect the resident's status.

(1) Coordination. Each assessment shall be conducted or coordinated with the appropriate participation of health professionals. Each assessment shall be conducted or coordinated by a registered nurse.

(2) Certification. Each person who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment. A registered nurse shall sign and certify that the assessment is completed.

(3) Penalty for falsification. An individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

(4) Use of independent assessors. If the department of human services or the department of inspections and appeals determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under subparagraph (3) above, the department of human services or the department of inspections and appeals may require that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the department of human services or the department of inspections and appeals for a period specified by the agency.

d. Comprehensive care plans.

(1) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan shall describe the following:

1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under subrule 81.13(10).

2. Any services that would otherwise be required under subrule 81.13(10), but are not provided due to the resident's exercise of rights under subrule 81.13(5), including the right to refuse treatment under subrule 81.13(5), paragraph "b," subparagraph (4).

(2) A comprehensive care plan shall be developed within seven days after completion of the comprehensive assessment by an interdisciplinary team and with the participation of the resident, the resident's case manager as appropriate and as allowed by the resident for those residents enrolled with a managed care organization, and the resident's family or legal representative to the extent practicable, and shall be periodically reviewed and revised by a team of qualified persons after each assessment.

The interdisciplinary team shall include the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.

(3) The services provided or arranged by the facility shall meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care.

e. Discharge summary. When the facility anticipates discharges, a resident shall have a discharge summary that includes:

(1) A recapitulation of the resident's stay.

(2) A final summary of the resident's status to include items in paragraph "b," subparagraph (2) above, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.

(3) A postdischarge plan of care developed with the participation of the resident and resident's family which will assist the resident to adjust to a new living environment.

f. Preadmission screening for mentally ill individuals and individuals with mental retardation. Rescinded IAB 9/7/11, effective 9/1/11.

g. Preadmission resident assessment. The facility shall conduct prior to admission a resident assessment of all persons seeking nursing facility placement. The assessment information gathered shall be similar to the data in the minimum data set (MDS) resident assessment tool.

81.13(10) Quality of care. Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

a. Activities of daily living. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress and groom; transfer and ambulate; toilet; eat, and to use speech, language or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve the resident's abilities specified in subparagraph (1) above.

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

b. Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility shall, if necessary, assist the resident:

(1) In making appointments.

(2) By arranging for transportation to and from the office of a medical practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

c. Pressure sores. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

d. Urinary incontinence. Based on the resident's comprehensive assessment, the facility shall ensure that:

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

e. Range of motion. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion.

f. Mental and psychosocial functioning. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction or increased withdrawn, angry or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

g. Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable.

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasopharyngeal ulcers and to restore, if possible, normal eating skills.

h. Accidents. The facility shall ensure that:

(1) The resident environment remains as free of accident hazards as is possible.

(2) Each resident receives adequate supervision and assistive devices to prevent accidents.

i. Nutrition. Based on a resident's comprehensive assessment, the facility shall ensure that a resident:

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

(2) Receives a therapeutic diet when there is a nutritional problem.

j. Hydration. The facility shall provide each resident with sufficient fluid intake to maintain proper hydration and health.

k. Special needs. The facility shall ensure that residents receive proper treatment and care for the following special services:

(1) Injections.

(2) Parenteral and enteral fluids.

(3) Colostomy, ureterostomy or ileostomy care.

(4) Tracheostomy care.

(5) Tracheal suctioning.

(6) Respiratory care.

(7) Foot care.

(8) Prostheses.

l. Unnecessary drugs.

(1) General. Each resident's drug regimen shall be free from unnecessary drugs. An unnecessary drug is any drug when used:

1. In excessive dose including duplicate drug therapy; or

2. For excessive duration; or

3. Without adequate monitoring; or

4. Without adequate indications for its use; or

5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

6. Any combinations of the reasons above.

(2) Antipsychotic drugs. Based on a comprehensive assessment of a resident, the facility shall ensure that:

1. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.

2. Residents who use antipsychotic drugs receive gradual dose reductions and behavioral programming, unless clinically contraindicated in an effort to discontinue these drugs.

m. Medication errors. The facility shall ensure that:

(1) It is free of significant medication error rates of 5 percent or greater.

(2) Residents are free of any significant medication errors.

81.13(11) Nursing services. The facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

a. Sufficient staff.

(1) The facility shall provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

1. Except when waived under paragraph "c," licensed nurses.

2. Other nursing personnel.

(2) Except when waived under paragraph "c," the facility shall designate a licensed nurse to serve as a charge nurse on each tour of duty.

b. Registered nurse.

(1) Except when waived under paragraph "c," the facility shall use the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

(2) Except when waived under paragraph "c," the facility shall designate a registered nurse to serve as the director of nursing on a full-time basis.

(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

c. Nursing facilities. Waiver of requirement to provide licensed nurses on a 24-hour basis. A facility may request a waiver from either the requirement that a nursing facility provide a registered nurse for at least eight consecutive hours a day, seven days a week, as specified in paragraph "b," or the requirement that a nursing facility provide licensed nurses on a 24-hour basis, including a charge nurse as specified in paragraph "a," if the following conditions are met:

(1) The facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel.

(2) The department of inspections and appeals determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility.

(3) The department of inspections and appeals finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility.

(4) A waiver granted under the conditions listed in paragraph "c" is subject to annual department of inspections and appeals review.

(5) In granting or renewing a waiver, a facility may be required by the department of inspections and appeals to use other qualified, licensed personnel.

(6) The department of inspections and appeals shall provide notice of a waiver granted under this paragraph to the state long-term care ombudsman established under Section 307(a)(12) of the Older Americans Act of 1965 and the protection and advocacy system in the state for the mentally ill and mentally retarded.

(7) The nursing facility that is granted a waiver under this paragraph shall notify residents of the facility or, where appropriate, the guardians or legal representatives of the residents and members of their immediate families of the waiver.

81.13(12) Dietary services. The facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

a. Staffing. The facility shall employ a qualified dietitian either full-time, part-time or on a consultant basis.

(1) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services who receives frequently scheduled consultation from a qualified dietitian.

(2) A qualified dietitian is one who is licensed by the state according to Iowa Code chapter 152A.

b. Sufficient staff. The facility shall employ sufficient support personnel competent to carry out the functions of the dietary service.

c. Menus and nutritional adequacy. Menus shall:

(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

(2) Be prepared in advance.

(3) Be followed.

d. Food. Each resident receives and the facility provides:

(1) Food prepared by methods that conserve nutritive value, flavor and appearances.

(2) Food that is palatable, attractive and at the proper temperature.

(3) Food prepared in a form designed to meet individual needs.

(4) Substitutes offered of similar nutritive value to residents who refuse food served.

e. Therapeutic diets. Therapeutic diets shall be prescribed by the attending physician.

f. Frequency of meals.

(1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There shall be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in subparagraph (4) below.

(3) The facility shall offer snacks at bedtime daily.

(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

g. Assistive devices. The facility shall provide special eating equipment and utensils for residents who need them.

h. Sanitary conditions. The facility shall:

(1) Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(2) Store, prepare, distribute and serve food under sanitary conditions.

(3) Dispose of garbage and refuse properly.

81.13(13) Physician services. A physician shall personally approve in writing a recommendation that an individual be admitted to a facility. Each resident shall remain under the care of a physician.

a. Physician supervision. The facility shall ensure that:

(1) The medical care of each resident is supervised by a physician.

(2) Another physician supervises the medical care of residents when their attending physician is unavailable.

b. Physician visits. The physician shall:

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph "c" below.

(2) Write, sign and date progress notes at each visit.

(3) Sign and date all orders.

c. Frequency of physician visits.

(1) The resident shall be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

(2) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

(3) Except as provided in paragraph "e," all required physician visits shall be made by the physician personally.

d. Availability of physicians for emergency care. The facility shall provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

e. Performance of physician tasks in nursing facilities. Any required physician task in a nursing facility (including tasks which the rules specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility, but who is working in collaboration with a physician except where prohibited by state law.

81.13(14) Specialized services. When indicated, specialized services shall be provided to residents as follows:

a. Specialized rehabilitative services. Specialized rehabilitative services shall be provided by qualified personnel under the written order of a physician. If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, and occupational therapy, are required in the resident's comprehensive plan of care, the facility shall:

- (1) Provide the required services; or
- (2) Obtain the required services from an outside provider of specialized rehabilitative services.

b. Specialized services for mental illness. "Specialized services for mental illness" means services provided in response to an exacerbation of a resident's mental illness that:

- (1) Are beyond the normal scope and intensity of nursing facility responsibility;
- (2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;
- (3) Are provided through a professionally developed plan of care with specific goals and interventions;

- (4) May be provided only by a specialized licensed or certified practitioner;

- (5) Are expected to result in specific, identified improvements in the resident's psychiatric status to the level before the exacerbation of the resident's mental illness; and

- (6) May include:

1. Acute inpatient psychiatric treatment. When inpatient psychiatric treatment may be prevented through specialized services provided in the nursing facility, services provided in the nursing facility are preferred.

2. Initial psychiatric evaluation to determine a resident's diagnosis and to develop a plan of care.

3. Follow-up psychiatric services by a psychiatrist to evaluate resident response to psychotropic medications, to modify medication orders and to evaluate the need for ancillary therapy services.

4. Psychological testing required for a specific differential diagnosis that will result in the adoption of appropriate treatment services.

5. Individual or group psychotherapy as part of a plan of care addressing specific symptoms.

6. Any clinically appropriate service which is available through the Iowa plan for behavioral health and for which the member meets eligibility criteria.

c. Specialized services for intellectual disability. "Specialized services for intellectual disability" means services that:

- (1) Are beyond the normal scope and intensity of nursing facility responsibility;

- (2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;

- (3) Are provided through a professionally developed plan of care with specific goals and interventions;

- (4) Must be supervised by a qualified intellectual disability professional; and

- (5) May include:

1. A functional assessment of maladaptive behaviors.

2. Development and implementation of a behavioral support plan.

3. Community living skills training for members who desire to live in a community setting and for whom community living is appropriate as determined by the Level II evaluation. Training may include adaptive behavior skills, communication skills, social skills, personal care skills, and self-advocacy skills.

81.13(15) Dental services. The facility shall assist residents in obtaining routine and 24-hour emergency dental care. The facility shall:

a. Provide or obtain from an outside resource the following dental services to meet the needs of each resident:

- (1) Routine dental services to the extent covered under the state plan.
- (2) Emergency dental services.

b. If necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office.

c. Promptly refer residents with lost or damaged dentures to a dentist.

81.13(16) Pharmacy services. The facility shall provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement. The nursing facility may permit a certified medication aide to administer drugs, but only under the general supervision of a licensed nurse.

a. Procedures. A facility shall provide pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

b. Service consultation. The facility shall employ or obtain the services of a licensed pharmacist who:

- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility.
- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.
- (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

c. Drug regimen review.

(1) The drug regimen of each resident shall be reviewed at least once a month by a licensed pharmacist.

(2) The pharmacist shall report any irregularities to the attending physician and the director of nursing, and these reports shall be acted upon.

d. Labeling of drugs and biologicals. Drugs and biologicals used in the facility shall be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

e. Storage of drugs and biologicals.

(1) In accordance with state and federal laws, the facility shall store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.

(2) The facility shall provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

f. Consultant pharmacists. When the facility does not employ a licensed pharmacist, it shall have formal arrangements with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration and disposal and record keeping of drugs and biologicals. The formal arrangements with the licensed pharmacist shall include separate written contracts for pharmaceutical vendor services and consultant pharmacist services. The consultant's visits are scheduled to be of sufficient duration and at a time convenient to work with nursing staff on the resident care plan, consult with the administrator and others on developing and implementing policies and procedures, and planning in-service training and staff development for employees. The consultant shall provide monthly drug regimen review reports. The facility shall provide reimbursement for consultant pharmacists based on fair market value. Documentation of consultation shall be available for review in the facility.

81.13(17) Infection control. The facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.

a. *Infection control program.* The facility shall establish an infection control program under which it:

- (1) Investigates, controls and prevents infections in the facility.
- (2) Decides what procedures, such as isolation, should be applied to an individual resident.
- (3) Maintains a record of incidents and corrective actions related to infections.

b. *Preventing spread of infection.*

(1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility shall isolate the resident.

(2) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility shall require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

c. *Linens.* Personnel shall handle, store, process, and transport linens so as to prevent the spread of infection.

81.13(18) Physical environment. The facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.

a. *Life safety from fire.* Except as provided in subparagraph (1) or (3) below, the facility shall meet the applicable provisions of the 1985 edition of the Life Safety Code of the National Fire Protection Association.

(1) A facility is considered to be in compliance with this requirement as long as the facility:

1. On November 26, 1982, complied with or without waivers with the requirements of the 1967 or 1973 editions of the Life Safety Code and continues to remain in compliance with those editions of the code; or

2. On May 9, 1988, complied, with or without waivers, with the 1981 edition of the Life Safety Code and continues to remain in compliance with that edition of the Code.

(2) When Medicaid nursing facilities and Medicaid distinct part nursing facility providers request a waiver of Life Safety Code requirements in accordance with Subsection 1919(d)(2)(B)(i) of the Social Security Act, the department of inspections and appeals shall forward the requests to the Centers for Medicare and Medicaid Services Regional Office for review and approval.

(3) The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare and Medicaid Services finds that a fire and safety code imposed by state law adequately protects patients, residents and personnel in long-term care facilities.

b. *Emergency power.*

(1) An emergency electrical power system shall supply power adequate at least for lighting all entrances and exits, equipment to maintain the fire detection, alarm and extinguishing systems, and life support systems in the event the normal electrical supply is interrupted.

(2) When life support systems are used that have no nonelectrical backup, the facility shall provide emergency electrical power with an emergency generator, as defined in NFPA 99, Health Care Facilities, that is located on the premises.

c. *Space and equipment.* The facility shall:

(1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care.

(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

d. *Resident rooms.* Resident rooms shall be designed and equipped for adequate nursing care, comfort and privacy of residents.

(1) Bedrooms shall:

1. Accommodate no more than four residents.

2. Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.

3. Have direct access to an exit corridor.

4. Be designed or equipped to ensure full visual privacy for each resident.

5. In facilities initially certified after March 31, 1992, except in private rooms, each bed shall have ceiling-suspended curtains, which extend around the bed to provide total visual privacy, in combination with adjacent walls and curtains.

6. Have at least one window to the outside.

7. Have a floor at or above grade level.

(2) The facility shall provide each resident with:

1. A separate bed of proper size and height for the convenience of the resident.

2. A clean, comfortable mattress.

3. Bedding appropriate to the weather and climate.

4. Functional furniture appropriate to the resident's needs and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

(3) The department of inspections and appeals may permit variations in requirements specified in paragraph "d," subparagraph (1), numbers 1 and 2 above relating to rooms in individual cases when the facility demonstrates in writing that the variations are required by the special needs of the residents and will not adversely affect residents' health and safety.

e. Toilet facilities. Each resident room shall be equipped with or located adjacent to toilet facilities unless a waiver is granted by the department of inspections and appeals. Additionally, each resident room shall be equipped with or located adjacent to bathing facilities.

f. Resident call system. The nurse's station shall be equipped to receive resident calls through a communication system from:

(1) Resident rooms.

(2) Toilet and bathing facilities.

g. Dining and resident activities. The facility shall provide one or more rooms designated for resident dining and activities. These rooms shall:

(1) Be well lighted.

(2) Be well ventilated, with nonsmoking areas identified.

(3) Be adequately furnished.

(4) Have sufficient space to accommodate all activities.

h. Other environmental conditions. The facility shall provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The facility shall:

(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.

(2) Have adequate outside ventilation by means of windows or mechanical ventilation or a combination of the two.

(3) Equip corridors with firmly secured handrails on each side.

(4) Maintain an effective pest control program so that the facility is free of pests and rodents.

81.13(19) Administration. A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

a. Licensure. A facility shall be licensed under applicable state and federal law.

b. Compliance with federal, state and local laws and professional standards. The facility shall operate and provide services in compliance with all applicable federal, state, and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

c. Relationship to other Department of Health and Human Services (HHS) regulations. In addition to compliance with these rules, facilities shall meet the applicable provisions of other HHS regulations, including, but not limited to, those pertaining to nondiscrimination on the basis of race, color, or national origin, nondiscrimination on the basis of handicap, nondiscrimination on the basis of age, protection of human subjects of research, and fraud and abuse. Although these regulations are not in themselves considered requirements under these rules, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with federal funds.

d. Governing body.

(1) The facility shall have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.

(2) The governing body appoints the administrator who is:

1. Licensed by the state.
2. Responsible for management of the facility.

e. Required training of nurse aides.

(1) Definitions.

“*Licensed health professional*” means a physician; physician assistant; nurse practitioner; physical, speech or occupational therapist; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

“*Nurse aide*” means any person providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide these services without pay.

(2) General rule. A facility shall not use any person working in the facility as a nurse aide for more than four months, on a permanent basis, unless:

1. That person is competent to provide nursing and nursing-related services.
2. That person has completed a training and competency evaluation program or a competency evaluation program approved by the department of inspections and appeals; or that person has been deemed or determined competent by the department of inspections and appeals.

(3) Nonpermanent employees. A facility shall not use on a temporary, per diem, leased, or any basis other than a permanent employee any person who does not meet the requirements in subparagraph (2).

(4) Competency. A facility shall not use any person who has worked less than four months as a nurse aide in that facility unless the person:

1. Is a permanent employee and is in a nurse aide training and competency evaluation program approved by the department of inspections and appeals;
2. Has demonstrated competence through satisfactory participation in a nurse aide training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals; or
3. Has been deemed or determined competent by the department of inspections and appeals.

(5) Registry verification. Before allowing a person to serve as a nurse aide, a facility shall receive registry verification that the person has met competency evaluation requirements unless:

1. The person is a permanent employee and is in a training and competency evaluation program approved by the department of inspections and appeals; or
2. The person can prove that the person has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals and has not yet been included in the registry. Facilities shall follow up to ensure that such a person actually becomes registered.

(6) Multistate registry verification. Before allowing a person to serve as a nurse aide, a facility shall seek information from every state registry the facility believes will include information on the person.

(7) Required retraining. If since October 1, 1990, there has been a continuous period of 24 consecutive months during none of which the person provided nursing or nursing-related services for monetary compensation, the person shall complete a new training and competency evaluation program or a new competency evaluation program.

(8) Regular in-service education. The facility shall complete a performance review of every nurse aide at least once every 12 months and shall provide regular in-service education based on the outcome of these reviews. The in-service training shall:

1. Be sufficient to ensure the continuing competencies of nurse aides, but shall be no less than 12 hours per year.

2. Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff.

3. For nurse aides providing services to persons with cognitive impairments, also address the care of the cognitively impaired.

f. Proficiency of nurse aides. The facility shall ensure that nurse aides are able to demonstrate competency in skills and technique necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

g. Staff qualifications.

(1) The facility shall employ on a full-time, part-time, or consultant basis those professionals necessary to carry out the provisions of these conditions of participation.

(2) Professional staff shall be licensed, certified or registered in accordance with applicable state laws.

h. Use of outside resources.

(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility shall have that service furnished to residents by a person or agency outside the facility under an arrangement described in Section 1861(w) of the Omnibus Budget Reconciliation Act of 1987 or an agreement described in subparagraph (2) below.

(2) Arrangements or agreements pertaining to services furnished by outside resources shall specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility and for the timeliness of the services.

i. Medical director.

(1) The facility shall designate a physician to serve as medical director.

(2) The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility.

j. Laboratory services.

(1) The facility shall provide or obtain clinical laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own laboratory services, the services shall meet the applicable conditions for coverage of the services furnished by laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

2. If the facility provides blood bank and transfusion services, it shall meet the requirements for laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

3. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be approved or licensed to test specimens in the appropriate specialties or subspecialties of service in accordance with 42 CFR Part 493 as amended to October 1, 1990.

4. If the facility does not provide laboratory services on site, it shall have an agreement to obtain these services only from a laboratory that meets the requirements of 42 CFR Part 493 as amended to October 1, 1990, or from a physician's office.

(2) The facility shall:

1. Provide or obtain laboratory services only when ordered by the attending physician.

2. Promptly notify the attending physician of the findings.

3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.

4. File in the resident's clinical record signed and dated reports of clinical laboratory services.

k. Radiology and other diagnostic services.

(1) The facility shall provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own diagnostic services, the services shall meet the applicable conditions of participation for hospitals.

2. If the facility does not provide its own diagnostic services, it shall have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.

- (2) The facility shall:
 1. Provide or obtain radiology and other diagnostic services only when ordered by the attending physician.
 2. Promptly notify the attending physician of the findings.
 3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.
 4. File in the resident's clinical record signed and dated reports of X-ray and other diagnostic services.
 - l. *Clinical records.*
 - (1) The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.
 - (2) Clinical records shall be retained for:
 1. The period of time required by state law.
 2. Five years from the date of discharge when there is no requirement in state law.
 3. For a minor, three years after a resident reaches legal age under state law.
 - (3) The facility shall safeguard clinical record information against loss, destruction, or unauthorized use.
 - (4) The facility shall keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:
 1. Transfer to another health care institution.
 2. Law.
 3. Third-party payment contract.
 4. The resident.
 - (5) The clinical record shall contain:
 1. Sufficient information to identify the resident.
 2. A record of the resident's assessments.
 3. The plan of care and services provided.
 4. The results of any preadmission screening conducted by the state.
 5. Progress notes.
 - m. *Disaster and emergency preparedness.*
 - (1) The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.
 - (2) The facility shall train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out staff drills using those procedures.
 - n. *Transfer agreement.*
 - (1) The facility shall have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably ensures that:
 1. Residents will be transferred from the facility to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician.
 2. Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether the residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.
 - (2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.
 - o. *Quality assessment and assurance.*
 - (1) A facility shall maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least three other members of the facility's staff.

- (2) The quality assessment and assurance committee:
 1. Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary.
 2. Develops and implements appropriate plans of action to correct identified quality deficiencies.
- (3) The state or the Secretary of the Department of Health and Human Services may not require disclosure of the records of the committee except insofar as the disclosure is related to the compliance of the committee with the requirements of this paragraph.
- (4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
 - p. Disclosure of ownership.*
 - (1) The facility shall comply with the disclosure requirements of 42 CFR 420.206 and 455.104.
 - (2) The facility shall provide written notice to the department of inspections and appeals at the time of change, if a change occurs in:
 1. Persons with an ownership or control interest.
 2. The officers, directors, agents, or managing employees.
 3. The corporation, association, or other company responsible for the management of the facility.
 4. The facility's administrator or director of nursing.
 - (3) The notice specified in subparagraph (2) above shall include the identity of each new individual or company.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.14(249A) Audits.

81.14(1) *Audit of financial and statistical report.* Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report, Form 470-0030, are reasonable and proper according to the rules set forth in 441—81.6(249A). The aforementioned audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agent(s).

a. When a proper per diem rate cannot be determined, through generally accepted and customary auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing six-month period and if the situation is not remedied on the subsequent Financial and Statistical Report, Form 470-0030, the health facility shall be suspended and eventually canceled from the nursing facility program, or

b. When a health facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing six-month period. The department may, after considering the seriousness of the exception, make the reduction.

81.14(2) *Audit of proper billing and handling of patient funds.*

a. The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals, and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 81.4(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, any sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation which would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph “*d.*,” the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general’s office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit which are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) “*a*” and 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.15(249A) Nurse aide training and testing programs. Rescinded IAB 12/9/92, effective 2/1/93.

441—81.16(249A) Nurse aide requirements and training and testing programs.

81.16(1) Deemed meeting of requirements. A nurse aide is deemed to satisfy the requirement of completing a nurse aide training and competency evaluation approved by the department of inspections and appeals if:

a. The nurse aide successfully completed a nurse aide training and competency evaluation program before July 1, 1989, and

(1) At least 60 clock hours were substituted for 75 clock hours, and the person has made up at least the difference in the number of clock hours in the program the person completed and 75 clock hours in supervised practical nurse aide training or in regular in-service nurse aide education, or

(2) The person was found to be competent (whether or not by the state) after completion of a nurse aide training of at least 100 clock hours’ duration, or

(3) The person can demonstrate that the person served as a nurse aide at one or more facilities of the same employer in Iowa for at least 24 consecutive months before December 19, 1989, or

(4) The person completed, before July 1, 1989, a nurse aide training and competency evaluation program that the department of inspections and appeals determines would have met the requirements for approval at the time it was offered; or

b. The person is a veteran, an active duty service member, or a member of the reserve forces, who has:

(1) Successfully completed a U.S. military training program that includes a curriculum comparable to the nurse aide training program required by this rule and has documented successful completion of that program with either a diploma, certifications, or Form DD 214 showing completion of hospital corpsman or medical service specialist or equivalent training, and

(2) Provided documentation showing that the person has 75 clock hours of practical experience in a nurse aide role, which may include classroom instruction, prior equivalent experience, or a combination of the two, and

(3) Successfully completed the nurse aide training and competency examination.

81.16(2) State review and approval of nurse aide training and competency evaluation programs or competency evaluation programs.

a. The department of inspections and appeals shall, in the course of all surveys, determine whether the nurse aide training and evaluation requirements of 81.13(19) “*e*” and 81.16(1) are met.

b. Requirements for approval of programs.

(1) Before the department of inspections and appeals approves a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall determine whether:

1. A nurse aide training and competency evaluation program meets the course requirements of 81.16(3).

2. A nurse aide competency evaluation program meets the requirements of 81.16(4).

(2) Except as provided by paragraph 81.16(2)“f,” the department of inspections and appeals shall not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility which, in the previous two years:

1. Has operated under a nurse staffing waiver for a period in excess of 48 hours per week; or

2. Has been subject to an extended or partial extended survey; or

3. Has been assessed a civil money penalty of not less than \$5,000; or

4. Has operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility’s residents; or

5. Pursuant to state action, was closed or had its residents transferred; or

6. Has been terminated from participation in the Medicaid or Medicare program; or

7. Has been denied payment under subrule 81.40(1) or 81.40(2).

(3) Rescinded IAB 10/7/98, effective 12/1/98.

c. Application process. Applications shall be submitted to the department of inspections and appeals before a new program begins and every two years thereafter on Form 427-0517, Application for Nurse Aide Training. The department of inspections and appeals shall, within 90 days of the date of a request or receipt of additional information from the requester:

(1) Advise the requester whether or not the program has been approved; or

(2) Request additional information from the requesting entity.

d. Duration of approval. The department of inspections and appeals shall not grant approval of a nurse aide training and competency evaluation program for a period longer than two years. A program shall notify the department of inspections and appeals and the department of inspections and appeals shall review that program when there are substantive changes made to that program within the two-year period.

e. Withdrawal of approval.

(1) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program offered by or in a facility described in 81.16(2)“b”(2).

(2) The department of inspections and appeals may withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program if the department of inspections and appeals determines that any of the applicable requirements for approval or registry, as set out in subrule 81.16(3) or 81.16(4), are not met.

(3) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or a nurse aide competency evaluation program if the entity providing the program refuses to permit unannounced visits by the department of inspections and appeals.

(4) If the department of inspections and appeals withdraws approval of a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall notify the program in writing, indicating the reasons for withdrawal of approval of the program. Students who have started a training and competency evaluation program from which approval has been withdrawn shall be allowed to complete the course.

f. An exception to subparagraph 81.16(2)“b”(2) may be granted by the department of inspections and appeals (DIA) for 75-hour nurse aide training courses offered in (but not by) a facility under the following conditions:

(1) The facility has submitted Form 470-3494, Nurse Aide Education Program Waiver Request, to the DIA to request a waiver for each 75-hour nurse aide training course to be offered in (but not by) the facility.

(2) The 75-hour nurse aide training is offered in a facility by an approved nurse aide training and competency evaluation program (NATCEP).

(3) No other NATCEP program is offered within 30 minutes' travel from the facility, unless the facility can demonstrate the distance or program would create a hardship for program participants.

(4) The facility is in substantial compliance with the federal requirements related to nursing care and services.

(5) The facility is not a poor performing facility.

(6) Employees of the facility do not function as instructors for the program unless specifically approved by DIA.

(7) The NATCEP sponsoring the 75-hour nursing aide training course is responsible for program administration and for ensuring that program requirements are met.

(8) The NATCEP has submitted an evaluation to the DIA indicating that an adequate teaching and learning environment exists for conducting the course.

(9) The NATCEP has developed policies for communicating and resolving problems encountered during the course, including notice by the facility to the program instructor and students on how to contact the DIA to register any concerns encountered during the course.

(10) The NATCEP shall require the program instructor and students to complete an evaluation of the course. The instructor shall return the completed evaluations to the NATCEP which shall return the evaluations to DIA.

81.16(3) *Requirements for approval of a nurse aide training and competency evaluation program.* The department has designated the department of inspections and appeals to approve required nurse aide training and competency evaluation programs. Policies and procedures governing approval of the programs are set forth in these rules.

a. For a nurse aide training and competency evaluation program to be approved, such program shall, at a minimum:

(1) Consist of no less than 75 clock hours of training, and

(2) Include at least the subjects specified in 81.16(3) "b," and

(3) Include at least 30 hours of didactic theory instruction, which may be provided in a classroom setting or through online course curricula, and

(4) Include at least 15 hours of laboratory experience provided in a face-to-face environment that complements the didactic theory curricula, and

(5) Include 30 hours of supervised clinical training in a face-to-face environment and supervised by a department of inspections and appeals-approved instructor in a manner not inconsistent with the licensing requirements of the Iowa board of nursing, and

(6) Ensure that students do not independently perform any services for which they have not been trained and found proficient by the department of inspections and appeals-approved instructor, and

(7) Meet the following requirements for department of inspections and appeals-approved instructors who train nurse aides:

1. The training of nurse aides shall be performed by or under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which shall be in the provision of long-term care facility services.

2. Instructors shall be registered nurses and shall have completed a course in teaching adults or have experience teaching adults or supervising nurse aides.

3. In a facility-based program, when the director of nursing is a registered nurse, the training of nurse aides may be performed by registered nurses under the general supervision of the director of nursing for the facility. The director of nursing is prohibited from performing the actual training.

4. Other personnel from the health professions may supplement the instructor. Supplemental personnel shall have at least one year of experience in their fields.

5. The ratio of department of inspections and appeals-approved instructors to students shall not exceed one registered nurse, or licensed practical nurse functioning as an assistant to a registered nurse, who is in the proximate area in the clinical setting, for every ten students in the clinical setting, and

(8) Contain information regarding competency evaluation through written or oral examination and skills demonstration.

b. The curriculum of the nurse aide training program shall include:

(1) At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:

1. Communication and interpersonal skills.
2. Infection control.
3. Safety and emergency procedures including the Heimlich maneuver.
4. Promoting residents' independence.
5. Respecting residents' rights.

(2) Basic nursing skills:

1. Taking and recording vital signs.
2. Measuring and recording height and weight.
3. Caring for the residents' environment.
4. Recognizing abnormal changes in body functioning and the importance of reporting these changes to a supervisor.
5. Caring for residents when death is imminent.

(3) Personal care skills, including, but not limited to:

1. Bathing.
2. Grooming, including mouth care.
3. Dressing.
4. Toileting.
5. Assisting with eating and hydration.
6. Proper feeding techniques.
7. Skin care.
8. Transfers, positioning, and turning.

(4) Mental health and social service needs:

1. Modifying aide's behavior in response to residents' behavior.
2. Awareness of developmental tasks associated with the aging process.
3. How to respond to resident behavior.
4. Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity.
5. Using the resident's family as a source of emotional support.

(5) Care of cognitively impaired residents:

1. Techniques for addressing the unique needs and behaviors of persons with dementia (Alzheimer's and others).
2. Communicating with cognitively impaired residents.
3. Understanding the behavior of cognitively impaired residents.
4. Appropriate responses to the behavior of cognitively impaired residents.
5. Methods of reducing the effects of cognitive impairments.

(6) Basic restorative services:

1. Training the resident in self-care according to the resident's ability.
2. Use of assistive devices in transferring, ambulation, eating and dressing.
3. Maintenance of range of motion.
4. Proper turning and positioning in bed and chair.
5. Bowel and bladder training.
6. Care and use of prosthetic and orthotic devices.

(7) Residents' rights:

1. Providing privacy and maintenance of confidentiality.
2. Promoting the residents' rights to make personal choices to accommodate their needs.
3. Giving assistance in resolving grievances and disputes.

4. Providing needed assistance in getting to and participating in resident and family groups and other activities.

5. Maintaining care and security of residents' personal possessions.

6. Promoting the residents' rights to be free from abuse, mistreatment, and neglect and the need to report any instances of this type of treatment to appropriate facility staff.

7. Avoiding the need for restraints in accordance with current professional standards.

c. Prohibition of charges.

(1) A nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program or competency evaluation program may not be charged for any portion of the program including any fees for textbooks, course materials, or nurse aide competency evaluations.

(2) If a person who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility no later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program, the facility shall reimburse the nurse aide for costs incurred in completing the program or competency evaluation on a pro rata basis during the period in which the person is employed as a nurse aide. The formula for paying the nurse aides on a pro rata basis shall be as follows:

1. Add all costs incurred by the nurse aide for the course, books, and competency evaluations.

2. Divide the total arrived at in paragraph "1" above by 12 to prorate the costs over a one-year period and establish a monthly rate.

3. The nurse aide shall be reimbursed the monthly rate each month the nurse aide works at the facility until one year from the time the nurse aide completed the course.

d. Setting and equipment. The classroom shall have appropriate equipment, be of adequate size, and not interfere with resident activities.

e. Records and reports. Nurse aide education programs approved by the department of inspections and appeals shall:

(1) Notify the department of inspections and appeals:

1. Of dates of classroom and clinical sessions as well as location of classrooms and clinical practice sites before each course begins and if the course is canceled.

2. When a facility or other training entity will no longer be offering nurse aide training courses.

3. Whenever the person coordinating the training program is hired or terminates employment.

(2) Keep a list of faculty members and their qualifications available for department review.

(3) Provide each nurse aide a record of skills for which the nurse aide has been found competent during the course and which may be performed before completion of the competency evaluation.

(4) Complete a lesson plan for each unit which includes behavioral objectives, a topic outline and student activities and experiences.

(5) Provide the student, within 30 days of the last class period, evidence of having successfully completed the course.

81.16(4) Nurse aide competency evaluation. A competency evaluation program shall contain a written or oral portion and a skills demonstration portion.

a. Notification to person. The department of inspections and appeals shall advise in advance any person who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the state's nurse aide registry.

b. Content of the competency evaluation program.

(1) Written or oral examinations. The competency evaluation shall:

1. Allow an aide to choose between a written and oral examination.

2. Address each of the course requirements listed in 81.16(3) "b."

3. Be developed from a pool of test questions, only a portion of which is used in any one examination.

4. Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations.

5. If oral, be read from a prepared text in a neutral manner.

6. Be tested for reliability and validity using a nationally recognized standard as determined by the department of education.

7. Be in English, unless the prevailing language used in the facility where a nurse aide will be working is other than English.

(2) Demonstration of skills. The skills demonstration evaluation shall consist of a demonstration of randomly selected items drawn from a pool consisting of tasks generally performed by nurse aides. This pool of skills shall include all of the personal care skills listed in 81.16(3) "b"(3).

c. Administration of the competency evaluation.

(1) The competency examination shall be administered and evaluated only by an entity approved by the department of inspections and appeals, which is neither a skilled nursing facility that participates in Medicare nor a nursing facility that participates in Medicaid.

(2) Charging nurse aides for competency testing is prohibited in accordance with 81.16(3) "c."

(3) The skills demonstration part of the evaluation shall be performed in a facility or laboratory setting comparable to the setting in which the person will function as a nurse aide and shall be administered and evaluated by a registered nurse with at least one year's experience in providing care for the elderly or the chronically ill of any age.

d. Facility proctoring of the competency evaluation.

(1) The competency evaluation may, at the nurse aide's option, be conducted at the facility in which the nurse aide is or will be employed unless the facility is prohibited from being a competency evaluation site.

(2) The department of inspections and appeals may permit the competency evaluation to be proctored by facility personnel if the department of inspections and appeals finds that the procedure adopted by the facility ensures that the competency evaluation program:

1. Is secure from tampering.

2. Is standardized and scored by a testing, educational, or other organization approved by the department of inspections and appeals.

3. Requires no scoring by facility personnel.

(3) The department of inspections and appeals shall retract the right to proctor nurse aide competency evaluations from facilities in which the department of inspections and appeals finds any evidence of impropriety, including evidence of tampering by facility staff.

e. Successful completion of the competency evaluation program.

(1) A score of 70 percent or above is passing for both the written or oral and skills demonstration parts of the test.

(2) A record of successful completion of the competency evaluation shall be included in the nurse aide registry within 30 days of the date the person is found to be competent.

(3) The competency testing entity shall inform the nurse aide of the test score within 30 calendar days of the completion of the test and shall inform the nurse aide registry of the nurse aide's scores within 20 calendar days after the test is administered.

f. Unsuccessful completion of the competency evaluation program.

(1) If the person does not complete the evaluation satisfactorily, the person shall be advised in writing within ten working days after the test is scored:

1. Of the areas which the person did not pass.

2. That the person has three opportunities to take the evaluation.

(2) Each person shall have three opportunities to pass each part of the test. If one part of the test is failed, only that part need be taken a second or third time. If either part of the test is failed three times, the 75-hour course shall be taken or retaken before the test can be taken again.

g. Storage of evaluation instrument. The person responsible for administering a competency evaluation shall provide secure storage of the evaluation instruments when they are not being administered or processed.

h. Application process. Entities wishing to secure approval for a competency evaluation program shall submit a copy of the evaluation plan and procedures to the department of inspections and appeals. The department of inspections and appeals shall notify the applicant of its decision within 90 days of

receipt of the application. The notification shall include the reason for not giving approval if approval is denied and the applicable rule citation.

81.16(5) Registry of nurse aides.

a. Establishment of registry. The department of inspections and appeals shall establish and maintain a registry of nurse aides that meets the following requirements. The registry:

(1) Shall include, at a minimum, the information required in 81.16(5) "c."

(2) Shall be sufficiently accessible to meet the needs of the public and health care providers promptly.

(3) Shall provide that any response to an inquiry that includes a finding of abuse, neglect, mistreatment of a resident or misappropriation of property also include any statement made by the nurse aide which disputes the finding.

b. Registry operation.

(1) Only the department of inspections and appeals may place on the registry findings of abuse, neglect, mistreatment of a resident or misappropriation of property.

(2) The department of inspections and appeals shall determine which persons:

1. Have successfully completed a nurse aide training and competency evaluation program or nurse aide competency evaluation program.

2. Have been deemed as meeting these requirements.

3. Do not qualify to remain on the registry because they have performed no nursing or nursing-related services for monetary compensation during a period of 24 consecutive months.

(3) The department of inspections and appeals shall not impose any charges related to registration on persons listed in the registry.

(4) The department of inspections and appeals shall provide information on the registry promptly.

c. Registry content.

(1) The registry shall contain at least the following information on each person who has successfully completed a nurse aide training and competency evaluation program or competency evaluation program which was approved by the department of inspections and appeals or who may function as a nurse aide because of having been deemed competent:

1. The person's full name.

2. Information necessary to identify each person.

3. The date the person became eligible for placement in the registry through successfully completing a nurse aide training and competency evaluation program or competency evaluation or by being deemed competent.

4. The following information on any finding by the department of inspections and appeals of abuse, neglect, mistreatment of residents or misappropriation of property by the person: documentation of the department of inspections and appeals' investigation, including the nature of the allegation and the evidence that led the department of inspections and appeals to conclude that the allegation was valid; the date of the hearing, if the person chose to have one, and its outcome; and a statement by the person disputing the allegation, if the person chooses to make one. This information must be included in the registry within ten working days of the finding and shall remain in the registry permanently, unless the finding was made in error, the person was found not guilty in a court of law, or the department of inspections and appeals is notified of the person's death.

5. A record of known convictions by a court of law of a person convicted of abuse, neglect, mistreatment or misappropriation of resident property.

(2) The registry shall remove entries for persons who have performed no nursing or nursing-related services for monetary compensation for a period of 24 consecutive months unless the person's registry entry includes documented findings or convictions by a court of law of abuse, neglect, mistreatment or misappropriation of property.

d. Disclosure of information. The department of inspections and appeals shall:

(1) Disclose all of the information listed in 81.16(5) "c"(1), (3), and (4) to all requesters and may disclose additional information it deems necessary.

(2) Promptly provide persons with all information contained in the registry about them when adverse findings are placed on the registry and upon request. Persons on the registry shall have sufficient opportunity to correct any misstatements or inaccuracies contained in the registry.

e. Placement of names on nurse aide registry. The facility shall ensure that the name of each person employed as a nurse aide in a Medicare- or Medicaid-certified nursing facility in Iowa is submitted to the registry. The telephone number of the registry is (515)281-4963. The address is Nurse Aide Registry, Lucas State Office Building, Des Moines, Iowa 50319-0083.

(1) Persons employed as nurse aides shall complete Form 427-0496, Nurse Aide Registry Application, within the first 30 days of employment. This form shall be submitted to the department of inspections and appeals. Form 427-0496 may be obtained by calling or writing the nurse aide registry.

(2) A nurse aide who is not employed may apply for inclusion on the registry by submitting a copy of completed Form 427-0496 to the nurse aide registry.

(3) When the registry has received a signed application and entered the required training and testing information on the registry, a letter will be sent to the nurse aide that includes all the information the registry has on the nurse aide. A nurse aide may obtain a copy of the information on the registry by writing the nurse aide registry and requesting the information. The letter requesting the information must include the nurse aide's social security number, current or last facility of employment, date of birth and current mailing address and must be signed by the nurse aide.

81.16(6) Hearing. When there is an allegation of abuse against a nurse aide, the department of inspections and appeals shall investigate that allegation. When the investigation by the department of inspections and appeals makes a finding of an act of abuse, the nurse aide named will be notified of this finding and the right to a hearing. The nurse aide shall have 30 days to request a hearing. The request shall be in writing and shall be sent to the department of inspections and appeals. The hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10. After 30 days, if the nurse aide fails to appeal, or when all appeals are exhausted, the nurse aide registry will include a notation that the nurse aide has a founded abuse report on record if the final decision indicates the nurse aide performed an abusive act.

81.16(7) Appeals. Adverse decisions made by the department of inspections and appeals in administering these rules may be appealed pursuant to department of inspections and appeals rules 481—Chapter 10.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3718C, IAB 3/28/18, effective 5/2/18]

441—81.17(249A) Termination procedures. Rescinded IAB 5/10/95, effective 7/1/95.

441—81.18(249A) Sanctions.

81.18(1) Penalty for falsification of a resident assessment. An individual, who willfully and knowingly certifies a material and false statement in a resident assessment, is subject to a civil money penalty of not less than \$100 or more than \$1,000 for each falsified assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not less than \$500 nor more than \$5,000 for each falsified assessment. These fines shall be administratively assessed by the department of inspections and appeals.

a. Factors determining the size of fine. In determining the monetary amount of the penalty, the director of the department of inspections and appeals or the director's designee may consider evidence of the circumstances surrounding the violation, including, but not limited to, the following factors:

- (1) The number of assessments willingly and knowingly falsified.
- (2) The history of the individual relative to previous assessment falsifications.
- (3) The intent of the individual who falsifies an assessment or causes an assessment to be falsified.
- (4) The areas of assessment falsified or caused to be falsified and the potential for harm to the resident.

(5) The relationship of the falsification of assessment to falsification of other records at the time of the visit.

b. Notification of a fine imposed for falsification of assessments or causing another individual to falsify an assessment shall be served upon the individual personally or by certified mail.

c. Appeals of fines. Notice of intent to formally contest the fine shall be given to the department of inspections and appeals in writing and be postmarked within 20 working days after receipt of the notification of the fine. An administrative hearing will be conducted pursuant to Iowa Code chapter 17A and department of inspections and appeals rules 481—Chapter 10. An individual who has exhausted all administrative remedies and is aggrieved by the final action of the department of inspections and appeals may petition for judicial review in the manner provided by Iowa Code chapter 17A.

81.18(2) Use of independent assessors. If the department of inspections and appeals determines that there has been a knowing and willful certification of false assessments, or the causation of knowing and willful false assessments, the department of inspections and appeals may require that resident assessments be conducted and certified by individuals independent of the facility and who are approved by the state.

a. Criteria used to determine the need for independent assessors shall include:

(1) The involvement of facility management in the falsification of or causing resident assessments to be falsified.

(2) The facility's response to the falsification of or causing resident assessments to be falsified.

(3) The method used to prepare facility staff to do resident assessments.

(4) The number of individuals involved in the falsification.

(5) The number of falsified resident assessments.

(6) The extent of harm to residents caused by the falsifications.

b. The department of inspections and appeals will specify the length of time that these independent assessments will be conducted and when they will begin. This determination will be based on the extent of assessments and reassessments needed and the plan submitted by the facility to ensure falsifications will not occur in the future.

c. The individuals or agency chosen by the facility to conduct the independent assessments shall be approved by the department of inspections and appeals before conducting any assessments. The approval will be based on the ability of the individual or agency to conduct resident assessments in accordance with the applicable rules. Any costs incurred shall be the responsibility of the facility.

d. Notice of the requirement to obtain independent assessments will be in writing and sent to the facility by certified mail or personal service. The notice shall include the date independent assessors are to begin assessments, information on how independent assessors are to be approved and the anticipated length of time independent assessors will be needed.

e. Criteria for removal of the requirement for independent assessors.

(1) Independent assessors shall be utilized until all residents assessed by the disciplines involved have been reassessed by the independent assessor.

(2) The facility shall submit a plan to the department of inspections and appeals for completing its own assessments.

(3) The department of inspections and appeals will evaluate the facility's proposal for ensuring assessments will not be falsified in the future.

f. Appeal procedures.

(1) A written notice to appeal shall be postmarked or personally served to the department of inspections and appeals within five working days after receipt of the notice requiring independent assessors.

(2) An evidentiary hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10 no later than 15 working days after receipt of the appeal.

(3) The written decision shall be rendered no later than ten working days after the hearing.

(4) The decision rendered is a proposed decision which may be appealed to the director of the department of inspections and appeals pursuant to department of inspections and appeals rules 481—Chapter 50.

(5) A notice of appeal stays the effective date of the requirement for independent assessments pending a final agency decision.

(6) Final agency action may be appealed pursuant to Iowa Code chapter 17A.

81.18(3) *Penalty for notification of time or date of survey.* Any individual who notifies, or causes to be notified, a nursing facility of the time or date on which a survey is scheduled to be conducted shall be subject to a fine not to exceed \$2,000.

81.18(4) *Failure to meet requirements for participation.* Rescinded IAB 5/10/95, effective 7/1/95. This rule is intended to implement Iowa Code section 249A.4.

441—81.19(249A) *Criteria related to the specific sanctions.* Rescinded IAB 5/10/95, effective 7/1/95.

441—81.20(249A) *Out-of-state facilities.* Payment will be made for care in out-of-state nursing facilities. For members enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

81.20(1) *Out-of-state providers.* Except for Medicare-certified hospital-based nursing facilities and special population nursing facilities, out-of-state providers shall be reimbursed at the same nursing facility rate they would receive from the Medicaid program in their state of residence or an amount equal to the sum of the Iowa non-state-operated nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)“f”(1) plus the non-direct care rate limit pursuant to subparagraph 81.6(16)“f”(1), whichever is lower.

a. Medicare-certified hospital-based nursing facilities providing skilled care in other states shall be reimbursed at an amount equal to the sum of the Iowa Medicare-certified hospital-based nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)“f”(3) plus the non-direct care rate component limit pursuant to subparagraph 81.6(16)“f”(3) if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

b. Special population nursing facilities shall be reimbursed at the same nursing facility rate they would receive from Medicaid in their state of residence or, if not participating in the Medicaid program in their state, they shall be reimbursed pursuant to subparagraph 81.6(16)“e”(2), if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

81.20(2) *Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).*

81.20(3) *Effective December 1, 2009, payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at zero percent of the rate paid to the facility by the Iowa Medicaid program.*

81.20(4) *Rescinded IAB 3/20/91, effective 3/1/91.*

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

[ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.21(249A) *Outpatient services.* Medicaid outpatient services provided by certified skilled nursing facilities are defined in the same way as the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 1991 Iowa Acts, House File 479, section 132, subsection 1, paragraph “i.”

441—81.22(249A) Rates for Medicaid eligibles.

81.22(1) Maximum client participation. A nursing facility may not charge more client participation for Medicaid-eligible clients as determined in rule 441—75.16(249A) than the maximum monthly allowable payment for their facility as determined according to 441—subrule 79.1(9) or rule 441—81.6(249A). When the department makes a retroactive increase in the maximum daily rate, the nursing facility can charge the client the increased amount for the retroactive period.

81.22(2) Beginning date of payment. When a resident becomes eligible for Medicaid payments for facility care, the facility shall accept Medicaid rates effective when the resident's Medicaid eligibility begins. A nursing facility is required to refund any payment received from a resident or family member for any period of time during which the resident is determined to be eligible for Medicaid.

Any refund owing shall be made no later than 15 days after the nursing facility first receives Medicaid payment for the resident for any period of time. Facilities may deduct the resident's client participation for the month from a refund of the amount paid for a month of Medicaid eligibility.

The beginning and renewal date of eligibility and resident client participation amounts may be obtained through the Iowa Medicaid portal access (IMPA) system. When the beginning Medicaid eligibility date is a future month, the facility shall accept the Medicaid rate effective the first of that future month.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 1806C, IAB 1/7/15, effective 3/1/15]

441—81.23(249A) State-funded personal needs supplement. A Medicaid member living in a nursing facility who has countable income for purposes of rule 441—75.16(249A) of less than \$50 per month shall receive a state-funded payment from the department for the difference between that countable income and \$50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code Supplement section 249A.30A.

441—81.24 to 81.30 Reserved.

DIVISION II
ENFORCEMENT OF COMPLIANCE

PREAMBLE

These rules specify remedies that may be used when a nursing facility is not in substantial compliance with the requirements for participation in the Medicaid program. These rules also provide for ensuring prompt compliance and specify that these remedies are in addition to any others available under state or federal law.

441—81.31(249A) Definitions.

“*CMS*” means the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services.

“*Deficiency*” means a nursing facility's failure to meet a participation requirement.

“*Department*” means the Iowa department of human services.

“*Immediate jeopardy*” means a situation in which immediate corrective action is necessary because the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

“*New admission*” means a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date. Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor are they subject to the denial of payment.

“*Noncompliance*” means any deficiency that causes a facility to not be in substantial compliance.

“*Plan of correction*” means a plan developed by the facility and approved by the department of inspections and appeals which describes the actions the facility shall take to correct deficiencies and specifies the date by which those deficiencies shall be corrected.

“*Standard survey*” means a periodic, resident-centered inspection which gathers information about the quality of service furnished in a facility to determine compliance with the requirements for participation.

“*Substandard quality of care*” means one or more deficiencies related to the participation requirements for resident behavior and facility practices, quality of life, or quality of care which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

“*Substantial compliance*” means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

“*Temporary management*” means the temporary appointment by the department of inspections and appeals of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility’s operation.

441—81.32(249A) General provisions.

81.32(1) Purpose of remedies. The purpose of remedies is to ensure prompt compliance with program requirements.

81.32(2) Basis for imposition and duration of remedies. The department of inspections and appeals, as the state survey agency under contract with the department, determines the remedy to be applied for noncompliance with program requirements. When the department of inspections and appeals chooses to apply one or more remedies specified in rule 441—81.34(249A), the remedies are applied on the basis of noncompliance found during surveys conducted by the department of inspections and appeals.

81.32(3) Number of remedies. The department of inspections and appeals may apply one or more remedies for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance.

81.32(4) Plan of correction requirement.

a. Except as specified in paragraph “b,” regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements shall submit a plan of correction for approval by the department of inspections and appeals.

b. A facility is not required to submit a plan of correction when the department of inspections and appeals determines the facility has deficiencies that are isolated and have a potential for minimal harm, but no actual harm has occurred.

81.32(5) Disagreement regarding remedies. If the department of inspections and appeals and CMS disagree on the decision to impose a remedy, the disagreement shall be resolved in accordance with rule 441—81.55(249A).

81.32(6) Notification requirements.

a. The department of inspections and appeals shall give the provider written notice of remedy, including the:

- (1) Nature of the noncompliance.
- (2) Which remedy is imposed.
- (3) Effective date of the remedy.
- (4) Right to appeal the determination leading to the remedy.

b. Except for civil money penalties and state monitoring imposed when there is immediate jeopardy, for all remedies specified in rule 441—81.34(249A) imposed when there is immediate jeopardy, the notice shall be given at least two calendar days before the effective date of the enforcement action.

c. Except for civil money penalties and state monitoring, notice shall be given at least 15 calendar days before the effective date of the enforcement action in situations where there is no immediate jeopardy.

d. The 2- and 15-day notice periods begin when the facility receives the notice, but in no event will the effective date of the enforcement action be later than 20 calendar days after the notice is sent.

e. For civil money penalties, the notices shall be given in accordance with rules 441—81.48(249A) and 441—81.51(249A).

f. For state monitoring imposed when there is immediate jeopardy, no prior notice is required.

81.32(7) Informal dispute resolution.

a. Opportunity to refute survey findings.

(1) For nonfederal surveys, the department of inspections and appeals (DIA) shall offer a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.

(2) For a federal survey, the Centers for Medicare and Medicaid Services (CMS) offers a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.

b. Delay of enforcement action.

(1) Failure of DIA or CMS, as appropriate, to complete informal dispute resolution timely cannot delay the effective date of any enforcement action against the facility.

(2) A facility may not seek a delay of any enforcement action against it on the grounds that informal dispute resolution has not been completed before the effective date of the enforcement action.

c. If a provider is subsequently successful, during the informal dispute resolution process, at demonstrating that deficiencies should not have been cited, the deficiencies are removed from the statement of deficiencies and any enforcement actions imposed solely as a result of those cited deficiencies are rescinded.

d. Notification. DIA shall provide the facility with written notification of the informal dispute resolution process.

441—81.33(249A) Factors to be considered in selecting remedies.

81.33(1) Initial assessment. In order to select the appropriate remedy, if any, to apply to a facility with deficiencies, the department of inspections and appeals shall determine the seriousness of the deficiencies.

81.33(2) Determining seriousness of deficiencies. To determine the seriousness of the deficiency, the department of inspections and appeals shall consider at least the following factors:

a. Whether a facility's deficiencies constitute:

(1) No actual harm with a potential for minimal harm.

(2) No actual harm with a potential for more than minimal harm, but not immediate jeopardy.

(3) Actual harm that is not immediate jeopardy.

(4) Immediate jeopardy to resident health or safety.

b. Whether the deficiencies:

(1) Are isolated.

(2) Constitute a pattern.

(3) Are widespread.

81.33(3) Other factors which may be considered in choosing a remedy within a remedy category. Following the initial assessment, the department of inspections and appeals may consider other factors, which may include, but are not limited to, the following:

a. The relationship of the one deficiency to other deficiencies resulting in noncompliance.

b. The facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

441—81.34(249A) Available remedies. In addition to the remedy of termination of the provider agreement, the following remedies are available:

1. Temporary management.
2. Denial of payment for all new admissions.
3. Civil money penalties.
4. State monitoring.
5. Closure of the facility in emergency situations or transfer of residents, or both.
6. Directed plan of correction.
7. Directed in-service training.

441—81.35(249A) Selection of remedies.

81.35(1) *Categories of remedies.* Remedies specified in rule 441—81.34(249A) are grouped into categories and applied to deficiencies according to the severity of noncompliance.

81.35(2) *Application of remedies.* After considering the factors specified in rule 441—81.33(249A), if the department of inspections and appeals applies remedies, as provided in paragraphs 81.35(3) “a,” 81.35(4) “a,” and 81.35(5) “a,” for facility noncompliance, instead of, or in addition to, termination of the provider agreement, the department of inspections and appeals shall follow the criteria set forth in 81.35(3) “b,” 81.35(4) “b,” and 81.35(5) “b,” as applicable.

81.35(3) *Category 1.*

a. Category 1 remedies include the following:

- (1) Directed plan of correction.
- (2) State monitoring.
- (3) Directed in-services training.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 1 when there:

- (1) Are isolated deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
- (2) Is a pattern of deficiencies that constitutes no actual harm with a potential for more than minimal harm but not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 1 to any deficiency.

81.35(4) *Category 2.*

a. Category 2 remedies include the following:

- (1) Denial of payment for new admissions.
- (2) Civil money penalties of \$50 to \$3,000 per day.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 2 when there are:

- (1) Widespread deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
- (2) One or more deficiencies that constitute actual harm that is not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 2 to any deficiency.

81.35(5) *Category 3.*

a. Category 3 remedies include the following:

- (1) Temporary management.
- (2) Immediate termination.
- (3) Civil money penalties of \$3,050 to \$10,000 per day.

b. When there is one or more deficiencies that constitute immediate jeopardy to resident health or safety, one or both of the following remedies shall be applied:

- (1) Temporary management.
- (2) Termination of the provider agreement.

In addition the department of inspections and appeals may impose a civil money penalty of \$3,050 to \$10,000 per day.

c. When there are widespread deficiencies that constitute actual harm that is not immediate jeopardy, the department of inspections and appeals may impose temporary management, in addition to Category 2 remedies.

81.35(6) *Plan of correction.*

a. Except as specified in paragraph “b,” each facility that has a deficiency with regard to a requirement for long-term care facilities shall submit a plan of correction for approval by the department of inspections and appeals, regardless of:

- (1) Which remedies are applied.
- (2) The seriousness of the deficiencies.

b. When there are only isolated deficiencies that the department of inspections and appeals determines constitute no actual harm with a potential for minimal harm, the facility need not submit a plan of correction.

81.35(7) *Appeal of a determination of noncompliance.*

a. A facility may request a hearing on a determination of noncompliance leading to an enforcement remedy. The affected nursing facility, or its legal representative or other authorized official, shall file the request for hearing in writing to the department of inspections and appeals within 60 days from receipt of the notice of the proposed denial, termination, or nonrenewal of participation, or imposition of a civil money penalty or other remedies.

(1) A request for a hearing shall be made in writing to the department of inspections and appeals within 60 days from receipt of the notice.

(2) Hearings shall be conducted pursuant to department of inspections and appeals rules 481—Chapter 10 and rule 481—50.6(10A), with an administrative law judge appointed as the presiding officer and with the department of inspections and appeals as the final decision maker, with subject matter jurisdiction.

b. A facility may not appeal the choice of remedy, including the factors considered by the department of inspections and appeals in selecting the remedy.

c. A facility may not challenge the level of noncompliance found by the department of inspections and appeals, except that in the case of a civil money penalty, a facility may challenge the level of noncompliance found by the department of inspections and appeals only if a successful challenge on this issue would affect the range of civil money penalty amounts that the department could collect.

d. Except when a civil remedy penalty is imposed, the imposition of a remedy shall not be stayed pending an appeal hearing.

441—81.36(249A) Action when there is immediate jeopardy.

81.36(1) *Terminate agreement or appoint temporary manager.* If there is immediate jeopardy to resident health or safety, the department of inspections and appeals shall appoint a temporary manager to remove the immediate jeopardy or the provider agreement shall be terminated within 23 calendar days of the last date of the survey.

The rules for appointment of a temporary manager in an immediate jeopardy situation are as follows:

a. The department of inspections and appeals shall notify the facility that a temporary manager is being appointed.

b. If the facility fails to relinquish control to the temporary manager, the provider agreement shall be terminated within 23 calendar days of the last day of the survey if the immediate jeopardy is not removed. In these cases, state monitoring may be imposed pending termination.

c. If the facility relinquishes control to the temporary manager, the department of inspections and appeals shall notify the facility that, unless it removes the immediate jeopardy, its provider agreement shall be terminated within 23 calendar days of the last day of the survey.

d. The provider agreement shall be terminated within 23 calendar days of the last day of survey if the immediate jeopardy has not been removed.

81.36(2) *Other remedies.* The department of inspections and appeals may also impose other remedies, as appropriate.

81.36(3) Notification of CMS. In a nursing facility or dually participating facility, if the department of inspections and appeals finds that a facility's noncompliance poses immediate jeopardy to resident health or safety, the department of inspections and appeals shall notify CMS of the finding.

81.36(4) Transfer of residents. The department shall provide for the safe and orderly transfer of residents when the facility is terminated from participation.

81.36(5) Notification of physicians and state board. If the immediate jeopardy is also substandard quality of care, the department of inspections and appeals shall notify attending physicians and the Iowa board of nursing home administrators of the finding of substandard quality of care.

441—81.37(249A) Action when there is no immediate jeopardy.

81.37(1) Termination of agreement or limitation of participation. If a facility's deficiencies do not pose immediate jeopardy to residents' health or safety, and the facility is not in substantial compliance, the facility's provider agreement may be terminated or the facility may be allowed to continue to participate for no longer than six months from the last day of the survey if:

- a. The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility's provider agreement;
- b. The department of inspections and appeals has submitted a plan of correction approved by CMS; and
- c. The facility agrees to repay payments received after the last day of the survey that first identified the deficiencies if corrective action is not taken in accordance with the approved plan of correction and posts bond acceptable to the department to guarantee the repayment.

81.37(2) Termination. If a facility does not meet the criteria for continuation of payment under subrule 81.37(1), the facility's provider agreement shall be terminated.

81.37(3) Denial of payment. Payment shall be denied for new admissions when the facility is not in substantial compliance three months after the last day of the survey.

81.37(4) Failure to comply. The provider agreement shall be terminated and all payments stopped to a facility for which participation was continued under subrule 81.37(1) if the facility is not in substantial compliance within six months of the last day of the survey.

441—81.38(249A) Action when there is repeated substandard quality of care.

81.38(1) General. If a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys, regardless of other remedies provided:

- a. Payment for all new admissions shall be denied, as specified in rule 441—81.40(249A).
- b. The department of inspections and appeals shall impose state monitoring, as specified in rule 441—81.42(249A) until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with all requirements and will remain in substantial compliance with all requirements.

81.38(2) Repeated noncompliance. For purposes of this rule, repeated noncompliance is based on the repeated finding of substandard quality of care and not on the basis that the substance of the deficiency or the exact deficiency was repeated.

81.38(3) Standard surveys to which this provision applies. Standard surveys completed by the department of inspections and appeals on or after October 1, 1990, are used to determine whether the threshold of three consecutive standard surveys is met.

81.38(4) Program participation.

a. The determination that a certified facility has repeated instances of substandard quality of care is made without regard to any variances in the facility's program participation (that is, any standard survey completed for Medicare, Medicaid or both programs will be considered).

b. Termination would allow the count of repeated substandard quality of care surveys to start over.

c. Change of ownership.

(1) A facility may not avoid a remedy on the basis that it underwent a change of ownership.

(2) In a facility that has undergone a change of ownership, the department of inspections and appeals may not restart the count of repeated substandard quality of care surveys unless the new owner

can demonstrate to the department of inspections and appeals that the poor past performance no longer is a factor due to the change in ownership.

81.38(5) Compliance. Facility alleges corrections or achieves compliance after repeated substandard quality of care is identified.

a. If a penalty is imposed for repeated substandard quality of care, it will continue until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with the requirements and that it will remain in substantial compliance for a period of time specified by the department of inspections and appeals.

b. A facility will not avoid the imposition of remedies or the obligation to demonstrate that it will remain in compliance when it:

- (1) Alleges correction of the deficiencies cited in the most recent standard survey; or
- (2) Achieves compliance before the effective date of the remedies.

441—81.39(249A) Temporary management. The department of inspections and appeals may appoint a temporary manager from qualified applicants.

81.39(1) Qualifications. The temporary manager must:

a. Be qualified to oversee correction of deficiencies on the basis of experience and education, as determined by the department of inspections and appeals.

b. Not have been found guilty of misconduct by any licensing board or professional society in any state.

c. Have, or a member of the manager's immediate family have, no financial ownership interest in the facility.

d. Not currently serve or, within the past two years, have served as a member of the staff of the facility.

81.39(2) Payment of salary. The temporary manager's salary:

a. Is paid directly by the facility while the temporary manager is assigned to that facility.

b. Shall be at least equivalent to the sum of the following:

(1) The prevailing salary paid by providers for positions of this type in the facility's geographic area.

(2) Additional costs that would have reasonably been incurred by the provider if the person had been in an employment relationship.

(3) Any other transportation and lodging costs incurred by the person in furnishing services under the arrangement up to the maximum per diem for state employees.

c. May exceed the amount specified in paragraph "b" if the department of inspections and appeals is otherwise unable to attract a qualified temporary manager.

81.39(3) Failure to relinquish authority to temporary management.

a. If a facility fails to relinquish authority to the temporary manager, the provider agreement shall be terminated in accordance with rule 441—81.57(249A).

b. A facility's failure to pay the salary of the temporary manager is considered a failure to relinquish authority to temporary management.

81.39(4) Duration of temporary management. Temporary management ends when the facility meets any of the conditions specified in subrule 81.56(3).

441—81.40(249A) Denial of payment for all new admissions.

81.40(1) Optional denial of payment. Except as specified in subrule 81.40(2), the denial of payment for all new admissions may be imposed when a facility is not in substantial compliance with the requirements.

81.40(2) Required denial of payment. Payment for all new admissions shall be denied when:

a. The facility is not in substantial compliance three months after the last day of the survey identifying the noncompliance; or

b. The department of inspections and appeals has cited a facility with substandard quality of care on the last three consecutive standard surveys.

81.40(3) Resumption of payments. Repeated instances of substandard quality of care. When a facility has repeated instances of substandard quality of care, payments to the facility resume on the date that:

a. The facility achieves substantial compliance as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

b. The department of inspections and appeals determines that the facility is capable of remaining in substantial compliance.

81.40(4) Resumption of payments. No repeated instances of substandard quality of care. When a facility does not have repeated instances of substandard quality of care, payments to the facility resume prospectively on the date that the facility achieves substantial compliance, as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

81.40(5) Restriction. No payments to a facility are made for the period between the date that the denial of payment remedy is imposed and the date the facility achieves substantial compliance, as determined by the department of inspections and appeals.

441—81.41(249A) Secretarial authority to deny all payments.

81.41(1) CMS option to deny all payment. If a facility has not met a requirement, in addition to the authority to deny payment for all new admissions as specified in rule 441—81.40(249A), CMS may deny any further payment to the state for all Medicaid residents in the facility. When CMS denies payment to the state, the department shall deny payment to the facility.

81.41(2) Resumption of payment. When CMS resumes payment to the state, the department shall also resume payment to the facility. The department shall make payments to the facility for the same periods for which payment is made to the state.

441—81.42(249A) State monitoring.

81.42(1) State monitor. A state monitor:

a. Oversees the correction of deficiencies specified by the department of inspections and appeals at the facility site and protects the facility's residents from harm.

b. Is an employee or a contractor of the department of inspections and appeals.

c. Is identified by the department of inspections and appeals as an appropriate professional to monitor cited deficiencies.

d. Is not an employee of the facility.

e. Does not function as a consultant to the facility.

f. Does not have an immediate family member who is a resident of the facility to be monitored.

81.42(2) Use of state monitor. A state monitor shall be used when the department of inspections and appeals has cited a facility with substandard quality of care deficiencies on the last three consecutive standard surveys.

81.42(3) Discontinuance of state monitor. State monitoring is discontinued when:

a. The facility has demonstrated that it is in substantial compliance with the requirement, and it will remain in compliance for a period of time specified by the department of inspections and appeals.

b. Termination procedures are completed.

441—81.43(249A) Directed plan of correction. The department of inspections and appeals or the temporary manager (with department of inspections and appeals' approval) may develop a plan of correction and require a facility to take action within specified time frames.

441—81.44(249A) Directed in-service training.

81.44(1) Required training. The department of inspections and appeals may require the staff of a facility to attend an in-service training program if:

a. The facility has a pattern of deficiencies that indicate noncompliance; and

b. Education is likely to correct the deficiencies.

81.44(2) Action following training. After the staff has received in-service training, if the facility has not achieved substantial compliance, the department of inspections and appeals may impose one or more other remedies.

81.44(3) Payment. The facility is responsible for the payment for the directed in-service training.

441—81.45(249A) Closure of a facility or transfer of residents, or both.

81.45(1) Closure during an emergency. In an emergency, the department and the department of inspections and appeals have the authority to:

- a. Transfer Medicaid and Medicare residents to another facility; or
- b. Close the facility and transfer the Medicaid and Medicare residents to another facility.

81.45(2) Required transfer in immediate jeopardy situations. When a facility's provider agreement is terminated for a deficiency that constitutes immediate jeopardy, the department arranges for the safe and orderly transfer of all Medicaid and Medicare residents to another facility.

81.45(3) All other situations. Except for immediate jeopardy situations, as specified in subrule 81.45(2), when a facility's provider agreement is terminated, the department arranges for the safe and orderly transfer of all Medicare and Medicaid residents to another facility.

441—81.46(249A) Civil money penalties—basis for imposing penalty. The department of inspections and appeals may impose a civil money penalty for the number of days a facility is not in substantial compliance with one or more participation requirements, regardless of whether or not the deficiencies constitute immediate jeopardy.

The department of inspections and appeals may impose a civil money penalty for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.

441—81.47(249A) Civil money penalties—when penalty is collected.

81.47(1) When facility requests a hearing.

a. A facility shall request a hearing on the determination of the noncompliance that is the basis for imposition of the civil money penalty within the time limit specified in subrule 81.35(7).

b. If a facility requests a hearing within the time specified in subrule 81.35(7), the department of inspections and appeals initiates collection of the penalty when there is a final administrative decision that upholds the department of inspections and appeals' determination of noncompliance after the facility achieves substantial compliance or is terminated.

81.47(2) When facility does not request a hearing. If a facility does not request a hearing, in accordance with subrule 81.47(1), the department of inspections and appeals initiates collection of the penalty when the facility:

- a. Achieves substantial compliance; or
- b. Is terminated.

81.47(3) When facility waives a hearing. If a facility waives its right to a hearing in writing, as specified in rule 441—81.49(249A), the department of inspections and appeals initiates collection of the penalty when the facility:

- a. Achieves substantial compliance; or
- b. Is terminated.

81.47(4) Accrual and computation of penalties. Accrual and computation of penalties for a facility that:

a. Requests a hearing or does not request a hearing as specified in rule 441—81.50(249A);

b. Waives its right to a hearing in writing, as specified in subrule 81.49(2) and rule 441—81.50(249A).

81.47(5) Collection. The collection of civil money penalties is made as provided in rule 441—81.52(249A).

441—81.48(249A) Civil money penalties—notice of penalty. The department of inspections and appeals shall notify the facility of intent to impose a civil money penalty in writing. The notice shall include, at a minimum, the following information:

1. The nature of the noncompliance.
2. The statutory basis for the penalty.
3. The amount of penalty per day of noncompliance.
4. Any factors specified in subrule 81.50(6) that were considered when determining the amount of the penalty.
5. The date on which the penalty begins to accrue.
6. When the penalty stops accruing.
7. When the penalty is collected.
8. Instructions for responding to the notice, including a statement of the facility's right to a hearing, and the implication of waiving a hearing, as provided in rule 441—81.49(249A).

441—81.49(249A) Civil money penalties—waiver of hearing, reduction of penalty amount.

81.49(1) Waiver of a hearing. The facility may waive the right to a hearing, in writing, within 60 days from the date of the notice of intent to impose the civil money penalty.

81.49(2) Reduction of penalty amount.

a. If the facility waives its right to a hearing, the department of inspections and appeals reduces the civil money penalty amount by 35 percent.

b. If the facility does not waive its right to a hearing, the civil money penalty is not reduced by 35 percent.

441—81.50(249A) Civil money penalties—amount of penalty.

81.50(1) Amount of penalty. The penalties are within the following ranges, set at \$50 increments:

a. Upper range—\$3,050 to \$10,000. Penalties in the range of \$3,050 to \$10,000 per day are imposed for deficiencies constituting immediate jeopardy, as specified in 81.50(4) "b."

b. Lower range—\$50 to \$3,000. Penalties in the range of \$50 to \$3,000 per day are imposed for deficiencies that do not constitute immediate jeopardy, but either caused actual harm, or caused no actual harm, but have the potential for more than minimal harm.

81.50(2) Basis for penalty amount. The amount of penalty is based on the department of inspections and appeals' assessment of factors listed in subrule 81.50(6).

81.50(3) Decreased penalty amounts. Except as specified in 81.50(4) "b," if immediate jeopardy is removed, but the noncompliance continues, the department of inspections and appeals shall shift the penalty amount to the lower range.

81.50(4) Increased penalty amounts.

a. Before the hearing, the department of inspections and appeals may propose to increase the penalty amount for facility noncompliance which, after imposition of a lower level penalty amount, becomes sufficiently serious to pose immediate jeopardy.

b. The department of inspections and appeals shall increase the penalty amount for any repeated deficiencies for which a lower level penalty amount was previously imposed, regardless of whether the increased penalty amount would exceed the range otherwise reserved for nonimmediate jeopardy deficiencies.

c. Repeated deficiencies are deficiencies in the same regulatory grouping of requirements found at the last survey, subsequently corrected, and found again at the next survey.

81.50(5) Review of the penalty. When an administrative law judge (or director of the department of inspections and appeals) finds that the basis for imposing a civil money penalty exists, the administrative law judge (or director) may not:

a. Set a penalty of zero or reduce a penalty to zero.

b. Review the exercise of discretion by the department of inspections and appeals to impose a civil money penalty.

c. Consider any factors in reviewing the amount of the penalty other than those specified in subrule 81.50(6).

81.50(6) Factors affecting the amount of penalty. In determining the amount of penalty, the department of inspections and appeals shall take into account the following factors:

- a. The facility's history of noncompliance, including repeated deficiencies.
- b. The facility's financial condition.
- c. The factors specified in rule 441—81.33(249A).
- d. The facility's degree of culpability. Culpability includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating circumstance in reducing the amount of the penalty.

81.50(7) Authority to settle penalties. The department of inspections and appeals has the authority to settle cases at any time before the evidentiary hearing.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

441—81.51(249A) Civil money penalties—effective date and duration of penalty.

81.51(1) When penalty begins to accrue. The civil money penalty may start accruing as early as the date the facility was first out of compliance, as determined by the department of inspections and appeals.

81.51(2) Duration of penalty. The civil money penalty is computed and collectible, as specified in rules 441—81.47(249A) and 441—81.52(249A), for the number of days of noncompliance until the date the facility achieves substantial compliance or, if applicable, the date of termination when:

- a. The department of inspections and appeals' decision of noncompliance is upheld after a final administrative decision;
- b. The facility waives its right to a hearing in accordance with rule 441—81.49(249A); or
- c. The time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

81.51(3) Penalty due. The entire accrued penalty is due and collectible, as specified in the notice sent to the provider under subrules 81.51(4) and 81.54(5).

81.51(4) Notice after facility achieves compliance. When a facility achieves substantial compliance, the department of inspections and appeals shall send a separate notice to the facility containing:

- a. The amount of penalty per day;
- b. The number of days involved;
- c. The total amount due;
- d. The due date of the penalty; and
- e. The rate of interest assessed on the unpaid balance beginning on the due date, as provided in rule 441—81.52(249A).

81.51(5) Notice to terminated facility. In the case of a terminated facility, the department of inspections and appeals shall send this penalty information after the:

- a. Final administrative decision is made;
- b. Facility has waived its right to a hearing in accordance with rule 441—81.49(249A); or
- c. Time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

81.51(6) Accrual of penalties when there is no immediate jeopardy.

a. In the case of noncompliance that does not pose immediate jeopardy, the daily accrual of civil money penalties is imposed for the days of noncompliance prior to the notice specified in rule 441—81.48(249A) and an additional period of no longer than six months following the last day of the survey.

b. After the period specified in paragraph "a," if the facility has not achieved substantial compliance, the provider agreement may be terminated.

81.51(7) Accrual of penalties when there is immediate jeopardy.

a. When a facility has deficiencies that pose immediate jeopardy, the provider agreement shall be terminated within 23 calendar days after the last day of the survey if the immediate jeopardy remains.

b. The accrual of the civil money penalty stops on the day the provider agreement is terminated.

81.51(8) Documenting substantial compliance.

a. If an on-site revisit is necessary to confirm substantial compliance and the provider can supply documentation acceptable to the department of inspections and appeals that substantial compliance was achieved on a date preceding the revisit, penalties only accrue until that date of correction for which there is written credible evidence.

b. If an on-site revisit is not necessary to confirm substantial compliance, penalties only accrue until the date of correction for which the department of inspections and appeals receives and accepts written credible evidence.

441—81.52(249A) Civil money penalties—due date for payment of penalty.

81.52(1) When payments are due.

a. A civil money penalty payment is due 15 days after a final administrative decision is made when:

- (1) The facility achieves substantial compliance before the final administrative decision; or
- (2) The effective date of termination occurs before the final administrative decision.

b. A civil money penalty is due 15 days after the time period for requesting a hearing has expired and a hearing request was not received when:

- (1) The facility achieves substantial compliance before the hearing request was due; or
- (2) The effective date of termination occurs before the hearing request was due.

c. A civil money penalty payment is due 15 days after receipt of the written request to waive a hearing when:

- (1) The facility achieved substantial compliance before the department of inspections and appeals received the written waiver of hearing; or
- (2) The effective date of termination occurs before the department of inspections and appeals received the written waiver of hearing.

d. A civil money penalty payment is due 15 days after substantial compliance is achieved when:

- (1) The final administrative decision is made before the facility came into compliance;
- (2) The facility did not file a timely hearing request before it came into substantial compliance; or
- (3) The facility waived its right to a hearing before it came into substantial compliance.

e. A civil money penalty payment is due 15 days after the effective date of termination, if before the effective date of termination:

- (1) The final administrative decision was made;
- (2) The time for requesting a hearing has expired and the facility did not request a hearing; or
- (3) The facility waived its right to a hearing.

f. In the cases specified in paragraph “*d.*,” the period of noncompliance may not extend beyond six months from the last day of the survey.

81.52(2) Deduction of penalty from amount owed. The amount of the penalty, when determined, may be deducted from any sum then or later owing by the department to the facility.

81.52(3) Interest. Interest of 10 percent per year is assessed on the unpaid balance of the penalty, beginning on the due date.

81.52(4) Penalties collected by the department. Rescinded IAB 3/9/11, effective 4/1/11.
[ARC 9402B, IAB 3/9/11, effective 4/1/11]

441—81.53(249A) Use of penalties collected by the department. Civil money penalties collected by the department shall be applied to the protection of the health or property of residents of facilities that the department of inspections and appeals finds deficient. Funds may be used for:

1. Time-limited expenses incurred in the process of relocating residents to home- and community-based settings or other facilities when a facility is closed or downsized pursuant to an agreement with the department;
2. Recovery of state costs related to the operation of a facility pending correction of deficiencies or closure;

3. Support and protection of residents of a facility that closes;
 4. Funding of projects to improve the quality of life and quality of care of nursing facility residents through quality improvement initiative grants awarded pursuant to 441—Chapter 166;
 5. Projects that support resident and family councils and other consumer involvement in ensuring quality care in facilities; and
 6. Reasonable expenses incurred by the department to administer, monitor, or evaluate the effectiveness of grants utilizing civil money penalty funds.
- [ARC 9402B, IAB 3/9/11, effective 4/1/11; ARC 3717C, IAB 3/28/18, effective 7/1/18]

441—81.54(249A) Continuation of payments to a facility with deficiencies.

81.54(1) Criteria.

a. The department may continue payments to a facility that is not in substantial compliance for the periods specified in subrule 81.54(3) if the following criteria are met:

- (1) The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility;
- (2) The department of inspections and appeals has submitted a plan and timetable for corrective action approved by CMS; and
- (3) The facility agrees to repay the department for all payments received under this provision if corrective action is not taken in accordance with the approved plan and timetable for corrective action and posts a bond acceptable to the department to guarantee agreement to repay.

b. The facility provider agreement may be terminated before the end of the correction period if the criteria in 81.54(1)“*a*” are not met.

81.54(2) Cessation of payments. If termination is not sought, either by itself or along with another remedy or remedies, or any of the criteria in 81.54(1)“*a*” are not met or agreed to by either the facility or the department, the facility shall receive no payments, as applicable, from the last day of the survey.

81.54(3) Period of continued payments. If the conditions in 81.54(1)“*a*” are met, the department may continue payments to a facility with noncompliance that does not constitute immediate jeopardy for up to six months from the last day of the survey.

81.54(4) Failure to achieve substantial compliance. If the facility does not achieve substantial compliance by the end of the period specified in subrule 81.54(3), the provider agreement for the facility may be terminated.

441—81.55(249A) State and federal disagreements involving findings not in agreement when there is no immediate jeopardy. This rule applies when CMS and the department of inspections and appeals disagree over findings of noncompliance or application of remedies.

81.55(1) Disagreement over whether facility has met requirements.

a. The department of inspections and appeals’ finding of noncompliance takes precedence when:

- (1) CMS finds the facility is in substantial compliance with the participation requirements; and
- (2) The department of inspections and appeals finds the facility has not achieved substantial compliance.

b. CMS’s findings of noncompliance take precedence when:

- (1) CMS finds that a facility has not achieved substantial compliance; and
- (2) The department of inspections and appeals finds the facility is in substantial compliance with the participation requirements.

c. When CMS’s survey findings take precedence, CMS may:

- (1) Impose any of the alternative remedies specified in rule 441—81.34(249A);
- (2) Terminate the provider agreement subject to the applicable conditions of rule 441—81.54(249A); and
- (3) Stop federal financial participation to the department for a nursing facility.

81.55(2) Disagreement over decision to terminate.

a. CMS’s decision to terminate the participation of a facility takes precedence when:

(1) Both CMS and the department of inspections and appeals find that the facility has not achieved substantial compliance; and

(2) CMS, but not the department of inspections and appeals, finds that the facility's participation should be terminated. CMS will permit continuation of payment during the period prior to the effective date of termination, not to exceed six months, if the applicable conditions of rule 441—81.54(249A) are met.

b. The department of inspections and appeals' decision to terminate a facility's participation and the procedures for appealing the termination take precedence when:

(1) The department of inspections and appeals, but not CMS, finds that a facility's participation should be terminated; and

(2) The department of inspections and appeals' effective date for the termination of the nursing facility's provider agreement is no later than six months after the last day of survey.

81.55(3) *Disagreement over timing of termination of facility.* The department of inspections and appeals' timing of termination takes precedence if it does not occur later than six months after the last day of the survey when both CMS and the department of inspections and appeals find that:

a. A facility is not in substantial compliance; and

b. The facility's participation should be terminated.

81.55(4) *Disagreement over remedies.*

a. When CMS or the department of inspections and appeals, but not both, establishes one or more remedies, in addition to or as an alternative to termination, the additional or alternative remedies will also apply when:

(1) Both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance; and

(2) Both CMS and the department of inspections and appeals find that no immediate jeopardy exists.

b. When CMS and the department of inspections and appeals establish one or more remedies, in addition to or as an alternative to termination, only the CMS remedies apply when both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance.

81.55(5) *One decision.* Regardless of whether CMS's or the department of inspections and appeals' decision controls, only one noncompliance and enforcement decision is applied to the Medicaid agreement, and for a dually participating facility, that same decision will apply to the Medicare agreement.

441—81.56(249A) Duration of remedies.

81.56(1) *Remedies continue.* Except as specified in subrule 81.56(2), alternative remedies continue until:

a. The facility has achieved substantial compliance as determined by the department of inspections and appeals based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit; or

b. The provider agreement is terminated.

81.56(2) *State monitoring.* In the cases of state monitoring and denial of payment imposed for repeated substandard quality of care, remedies continue until:

a. The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance; or

b. The provider agreement is terminated.

81.56(3) *Temporary management.* In the case of temporary management, the remedy continues until:

a. The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance;

b. The provider agreement is terminated; or

c. The facility which has not achieved substantial compliance reassumes management control. In this case, the department of inspections and appeals initiates termination of the provider agreement and may impose additional remedies.

81.56(4) Facility in compliance. If the facility can supply documentation acceptable to the department of inspections and appeals that it was in substantial compliance, and was capable of remaining in substantial compliance, if necessary, on a date preceding that of the revisit, the remedies terminate on the date that the department of inspections and appeals can verify as the date that substantial compliance was achieved.

441—81.57(249A) Termination of provider agreement.

81.57(1) Effect of termination. Termination of the provider agreement ends payment to the facility and any alternative remedy.

81.57(2) Basis of termination.

a. A facility's provider agreement may be terminated if a facility:

(1) Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present; or

(2) Fails to submit an acceptable plan of correction within the time frame specified by the department of inspections and appeals.

b. A facility's provider agreement shall be terminated if a facility:

(1) Fails to relinquish control to the temporary manager, if that remedy is imposed by the department of inspections and appeals; or

(2) Does not meet the eligibility criteria for continuation of payment as set forth in 81.37(1)“a.”

81.57(3) Notice of termination. Before a provider agreement is terminated, the department of inspections and appeals shall notify the facility and the public:

a. At least two calendar days before the effective date of termination for a facility with immediate jeopardy deficiencies; and

b. At least 15 calendar days before the effective date of termination for a facility with nonimmediate jeopardy deficiencies that constitute noncompliance.

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

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- ¹ Effective date of 81.16(4) delayed 30 days by the Administrative Rules Review Committee at its September 12, 1990, meeting; at the October 9, 1990, meeting the delay was extended to 70 days. Amendment effective 12/1/90 superseded the 70-day delay.
- ² Effective date of 81.10(5) delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its November 13, 1990, meeting.
- ³ Effective date of 81.13(7) “c”(1) delayed 70 days by the Administrative Rules Review Committee at its meeting held July 14, 1992; delay lifted by the Committee at its meeting held August 11, 1992, effective August 12, 1992.
- ⁴ Effective date of 81.6(3), first unnumbered paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held April 5, 1993.
- 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**.

OBJECTION

At its meeting held August 11, 1992, the Administrative Rules Review Committee voted to object to the amendments published in **ARC 3069A** on the grounds the amendments are unreasonable. This filing is published in IAB Vol. XIV No. 253 (06-10-92). It is codified as an amendment to paragraph 441 IAC 81.13(7)“c”(1).

In brief, this filing provides that care facilities shall not employ persons who have been found guilty in a court of law of abusing, neglecting or mistreating facility residents, or who have had a “finding” entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. Additionally, the filing eliminates a previous provision which allowed the Department of Inspections and Appeals some discretion in deciding whether the lifetime ban on employment should be applied.

This language originated in the federal government which mandated that the department adopt these provisions or possibly face sanctions. The Committee does not believe these amendments are an improvement to Iowa’s system and has the following objection. The Committee believes that the amendments published in **ARC 3069A** are unreasonable because of the inconsistency in the burdens of proof and the levels of procedural safeguards in the two proceedings. A facility employee may either be found guilty in a court of law or have an administrative finding entered into the registry. In either case the result is the same, the employee is permanently banned from further employment in a care facility; however, the two paths to the result are significantly different. The first proceeding is a criminal tribunal in which the burden of proof is “beyond a reasonable doubt.” The second proceeding is a simple administrative hearing in which the burden is “preponderance of the evidence.” The two proceedings also differ in the level of many other due process protections accorded to the individual. A criminal proceeding provides the accused with the opportunity for a trial by jury, competent legal counsel, strict rules of evidence and many procedural protections not present in administrative hearings. It should also be noted that the penalty in this situation—a lifetime ban on employment—is more serious than is usually imposed in contested cases. In licensee discipline cases, a license can be revoked, but the possibility of reinstatement exists; under this new rule no reinstatement is allowed, the facility employee is banned from employment no matter how serious or minor the offense or how far in the past it occurred. Because of the magnitude of this penalty, the Committee believes that the accused should be provided with greater procedural protections than are generally found in administrative hearings.

The Committee also believes this filing is unreasonable because it eliminates the discretion accorded to the Department of Inspections and Appeals to not apply the lifetime ban on employment. Under the previous rule, the department’s discretion in applying the employment ban acted as a safeguard against unjust results. It recognized that a person would make amends for past offenses and earn a second chance. The provision was a genuine improvement in the process; it recognized that flexibility was needed in government decision making and that some decisions should be made on a case-by-case basis. There does not appear to be any rational basis to justify the elimination of this safeguard and, therefore, the Committee believes this action to be unreasonable.

CHAPTER 82
INTERMEDIATE CARE FACILITIES FOR PERSONS
WITH AN INTELLECTUAL DISABILITY

[Prior to 7/1/83, Social Services[770] Ch 82]

[Prior to 2/11/87, Human Services[498]]

441—82.1(249A) Definition.

“Department” means the Iowa department of human services.

“Intermediate care facility for persons with an intellectual disability (ICF/ID)” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermediate care facility for persons with medical complexity” means an intermediate care facility for persons with an intellectual disability which provides health and rehabilitation services to individuals who require a skilled nursing level of care, have either a multiple organ dysfunction or severe single organ dysfunction, and require daily use of medical resources or technology.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4052C, IAB 10/10/18, effective 9/12/18]

441—82.2(249A) Licensing and certification. In order to participate in the program, a facility shall be licensed as an intermediate care facility for persons with an intellectual disability by the department of inspections and appeals under the department of inspections and appeals rules found in 481—Chapter 64. The facility shall meet the following conditions of participation:

82.2(1) Governing body and management.

a. Governing body. The facility shall identify an individual or individuals to constitute the governing body of the facility. The governing body shall:

- (1) Exercise general policy, budget, and operating direction over the facility.
- (2) Set the qualifications (in addition to those already set by state law) for the administrator of the facility.
- (3) Appoint the administrator of the facility.

b. Compliance with federal, state, and local laws. The facility shall be in compliance with all applicable provisions of federal, state and local laws, regulations and codes pertaining to health, safety, and sanitation.

c. Client records.

(1) The facility shall develop and maintain a record-keeping system that includes a separate record for each client and that documents the clients’ health care, active treatment, social information, and protection of the client’s rights.

(2) The facility shall keep confidential all information contained in the clients’ records, regardless of the form or storage method of the records.

(3) The facility shall develop and implement policies and procedures governing the release of any client information, including consents necessary from the client or parents (if the client is a minor) or legal guardian.

(4) Any individual who makes an entry in a client's record shall make it legibly, date it, and sign it.

(5) The facility shall provide a legend to explain any symbol or abbreviation used in a client's record.

(6) The facility shall provide each identified residential living unit with appropriate aspects of each client's record.

d. Services provided under agreements with outside sources.

(1) If a service required under this rule is not provided directly, the facility shall have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care.

(2) The agreement shall:

1. Contain the responsibilities, functions, objectives, and other terms agreed to by both parties.

2. Provide that the facility is responsible for ensuring that the outside services meet the standards for quality of services contained in this rule.

(3) The facility shall ensure that outside services meet the needs of each client.

(4) If living quarters are not provided in a facility owned by the ICF/ID, the ICF/ID remains directly responsible for the standards relating to physical environment that are specified in subrule 82.2(7), paragraphs "a" to "g," "j," and "k."

e. Disclosure of ownership. The facility shall supply to the licensing agency full and complete information, and promptly report any changes which would affect the current accuracy of the information, as to identify:

(1) Each person having a direct or indirect ownership interest of 5 percent or more in the facility and the owner in whole or in part of any property or assets (stock, mortgage, deed of trust, note or other obligation) secured in whole or in part by the facility.

(2) Each officer and director of the corporation, if the facility is organized as a corporation.

(3) Each partner, if the facility is organized as a partnership.

82.2(2) Client protections.

a. Protection of clients' rights. The facility shall ensure the rights of all clients. Therefore, the facility shall:

(1) Inform each client, parent (if the client is a minor), or legal guardian of the client's rights and the rules of the facility.

(2) Inform each client, parent (if the child is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.

(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints and the right to due process.

(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.

(5) Ensure that clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment.

(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.

(7) Provide each client with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs.

(8) Ensure that clients are not compelled to perform services for the facility and ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities.

(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice, and to send and receive unopened mail.

(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans.

(11) Ensure clients the opportunity to participate in social, religious, and community group activities.

(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and ensure that each client is dressed in the client's own clothing each day.

(13) Permit a husband and wife who both reside in the facility to share a room.

b. Client finances.

(1) The facility shall establish and maintain a system that ensures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients and precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

(2) The client's financial record shall be available on request to the client, parents (if the client is a minor), or legal guardian.

c. Communication with clients, parents, and guardians. The facility shall:

(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate.

(2) Answer communications from clients' families and friends promptly and appropriately.

(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate.

(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy.

(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations.

(6) Notify promptly the client's parents or guardian of any significant incidents or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

d. Staff treatment of clients.

(1) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

1. Staff of the facility shall not use physical, verbal, sexual or psychological abuse or punishment.

2. Staff shall not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

3. The facility shall prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

(2) The facility shall ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations shall be reported to the administrator or designated representative or to other officials in accordance with state law within five working days of the incident, and, if the alleged violation is verified, appropriate corrective action shall be taken.

82.2(3) Facility staffing.

a. Qualified intellectual disability professional. Each client's active treatment program shall be integrated, coordinated and monitored by a qualified intellectual disability professional who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and is one of the following:

(1) A doctor of medicine or osteopathy.

(2) A registered nurse.

(3) An individual who holds at least a bachelor's degree in a professional category specified in 82.2(3) "b"(5).

b. Professional program services.

(1) Each client shall receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Professional program staff shall work directly with clients and with paraprofessional, nonprofessional and other professional program staff who work with clients.

(2) The facility shall have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

(3) Professional program staff shall participate as members of the interdisciplinary team in relevant aspects of the active treatment process.

(4) Professional program staff shall participate in ongoing staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.

(5) Professional program staff shall be licensed, certified, or registered, as applicable, to provide professional services by the state in which the staff practices. Those professional program staff who do not fall under the jurisdiction of state licensure, certification, or registration requirements shall meet the following qualifications:

1. To be designated as an occupational therapist, an individual shall be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.

2. To be designated as an occupational therapy assistant, an individual shall be eligible for certification as an occupational therapy assistant by the American Occupational Therapy Association or another comparable body.

3. To be designated as a physical therapist, an individual shall be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.

4. To be designated as a physical therapy assistant, an individual shall be eligible for registration as a physical therapy assistant by the American Physical Therapy Association or be a graduate of a two-year college-level program approved by the American Physical Therapy Association or another comparable body.

5. To be designated as a psychologist, an individual shall have at least a master's degree in psychology from an accredited school.

6. To be designated as a social worker, an individual shall hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body or hold a bachelor of social work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.

7. To be designated as a speech-language pathologist or audiologist, an individual shall be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language Hearing Association or another comparable body or meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

8. To be designated as a professional recreation staff member, an individual shall have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

9. To be designated as a professional dietitian, an individual shall be eligible for registration by the American Dietetics Association.

10. To be designated as a human services professional, an individual shall have at least a bachelor's degree in a human services field (including, but not limited to, sociology, special education, rehabilitation counseling and psychology).

(6) If the client's individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of 82.2(3)"b"(5) are not required except for qualified intellectual disability professionals who must meet the requirements set forth in 82.2(3)"a."

c. Facility staffing.

(1) The facility shall not depend upon clients or volunteers to perform direct care services for the facility.

(2) There shall be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing: clients for whom a physician has ordered a medical care plan; clients who are aggressive, assaultive or security risks; more than 16 clients; or fewer than 16 clients within a multi-unit building.

(3) There shall be a responsible direct care staff person on duty on a 24-hour basis, when clients are present, to respond to injuries and symptoms of illness, and to handle emergencies, in each defined residential living unit housing: clients for whom a physician has not ordered a medical care plan; clients who are not aggressive, assaultive or security risks; and 16 or fewer clients.

(4) The facility shall provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.

d. Direct care (residential living unit) staff.

(1) The facility shall provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

(2) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

(3) Direct care staff shall be provided by the facility in the following minimum ratios of direct care staff to clients:

1. For each defined residential living unit serving children under the age of 12, severely and profoundly intellectually disabled clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff-to-client ratio is 1 to 3.2.

2. For each defined residential living unit serving moderately intellectually disabled clients, the staff-to-client ratio is 1 to 4.

3. For each defined residential living unit serving clients who function within the range of mild intellectual disability, the staff-to-client ratio is 1 to 6.4.

4. When there are no clients present in the living unit, a responsible staff member must be available by telephone.

e. Staff training program.

(1) The facility shall provide each employee with initial and continuing training that enables the employee to perform the employee's duties effectively, efficiently, and competently.

(2) For employees who work with clients, training shall focus on skills and competencies directed toward clients' developmental, behavioral, and health needs.

(3) Staff shall be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

(4) Staff shall be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

82.2(4) *Active treatment services.*

a. Active treatment.

(1) Each client shall receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this paragraph, that is directed toward: the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status.

(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

b. Admissions, transfers, and discharge.

(1) Clients who are admitted by the facility shall be in need of and receiving active treatment services.

(2) Admission decisions shall be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

(3) A preliminary evaluation shall contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

(4) If a client is to be either transferred or discharged, the facility shall have documentation in the client's record that the client was transferred or discharged for good cause, and shall provide a reasonable time to prepare the client and the client's parents or guardian for the transfer or discharge (except in emergencies).

(5) At the time of the discharge, the facility shall develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies, and shall provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

c. Individual program plan.

(1) Each client shall have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to identifying the client's needs, as described by the comprehensive functional assessments required in 82.2(4) "c"(3), and designing programs that meet the client's needs.

(2) Appropriate facility staff shall participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. For those clients enrolled with a managed care organization, the client's case manager shall participate as appropriate and as allowed by the client. Participation by the client, the client's parents (if the client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

(3) Within 30 days after admission, the interdisciplinary team shall perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment shall take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and shall:

1. Identify the presenting problems and disabilities and, where possible, their causes.
2. Identify the client's specific developmental strengths.
3. Identify the client's specific developmental and behavioral management needs.
4. Identify the client's need for services without regard to the actual availability of the services needed.
5. Include physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the client to be able to function in the community, and, as applicable, vocational skills.

(4) Within 30 days after admission, the interdisciplinary team shall prepare for each client an individual program plan that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by 82.2(4) "c"(3), and the planned sequence for dealing with those objectives. These objectives shall:

1. Be stated separately, in terms of a single behavioral outcome.
2. Be assigned projected completion dates.
3. Be expressed in behavioral terms that provide measurable indices of performance.
4. Be organized to reflect a developmental progression appropriate to the individual.
5. Be assigned priorities.

(5) Each written training program designed to implement the objectives in the individual program plan shall specify:

1. The methods to be used.
2. The schedule for use of the method.
3. The person responsible for the program.

4. The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.

5. The inappropriate client behaviors, if applicable.

6. Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

(6) The individual program plan shall also:

1. Describe relevant interventions to support the individual toward independence.

2. Identify the location where program strategy information (which shall be accessible to any person responsible for implementation) can be found.

3. Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

4. Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan shall specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support.

5. Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

6. Include opportunities for client choice and self-management.

(7) A copy of each client's individual program plan shall be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

d. Program implementation.

(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client shall receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

(2) The facility shall develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan shall be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

e. Program documentation.

(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives shall be documented in measurable terms.

(2) The facility shall document significant events that are related to the client's individual program plan and assessments and that contribute to an overall understanding of the client's ongoing level and quality of functioning.

f. Program monitoring and change.

(1) The individual program plan shall be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to, situations in which the client:

1. Has successfully completed an objective or objectives identified in the individual program plan.

2. Is regressing or losing skills already gained.

3. Is failing to progress toward identified objectives after reasonable efforts have been made.

4. Is being considered for training toward new objectives.

(2) At least annually, the comprehensive functional assessment of each client shall be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan shall be revised, as appropriate, repeating the process set forth in 82.2(4) "c."

(3) The facility shall designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who

have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to:

1. Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.
2. Ensure that these programs are conducted only with the written informed consent of the client, parent (if the client is a minor), or legal guardian.
3. Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other area that the committee believes needs to be addressed.

(4) The provisions of 82.2(4) "f"(3) may be modified only if, in the judgment of the department of inspections and appeals, court decrees, state law or regulations provide for equivalent client protection and consultation.

82.2(5) *Client behavior and facility practices.*

a. Facility practices—conduct toward clients.

(1) The facility shall develop and implement written policies and procedures for the management of conduct between staff and clients. These policies and procedures shall:

1. Promote the growth, development and independence of the client.
2. Address the extent to which client choice will be accommodated in daily decision making, emphasizing self-determination and self-management, to the extent possible.
3. Specify client conduct to be allowed or not allowed.
4. Be available to all staff, clients, parents of minor children, and legal guardians.

(2) To the extent possible, clients shall participate in the formulation of these policies and procedures.

(3) Clients shall not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.

b. Management of inappropriate client behavior.

(1) The facility shall develop and implement written policies and procedures that govern the management of inappropriate client behavior. These policies and procedures shall be consistent with the provisions of 82.2(5) "a." These procedures shall:

1. Specify all facility-approved interventions to manage inappropriate client behavior.
2. Designate these interventions on a hierarchy to be implemented ranging from most positive or least intrusive to least positive or most intrusive.
3. Ensure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and have been demonstrated to be ineffective.

4. Address the use of time-out rooms, the use of physical restraints, the use of drugs to manage inappropriate behavior, the application of painful or noxious stimuli, the staff members who may authorize the use of specified interventions, and a mechanism for monitoring and controlling the use of these interventions.

(2) Interventions to manage inappropriate client behavior shall be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.

(3) Techniques to manage inappropriate client behavior shall never be used for disciplinary purposes, for the convenience of staff or as a substitute for an active treatment program.

(4) The use of systematic interventions to manage inappropriate client behavior shall be incorporated into the client's individual program plan, in accordance with 82.2(4) "c"(4) and (5).

(5) Standing or as-needed programs to control inappropriate behavior are not permitted.

c. Time-out rooms.

(1) A client may be placed in a room from which egress is prevented only if the following conditions are met:

1. The placement is a part of an approved systematic time-out program as required by 82.2(5) "b."

2. The client is under the direct constant visual supervision of designated staff.
3. The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.

- (2) Placement of a client in a time-out room shall not exceed one hour.

- (3) Clients placed in time-out rooms shall be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.

- (4) A record of time-out activities shall be kept.

d. Physical restraints.

- (1) The facility may employ physical restraint only:

1. As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.

2. As an emergency measure, but only if absolutely necessary to protect the client or others from injury.

3. As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.

- (2) Authorizations to use or extend restraints as an emergency shall be in effect no longer than 12 consecutive hours and shall be obtained as soon as the client is restrained or stable.

- (3) The facility shall not issue orders for restraint on a standing or as-needed basis.

- (4) A client placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints, shall be released from the restraint as quickly as possible, and a record of these checks and usage shall be kept.

- (5) Restraints shall be designated and used so as not to cause physical injury to the client and so as to cause the least possible discomfort.

- (6) Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two-hour period in which restraint is employed, and a record of the activity shall be kept.

- (7) Barred enclosures shall not be more than three feet in height and shall not have tops.

e. Drug usage.

- (1) The facility shall not use drugs in doses that interfere with the individual client's daily living activities.

- (2) Drugs used for control of inappropriate behavior shall be approved by the interdisciplinary team and be used only as an integral part of the client's individual program plan that is directed specifically toward the reduction and eventual elimination of the behaviors for which the drugs are employed.

- (3) Drugs used for control of inappropriate behavior shall not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.

- (4) Drugs used for control of inappropriate behavior shall be monitored closely, in conjunction with the physician and the drug regimen review requirement at 82.2(6) "j," for desired responses and adverse consequences by facility staff, and shall be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

82.2(6) Health care services.

a. Physician services.

- (1) The facility shall ensure the availability of physician services 24 hours a day.

- (2) The physician shall develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care. This plan shall be integrated in the individual program plan.

- (3) The facility shall provide or obtain preventive and general medical care as well as annual physical examinations of each client that at a minimum include the following:

1. Evaluation of vision and hearing.

2. Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.

3. Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed.

4. Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section of diseases of the chest of the American Academy of Pediatrics, or both.

(4) To the extent permitted by state law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this subrule.

b. Physician participation in the individual program plan. A physician shall participate in:

(1) The establishment of each newly admitted client's initial individual program plan.

(2) If appropriate, physicians shall participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.

c. Nursing services. The facility shall provide clients with nursing services in accordance with their needs. These services shall include:

(1) Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process.

(2) The development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan.

(3) For those clients certified as not needing a medical care plan, a review of their health status which shall:

1. Be by a direct physical examination.

2. Be by a licensed nurse.

3. Be on a quarterly or more frequent basis depending on client need.

4. Be recorded in the client's record.

5. Result in any necessary action including referral to a physician to address client health problems.

(4) Other nursing care as prescribed by the physician or as identified by client needs.

(5) Implementing, with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to:

1. Training clients and staff as needed in appropriate health and hygiene methods.

2. Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control.

3. Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.

d. Nursing staff.

(1) Nurses providing services in the facility shall have a current license to practice in the state.

(2) The facility shall employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans.

(3) The facility shall utilize registered nurses as appropriate and required by state law to perform the health services specified in this subrule.

(4) If the facility utilizes only licensed practical or vocational nurses to provide health services, it shall have a formal arrangement with a registered nurse to be available for verbal or on-site consultation with the licensed practical or vocational nurse.

(5) Nonlicensed nursing personnel who work with clients under a medical care plan shall do so under the supervision of licensed persons.

e. Dental services.

(1) The facility shall provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists, either through organized dental services in-house or through arrangement.

(2) If appropriate, dental professionals shall participate in the development, review and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.

(3) The facility shall provide education and training in the maintenance of oral health.

f. Comprehensive dental diagnostic services. Comprehensive dental diagnostic services include:

(1) A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's oral condition, not later than one month after admission to the facility unless the examination was completed within 12 months before admission.

(2) Periodic examination and diagnosis performed at least annually, including radiographs when indicated and detection of manifestations of systemic disease.

(3) A review of the results of examination and entry of the results in the client's dental record.

g. Comprehensive dental treatment. The facility shall ensure comprehensive dental treatment services that include:

(1) The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist.

(2) Dental care needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

h. Documentation of dental services.

(1) If the facility maintains an in-house dental service, the facility shall keep a permanent dental record for each client, with a dental summary maintained in the client's living unit.

(2) If the facility does not maintain an in-house dental service, the facility shall obtain a dental summary of the results of dental visits and maintain the summary in the client's living unit.

i. Pharmacy services. The facility shall provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

j. Drug regimen review.

(1) A pharmacist with input from the interdisciplinary team shall review the drug regimen of each client at least quarterly.

(2) The pharmacist shall report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.

(3) The pharmacist shall prepare a record of each client's drug regimen reviews and the facility shall maintain that record.

(4) An individual medication administration record shall be maintained for each client.

(5) As appropriate, the pharmacist shall participate in the development, implementation, and review of each client's individual program plan either in person or through written report to the interdisciplinary team.

k. Drug administration. The facility shall have an organized system for drug administration that identifies each drug up to the point of administration. The system shall ensure that:

(1) All drugs are administered in compliance with the physician's orders.

(2) All drugs, including those that are self-administered, are administered without error.

(3) Unlicensed personnel are allowed to administer drugs only if state law permits.

(4) Clients are taught how to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.

(5) The client's physician is informed of the interdisciplinary team's decision that self-administration of medications is an objective for the client.

(6) No client self-administers medications until the client demonstrates the competency to do so.

(7) Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with state law.

(8) Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician.

l. Drug storage and record keeping.

(1) The facility shall store drugs under proper conditions of sanitation, temperature, light, humidity, and security.

(2) The facility shall keep all drugs and biologicals locked except when being prepared for administration. Only authorized persons may have access to the keys to the drug storage area. Clients who have been trained to self-administer drugs in accordance with 82.2(6) "k"(4) may have access to keys to their individual drug supply.

(3) The facility shall maintain records of the receipt and disposition of all controlled drugs.

(4) The facility shall, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in Schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq.).

(5) If the facility maintains a licensed pharmacy, the facility shall comply with the regulations for controlled drugs.

m. Drug labeling.

(1) Labeling of drugs and biologicals shall be based on currently accepted professional principles and practices, and shall include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.

(2) The facility shall remove from use outdated drugs and drug containers with worn, illegible, or missing labels.

(3) Drugs and biologicals packaged in containers designated for a particular client shall be immediately removed from the client's current medication supply if discontinued by the physician.

n. Laboratory services.

(1) For purposes of this subrule, "laboratory" means an entity for the microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

(2) If a facility chooses to provide laboratory services, the laboratory shall meet the management requirements specified in 42 CFR 493.1407 and provide personnel to direct and conduct the laboratory services.

The laboratory director shall be technically qualified to supervise the laboratory personnel and test performance and shall meet licensing or other qualification standards established by the state with respect to directors of clinical laboratories.

The laboratory director shall provide adequate technical supervision of the laboratory services and ensure that tests, examinations and procedures are properly performed, recorded and reported.

The laboratory director shall ensure that the staff has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently; is sufficient in number for the scope and complexity of the services provided; and receives in-service training appropriate to the type of complexity of the laboratory services offered.

The laboratory technologists shall be technically competent to perform test procedures and report test results promptly and proficiently.

(3) The laboratory shall meet the proficiency testing requirements specified in 42 CFR 493.801.

(4) The laboratory shall meet the quality control requirements specified in 42 CFR 493.1501.

(5) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be an approved Medicare laboratory.

82.2(7) Physical environment.

a. Client living environment.

(1) The facility shall not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

(2) The facility shall not segregate clients solely on the basis of their physical disabilities. It shall integrate clients who have ambulation deficits or who are deaf, blind, or have seizure disorders with others of comparable social and intellectual development.

b. Client bedrooms.

- (1) Bedrooms shall:
 1. Be rooms that have at least one outside wall.
 2. Be equipped with or located near toilet and bathing facilities.
 3. Accommodate no more than four clients unless granted a variance under 82.2(7)“b”(3).
 4. Measure at least 60 square feet per client in multiple-client bedrooms and at least 80 square feet in single-client bedrooms.
 5. In all facilities initially certified or in buildings constructed or with major renovations or conversions, have walls that extend from floor to ceiling.
- (2) If a bedroom is below grade level, it shall have a window that is usable as a second means of escape by the client occupying the rooms and shall be no more than 44 inches measured to the windowsill above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, in which case the window must be no more than 36 inches measured to the windowsill above the floor.
- (3) The department of inspections and appeals may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified intellectual disability professional certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours and documents the reasons why housing in a room of only four or fewer persons would not be medically feasible.
- (4) The facility shall provide each client with:
 1. A separate bed of proper size and height for the convenience of the client.
 2. A clean, comfortable mattress.
 3. Bedding appropriate to the weather and climate.
 4. Functional furniture appropriate to the client’s needs, and individual closet space in the client’s bedroom with clothes racks and shelves accessible to the client.
- c. Storage space in bedroom.* The facility shall provide:
 - (1) Space and equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety.
 - (2) Suitable storage space, accessible to clients, for personal possessions such as televisions, radios, prosthetic equipment and clothing.
- d. Client bathrooms.* The facility shall:
 - (1) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients.
 - (2) Provide for individual privacy in toilets, bathtubs, and showers.
 - (3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.
- e. Heating and ventilation.*
 - (1) Each client bedroom in the facility shall have at least one window to the outside and direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.
 - (2) The facility shall maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means and ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.
- f. Floors.* The facility shall have:
 - (1) Floors that have a resilient, nonabrasive, and slip-resistant surface.
 - (2) Nonabrasive carpeting, if the area used by clients is carpeted and serves clients who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor.
 - (3) Exposed floor surfaces and floor coverings that promote mobility in areas used by clients, and promote maintenance of sanitary conditions.
- g. Space and equipment.* The facility shall:
 - (1) Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations

if they are conducted in the facility) to enable staff to provide clients with needed services as required by this rule and as identified in each client's individual program plan.

(2) Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

(3) Provide adequate clean linen and dirty linen storage areas.

h. Emergency plan and procedures.

(1) The facility shall develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

(2) The facility shall communicate, periodically review, make the plan available, and provide training to the staff.

i. Evacuation drills.

(1) The facility shall hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and evaluate the effectiveness of emergency and disaster plans and procedures.

(2) The facility shall actually evacuate clients during at least one drill each year on each shift; make special provisions for the evacuation of clients with physical disabilities; file a report and evaluation on each evacuation drill; and investigate all problems with evacuation drills, including accidents, and take corrective action. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

(3) Facilities shall meet the requirements of 82.2(7) "i"(1) and (2) for any live-in and relief staff they utilize.

j. Fire protection.

(1) General.

1. Except as specified in 82.2(7) "i"(2), the facility shall meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the Life Safety Code (LSC) of the National Fire Protection Association, 1985 edition, which is incorporated by reference.

2. The department of inspections and appeals may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

3. A facility that meets the LSC definition of a residential board and care occupancy and that has 16 or fewer beds shall have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the LSC (Appendix F).

(2) Exceptions.

1. For facilities that meet the LSC definition of a health care occupancy, the Centers for Medicare and Medicaid Services may waive, for a period it considers appropriate, specific provisions of the LSC if the waiver would not adversely affect the health and safety of the clients and rigid application of specific provisions would result in an unreasonable hardship for the facility.

The department of inspections and appeals may apply the state's fire and safety code instead of the LSC if the Secretary of the Department of Health and Human Services finds that the state has a code imposed by state law that adequately protects a facility's clients.

Compliance on November 28, 1982, with the 1967 edition of the LSC or compliance on April 18, 1986, with the 1981 edition of the LSC, with or without waivers, is considered to be compliance with this standard as long as the facility continues to remain in compliance with that edition of the code.

2. For facilities that meet the LSC definition of a residential board and care occupancy and that have more than 16 beds, the department of inspections and appeals may apply the state's fire and safety code as specified above.

k. Paint. The facility shall:

(1) Use lead-free paint inside the facility.

(2) Remove or cover interior paint or plaster containing lead so that it is not accessible to clients.

l. Infection control.

(1) The facility shall provide a sanitary environment to avoid sources and transmission of infections. There shall be an active program for the prevention, control, and investigation of infection and communicable diseases.

(2) The facility shall implement successful corrective action in affected problem areas.

(3) The facility shall maintain a record of incidents and corrective actions related to infections.

(4) The facility shall prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.

82.2(8) *Dietetic services.*

a. Food and nutrition services.

(1) Each client shall receive a nourishing, well-balanced diet including modified and specially prescribed diets.

(2) A qualified dietitian shall be employed either full-time, part-time or on a consultant basis at the facility's discretion.

(3) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services.

(4) The client's interdisciplinary team, including a qualified dietitian and physician, shall prescribe all modified and special diets including those used as a part of a program to manage inappropriate client behavior.

(5) Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client's nutritional status and needs.

(6) Unless otherwise specified by medical needs, the diet shall be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.

b. Meal services.

(1) Each client shall receive at least three meals daily, at regular times comparable to normal mealtimes in the community with:

1. Not more than 14 hours between a substantial evening meal and breakfast of the following day, except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may elapse between a substantial evening meal and breakfast.

2. Not less than 10 hours between breakfast and the evening meal of the same day, except as provided under 82.2(8) "b"(1)"1."

(2) Food shall be served:

1. In appropriate quantity.

2. At appropriate temperature.

3. In a form consistent with the developmental level of the client.

4. With appropriate utensils.

(3) Food served to clients individually and uneaten shall be discarded.

c. Menus.

(1) Menus shall:

1. Be prepared in advance.

2. Provide a variety of foods at each meal.

3. Be different for the same days of each week and adjusted for seasonal change.

4. Include the average portion sizes for menu items.

(2) Menus for food actually served shall be kept on file for 30 days.

d. Dining areas and service. The facility shall:

(1) Serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician.

(2) Provide table service for all clients who can and will eat at a table, including clients in wheelchairs.

(3) Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.

(4) Supervise and staff dining rooms adequately to direct self-help dining procedure, to ensure that each client receives enough food and to ensure that each client eats in a manner consistent with the client's developmental level.

(5) Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or physician.

This rule is intended to implement Iowa Code section 249A.12.
[ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.3(249A) Conditions of participation for intermediate care facilities for persons with an intellectual disability. All intermediate care facilities for persons with an intellectual disability must enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

82.3(1) Procedures for establishing health care facilities as Title XIX facilities. All survey procedures and the certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual."

- a. The facility shall obtain the applicable license from the department of inspections and appeals.
- b. The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.
- c. The department shall transmit an application form and copies of standards to the facility.
- d. The facility shall complete its portion of the application form and submit it to the department.
- e. The department shall review the application form and forward it to the department of inspections and appeals.
- f. The department of inspections and appeals shall schedule and complete a survey of the facility.
- g. The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.
- h. The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division, department of inspections and appeals. This plan must be approved before the facility can be certified.
- i. The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.
- j. When certification is recommended, the department of inspections and appeals shall notify the department recommending terms and conditions of a provider agreement.
- k. The department shall review the certification data and:
 - (1) Transmit the provider agreement as recommended, or
 - (2) Transmit the provider agreement for a term less than recommended by the department of inspections and appeals or elect not to execute an agreement for reasons of good cause as defined in 82.3(2) "c."

82.3(2) Title XIX provider agreements. The health care facility must be recommended for certification by the Iowa department of inspections and appeals for participation as an intermediate care facility for persons with an intellectual disability before a provider agreement may be issued. All survey procedures and certification processes shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

- a. Terms of the agreement for facilities without deficiencies are as follows:
 - (1) The provider agreement shall be issued for a period not to exceed 12 months.
 - (2) The provider agreement shall be for the term of and in accordance with the provisions of certification, except that for good cause, the department may elect to execute an agreement for a term less than the period of certification, elect not to execute an agreement for reasons of good cause, or cancel an agreement.
- b. Terms of the agreement for facilities with deficiencies are as follows:

(1) A new provider agreement may be executed for a period not to exceed 60 days from the time required to correct deficiencies up to a period of 12 months.

(2) A new provider agreement may be issued for a period of up to 12 months subject to automatic cancellation 60 days following the scheduled date for correction unless required corrections have been completed or unless the survey agency finds and notifies the department that the facility has made substantial progress in correcting the deficiencies and has resubmitted in writing a new plan of correction acceptable to the survey agency.

(3) There will be no new agreement when the facility continues to be out of compliance with the same standard(s) at the end of the term of agreement.

c. The department may, for good cause, elect not to execute an agreement. Good cause shall be defined as a continued or repeated failure to operate an intermediate care facility for persons with an intellectual disability in compliance with rules and regulations of the program.

d. The department may at its option extend an agreement with a facility for two months under either of the following conditions:

(1) The health and safety of the residents will not be jeopardized thereby and the extension is necessary to prevent irreparable harm to the facility or hardship to the resident.

(2) It is impracticable to determine whether the facility is complying with the provisions and requirements of the provider agreement.

e. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation if the extension is necessary to ensure the orderly transfer of residents.

f. When the department of inspections and appeals survey indicates deficiencies in the areas of the Life Safety Code (LSC) or environment and sanitation, a timetable detailing corrective measures shall be submitted to the department of inspections and appeals before a provider agreement can be issued. This timetable shall not exceed two years from the date of initial certification and shall detail corrective steps to be taken and when corrections will be accomplished. The following shall apply in these instances.

(1) The department of inspections and appeals shall determine that the facility can make corrections within the two-year period.

(2) During the period allowed for corrections, the facility shall be in compliance with existing state fire safety and sanitation codes and regulations.

(3) The facility shall be surveyed at least semiannually until corrections are completed. The facility must have made substantial effort and progress in its plan of correction as evidenced by work orders, contracts, or other evidence.

82.3(3) Appeals of decertification. A facility may appeal a decertification action according to 441—subrule 81.13(28).

This rule is intended to implement Iowa Code section 249A.12.
[ARC 0582C, IAB 2/6/13, effective 4/1/13]

441—82.4 Rescinded, effective March 1, 1987.

441—82.5(249A) Financial and statistical report. All facilities wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the department. These reports shall be based on the following rules.

82.5(1) Failure to maintain records. Failure to maintain and submit adequate accounting or statistical records shall result in termination or suspension of participation in the program.

82.5(2) Accounting procedures. Financial information shall be based on that appearing in the audited financial statement. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases. Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. The schedule shall be required when necessary for a fair presentation of expense attributable to intermediate care facility patients.

82.5(3) *Submission of reports.* The facility's cost report shall be received by the Iowa Medicaid enterprise provider cost audit and rate setting unit no later than September 30 each year except as described in subrule 82.5(14).

a. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the Iowa Medicaid enterprise provider cost audit and rate setting unit to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 82.5(3) "c."

b. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report.

c. Failure to timely submit the complete report shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective October 1 and shall remain in effect until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

(2) The reduced rate 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 Iowa Medicaid enterprise provider cost audit and rate setting unit.

d. Amended reports. The department, in its sole discretion, may 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 submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem payment rate following a review of a financial and statistical report.

e. When an intermediate care facility for persons with an intellectual disability continues to include in the total costs an item or items which had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the facility may include the cost, but must include sufficient detail so the Iowa Medicaid enterprise provider cost audit and rate setting unit can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

f. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

82.5(4) *Payment at new rate.* When a new rate is established, payment at the new rate shall be effective with services rendered as of the first day of the month in which the report is postmarked, or if the report was personally delivered, the first day of the month in which the report was received by the department. Adjustments shall be included in the payment the third month after the receipt of the report.

82.5(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Expenses which pertain to an entire year shall be properly amortized by month in order to be properly recorded for the annual fiscal year report. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

82.5(6) *Census of Medicaid members.* Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

82.5(7) Patient days. In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

82.5(8) Opinion of accountant. The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

82.5(9) Calculating patient days. When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient status at midnight each day. A patient whose status changes from one class to another shall be shown as discharged from the previous status and admitted to the new status on the same day.

b. When a member is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

82.5(10) Revenues. Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services are those services which include room, board, nursing services, and such services as supervision, feeding, incontinency, and similar services, for which the associated costs are in nursing service.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private-pay residents of items or services which are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

82.5(11) Limitation of expenses. Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs. These taxes are considered in computing the fee for services for proprietary institutions.

b. Fees paid directors and nonworking officer's salaries are not allowed as reimbursable costs.

c. Personal travel and entertainment are not allowed as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal shall be prorated. Amounts that appear excessive may be limited after considering the specific circumstances. Records shall be maintained to substantiate the indicated charges.

d. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

e. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility,

consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including, but not limited to, salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include, but are not limited to, costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the Iowa Medicaid enterprise provider cost audit and rate setting unit. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the Iowa Medicaid enterprise provider cost audit and rate setting unit with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 82.5(3) "c."

(2) Reasonableness—requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary—requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) The base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$1,926 per month plus \$20.53 per month per licensed bed capacity for each bed over 60, not to exceed \$2,852 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On a semiannual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by the inflation factor applied to facility rates.

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership as are maintained for any employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for employees as set forth in subparagraphs 82.5(11) "e"(4) to 82.5(11) "e"(6) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the intermediate care facility for persons with an intellectual disability for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. If an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the facility. In no case shall the amount of salary for one employee allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

f. Management fees and home office costs shall be allowed only to the extent that they are related to patient care and replace or enhance but do not duplicate functions otherwise carried out in a facility.

g. Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide, may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made. For change of ownership, refer to subrule 82.5(12).

h. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) "Necessary" requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) "Proper" requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

i. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

j. A facility entering into a new or renewed rent or lease agreement on or after June 1, 1994, shall be subject to the provisions of this paragraph.

When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be the lesser of the actual rent payments made under the terms of the lease or an annual reasonable rate of return applied to the cost of the facility. The cost of the facility shall be determined as the historical cost of the facility in the hands of the owner when the facility first

entered the Iowa Medicaid program. Where the facility has previously participated in the program, the cost of the facility shall be determined as the historical cost of the facility, as above, less accumulated depreciation claimed for cost reimbursement under the program. The annual reasonable rate of return shall be defined as one and one-half times the annualized interest rate of 30-year Treasury bonds as reported by the Federal Reserve Board on a weekly-average basis, at the date the lease was entered into.

When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be limited to the lesser of the actual rent payments made under the terms of the lease or the amount of property costs that would otherwise have been allowable under the Iowa Medicaid program to an owner-provider of that facility.

The lessee shall submit a copy of the lease agreement, documentation of the cost basis used and a schedule demonstrating that the limitations have been met with the first cost report filed for which lease costs are claimed.

k. Each facility which supplies transportation services as defined in Iowa Code section 324A.1, subsection 1, shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910 at the time of annual contract renewal. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation, public transit division, shall result in disallowance of vehicle costs and other costs associated with transporting residents.

l. Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

m. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are not allowable expenses:

- (1) Any fees or portion of fees used or designated for lobbying.
- (2) Nonrefundable and unused retainers.
- (3) Fees paid by the facility for the benefit of employees.

(4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. EXCEPTION: Facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the following conditions are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,
2. The costs are reasonable expenditures for the services obtained,
3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and
4. The facility prevails on the disputed issue.

n. Penalties or fines imposed by federal or state agencies are not allowable expenses.

o. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

82.5(12) Termination or change of owner.

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association, in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing home is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of the property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next semiannual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities which have changed or will change ownership shall continue at the rate allowed the previous owner.

82.5(13) Assessed fee. The fee assessed pursuant to 441—Chapter 36 shall not be an allowable cost for cost reporting and audit purposes. In lieu of treating the fee as an allowable cost, a per diem assessment amount is added to the reimbursement rate calculated under subrule 82.5(14), not subject to the maximum allowable base cost or maximum rate set at the eightieth percentile. The per diem assessment amount will be calculated by dividing the annual assessment paid by the reported total patient days.

82.5(14) Payment to new facility. A facility receiving Medicaid ICF/ID certification on or after July 1, 1992, shall be subject to the provisions of this subrule.

a. A facility receiving initial Medicaid certification for ICF/ID level of care shall submit a budget for six months of operation beginning with the month in which Medicaid certification is given. The budget shall be submitted at least 30 days in advance of the anticipated certification date. The Medicaid per diem rate for a new facility shall be based on the submitted budget subject to review by the accounting firm under contract with the department. The rate shall be subject to a maximum set at the eightieth percentile of all participating community-based Iowa ICFs/ID with established base rates. The eightieth percentile maximum rate shall be adjusted July 1 of each year. The state hospital schools shall not be included in the compilation of facility costs. The beginning rates for a new facility shall be effective with the date of Medicaid certification.

b. Initial cost report. Following six months of operation as a Medicaid-certified ICF/ID, the facility shall submit a report of actual costs. The rate computed from this cost report shall be adjusted

to 100 percent occupancy plus the annual percentage increase of the Consumer Price Index for all urban consumers, U.S. city average (hereafter referred to as the Consumer Price Index). For the period beginning July 1, 2009, and ending June 30, 2010, 3 percent shall be used to adjust costs for inflation, instead of the annual percentage increase of the Consumer Price Index. Business start-up and organization costs shall be accounted for in the manner prescribed by the Medicare and Medicaid standards. Any costs that are properly identifiable as start-up costs, organization costs or capitalizable as construction costs must be appropriately classified as such.

(1) Start-up costs. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, the costs must be capitalized as deferred charges and amortized over a five-year period.

Start-up costs include, for example, administrative and program staff salaries, heat, gas and electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, and housekeeping.

(2) Organization costs. Organization costs are those costs directly related to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and affect the costs of future periods of operation. Organization costs must be amortized over a five-year period.

1. Allowable organization costs. Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and bylaws, legal agreements, minutes of organization meetings, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to states for incorporation.

2. Unallowable organization costs. The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees; costs of qualifying the issues with the appropriate state or federal authorities; and stamp taxes.

c. Standardization of cost reporting period for new facilities.

(1) Facilities receiving initial certification between July 1 and December 31 (inclusive) shall submit three successive six-month cost reports covering their first 18 months of operation. The fourth six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

(2) Facilities receiving initial certification between January 1 and June 30 (inclusive) shall submit two successive six-month cost reports covering the first 12 months of operation. The third six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

(3) All facilities shall comply with the requirements of subrule 82.5(3) when submitting reports.

d. Completion of 12 months of operation. Following the first 12 months of operation as a Medicaid-certified ICF/ID as described in subrule 82.5(14), the facility shall submit a cost report for the second six months of operation. An on-site audit of facility costs shall be performed by the accounting firm under contract with the department. Based on the audited cost report, a rate shall be established for the facility. This rate shall be considered the base rate until rebasing of facility costs occurs.

(1) A new maximum allowable base cost will be calculated each year by increasing the prior year's maximum allowable base by the annual percentage increase of the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, the prior year's maximum allowable base cost shall be increased by 3 percent, instead of the annual percentage increase of the Consumer Price Index.

(2) Each year's maximum allowable base cost represents the maximum amount that can be reimbursed.

e. Maximum rate. Facilities shall be subject to a maximum rate set at the eightieth percentile of the total per diem cost of all participating community-based ICFs/MR with established base rates.

The eightieth percentile maximum rate shall be adjusted July 1 of each year using cost reports on file December 31 of the previous year.

f. Incentive factor. New facilities which complete the second annual period of operation that have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index, as described in 82.5(14)“*d*,” shall be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem cost for the annual period just completed is the incentive factor. For the period beginning July 1, 2009, and ending June 30, 2010, the incentive factor shall be calculated using 3 percent in place of the percentage increase of the Consumer Price Index.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the next annual period of operation.

(2) Facilities whose annual per unit cost decreased from the prior year shall be given their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment.

g. Reimbursement for first annual period. The reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year’s actual or the projected reimbursement per diem by the Consumer Price Index plus one. For the period beginning July 1, 2009, and ending June 30, 2010, the projected reimbursement will be determined using a multiplier of 3 percent instead of the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility shall receive as reimbursement in the following period the maximum allowable base as calculated.

(3) All calculated per diem rates shall be subject to the prevailing maximum rate.

82.5(15) *Payment to new owner.* An existing facility with a new owner shall continue with the previous owner’s per diem rate until a new financial and statistical report has been submitted and a new rate established according to subrule 82.5(16). The facility may submit a report for the period of July 1 to June 30 or may submit two cost reports within the fiscal year provided the second report covers a period of at least six months ending on the last day of the fiscal year. The facility shall notify the department of the reporting option selected.

82.5(16) *Payment to existing facilities.* The following reimbursement limits shall apply to all non-state-owned ICFs/MR:

a. Each facility shall file a cost report covering the period from January 1, 1992, to June 30, 1992. This cost report shall be used to establish a reimbursement rate to be paid to the facility and shall be used to establish the base allowable cost per unit to be used in future reimbursement rate calculations. Subsequent cost reports shall be filed annually by each facility covering the 12 months from July 1 to June 30.

b. The reimbursement rate established based on the report covering January 1, 1992, to June 30, 1992, shall be calculated using the method in place prior to July 1, 1992, including inflation and incentive factors.

c. The audited per unit cost from the January 1, 1992, to June 30, 1992, cost report shall become the initial allowable base cost. A new maximum allowable base cost will be calculated each year as described in 82.5(14)“*d*.”

d. Facilities which have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index or of less than 3 percent for rates effective July 1, 2009, through June 30, 2010, shall be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem costs for the annual period just completed is the incentive factor.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the following annual period.

(2) Facilities whose annual per unit cost decreased from the prior year shall receive their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment. For the period beginning July 1, 2009, and ending June 30, 2010, 3 percent shall be used in lieu of the percentage increase in the Consumer Price Index.

e. Administrative costs shall not exceed 18 percent of total facility costs. Administrative costs are comprised of those costs incurred in the general management and administrative functions of the facility. Administrative costs include, but are not necessarily limited to, the administrative portion of the following:

- (1) Administrator's salary.
- (2) Assistant administrator's salary.
- (3) Bookkeeper's salary.
- (4) Other accounting and bookkeeping costs.
- (5) Other clerical salaries and clerical costs.
- (6) Administrative payroll taxes.
- (7) Administrative unemployment taxes.
- (8) Administrative group insurance.
- (9) Administrative general liability and worker's compensation insurance.
- (10) Directors' and officers' insurance or salaries.
- (11) Management fees.
- (12) Indirect business expenses and other costs related to the management of the facility including home office and other organizational costs.
- (13) Legal and professional fees.
- (14) Dues, conferences and publications.
- (15) Postage and telephone.
- (16) Administrative office supplies and equipment, including depreciation, rent, repairs, and maintenance as documented by a supplemental schedule which identifies the portion of repairs and maintenance, depreciation, and rent which applies to office supplies and equipment.
- (17) Data processing and bank charges.
- (18) Advertising.
- (19) Travel, entertainment and vehicle expenses not directly involving residents.

f. Facility rates shall be rebased using the cost report for the year covering state fiscal year 1996 and shall subsequently be rebased each four years. The department shall consider allowing special rate adjustments between rebasing cycles if:

- (1) An increase in the minimum wage occurs.
- (2) A change in federal regulations occurs which necessitates additional staff or expenditures for capital improvements, or a change in state or federal law occurs, or a court order with force of law mandates program changes which necessitate the addition of staff or other resources.
- (3) A decision is made by a facility to serve a significantly different client population or to otherwise make a dramatic change in program structure (documentation and verification will be required).
- (4) A facility increases or decreases licensed bed capacity by 20 percent or more.

g. Total patient days for purposes of the computation shall be inpatient days as determined in subrule 82.5(7) or 80 percent of the licensed capacity of the facility, whichever is greater. The reimbursement rate shall be determined by dividing total reported patient expenses by total patient days during the reporting period. This cost per day will be limited by an inflation increase which shall not exceed the percentage change in the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, the inflation increase shall be 3 percent, notwithstanding the percentage change in the Consumer Price Index.

h. State-owned ICFs/MR shall submit semiannual cost reports and shall receive semiannual rate adjustments based on actual costs of operation inflated by the percentage change in the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, costs of operation shall be inflated by 3 percent instead of the percentage change in the Consumer Price Index.

i. The projected reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index plus one. For the period beginning July 1, 2009, and ending June 30, 2010, the projected reimbursement will be determined using a multiplier of 3 percent instead of the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility shall receive as reimbursement in the following period the maximum allowable base as calculated.

This rule is intended to implement Iowa Code sections 249A.12 and 249A.16.

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10; ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 0995C, IAB 9/4/13, effective 11/1/13; ARC 2886C, IAB 1/4/17, effective 2/8/17]

441—82.6(249A) Eligibility for services.

82.6(1) *Interdisciplinary team.* The initial evaluation for admission shall be conducted by an interdisciplinary team. The team shall consist of a physician, a social worker, and other professionals. At least one member of the team shall be a qualified intellectual disability professional.

82.6(2) *Evaluation.* The evaluation shall include a comprehensive medical, social, and psychological evaluation. The comprehensive evaluation shall include:

a. Diagnoses, summaries of present medical, social and where appropriate, developmental findings, medical and social family history, mental and physical functional capacity, prognoses, range of service needs, and amounts of care required.

b. An evaluation of the resources available in the home, family, and community.

c. An explicit recommendation with respect to admission or in the case of persons who make application while in the facility, continued care in the facility. Where it is determined that intermediate care facility for persons with an intellectual disability services are required by an individual whose needs might be met through the use of alternative services which are currently unavailable, this fact shall be entered in the record, and plans shall be initiated for the active exploration of alternatives.

d. An individual plan for care shall include diagnosis, symptoms, complaints or complications indicating the need for admission, a description of the functional level of the resident; written objective; orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services, and special procedures designed to meet the objectives; and plans for continuing care, including provisions for review and necessary modifications of the plan, and discharge.

e. Written reports of the evaluation and the written individual plan of care shall be delivered to the facility and entered in the individual's record at the time of admission or, in the case of individuals already in the facility, immediately upon completion.

82.6(3) *Certification statement.* Eligible individuals may be admitted to an intermediate care facility for persons with an intellectual disability upon the certification of a physician that there is a necessity for care at the facility. For clients enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Eligibility shall continue as long as a valid need for the care exists.

82.6(4) Rescinded IAB 4/9/97, effective 6/1/97.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.7(249A) Initial approval for ICF/ID care.

82.7(1) *Referral through targeted case management.* Persons seeking ICF/ID placement shall be referred through targeted case management. The case management program shall:

a. Identify appropriate service alternatives;

b. Inform the person of the alternatives; and

c. Refer a person without appropriate alternatives to the department.

82.7(2) *Approval of placement by department.*

a. Within 30 days of receipt of a referral, the department shall:

- (1) Approve ICF/ID placement;
- (2) Offer a home- or community-based alternative; or
- (3) Refer the person back to the targeted case management program for further consideration of service needs.

b. Once ICF/ID placement is approved, including approval of ICF/ID level of care as described in subrule 82.7(3), the eligible person, or the person's representative, is free to seek placement in the facility of the person's or the person's representative's choice, subject to the provision of ICF/ID services through managed care pursuant to 441—Chapter 73.

82.7(3) *Approval of level of care.* Medicaid payment shall be made for ICF/ID care upon certification of need for this level of care by a licensed physician of medicine or osteopathy and approval by the Iowa Medicaid enterprise (IME) medical services unit.

82.7(4) *Appeal rights.* Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.12 as amended by 2012 Iowa Acts, Senate File 2336, section 58.

[**ARC 8207B**, IAB 10/7/09, effective 12/1/09; **ARC 8446B**, IAB 1/13/10, effective 2/17/10; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—82.8(249A) Determination of need for continued stay. For clients not enrolled with a managed care organization, certification of need for continued stay shall be made according to procedures established by the Iowa Medicaid enterprise (IME) medical services unit. For all clients enrolled with a managed care organization, the managed care organization shall review the Medicaid client's need for continued care in an ICF/ID at least annually. The managed care organization must submit documentation to the IME medical services unit for all reviews that indicate a change in the client's level of care. The IME medical services unit shall make a final determination for any reviews that indicate a change in the level of care.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 8207B**, IAB 10/7/09, effective 12/1/09; **ARC 8446B**, IAB 1/13/10, effective 2/17/10; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—82.9(249A) Arrangements with residents.

82.9(1) *Resident care agreement.* The ICF/ID Resident Care Agreement, Form 470-0374, shall be used as a three-party contract among the facility, the resident, and the department to spell out the duties, rights, and obligation of all parties.

82.9(2) *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any Medicaid payment is made. Medicaid will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

82.9(3) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department of inspections and appeals and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent, the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, itemized, dated receipt shall be required to be deposited in the resident's files.

d. The receipts for each resident shall be kept until canceled by auditors.

e. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department of inspections and appeals representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

f. Upon a member's death, a receipt shall be obtained from the next of kin or the member's guardian before releasing the balance of the personal needs funds. When the member has been receiving a grant from the department for all or part of the personal needs, any funds shall revert to the department. The department shall turn the funds over to the member's estate.

82.9(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that the resident is accorded privacy and uncensored communication with others by mail and telephone and with persons of the resident's choice except when therapeutic or security reasons dictate otherwise. Any limitations or restrictions imposed shall be approved by the administrator and the reasons noted shall be made a part of the resident's record.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10; ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.10(249A) Discharge and transfer.

82.10(1) *Notice.* When a Medicaid member requests transfer or discharge to a community setting, or another person requests this for the member, the administrator shall promptly notify a targeted case management provider. Names of local providers are available from the department's local office. This shall be done in sufficient time to permit a case manager to assist in the decision and planning for the transfer or discharge.

82.10(2) *Case activity report.* A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or member enters the facility, changes level of care, or is discharged from the facility.

82.10(3) *Plan.* The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

82.10(4) *Transfer records.* When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

a. A transfer form of diagnosis.

b. Aid to daily living information.

c. Transfer orders.

d. Nursing care plan.

e. Physician's or qualified intellectual disability professional's orders for care.

f. The resident's personal records.

g. When applicable, the personal needs fund record.

82.10(5) *Income refund.* When a resident leaves the facility during the month, any unused portion of the resident's income shall be refunded.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10; ARC 0582C, IAB 2/6/13, effective 4/1/13]

441—82.11(249A) Continued stay review. Rescinded **ARC 2361C**, IAB 1/6/16, effective 1/1/16.

441—82.12(249A) Quality of care review. Rescinded **ARC 2361C**, IAB 1/6/16, effective 1/1/16.

441—82.13(249A) Records.

82.13(1) Content. The facility shall as a minimum maintain the following records:

a. All records required by the department of public health and the department of inspections and appeals.

b. Medical records as required by Section 1902(a)(31) of Title XIX of the Social Security Act.

c. Records of all treatments, drugs and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

d. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.

e. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

f. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

g. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for residents in skilled, intermediate, and residential care.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.

h. Resident accounts.

i. Inservice education program records.

j. Inspection reports pertaining to conformity with federal, state, and local laws.

k. Residents' personal records.

l. Residents' medical records.

m. Disaster preparedness reports.

82.13(2) Retention. Records shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

82.13(3) Change of owner. All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code section 249A.12.

441—82.14(249A) Payment procedures.

82.14(1) Method of payment. Facilities shall be reimbursed under a cost-related vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—82.5(249A).

82.14(2) Payment responsibility. Rescinded IAB 7/11/12, effective 7/1/12.

82.14(3) Rescinded IAB 8/9/89, effective 10/1/89.

82.14(4) Periods authorized for payment.

a. Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in an intermediate care facility for persons with an intellectual disability.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent to visit home for a maximum of 30 days annually. Additional days may be approved for special programs of evaluation, treatment or habilitation outside the facility. Documentation as to the appropriateness and therapeutic value of resident visits and outside programming, signed by a physician or qualified intellectual disability professional, shall be maintained at the facility.

e. Payment will be approved for a period not to exceed ten days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for visitation or hospitalization from facilities with more than 15 beds will be made at 80 percent of the allowable audited costs for those beds. Facilities with 15 or fewer beds will be reimbursed at 95 percent of the allowable audited costs for those beds.

82.14(5) *Supplementation.* Only the amount of client participation may be billed to the resident for the cost of care. No supplementation of the state payment shall be made by any person.

EXCEPTION: The resident, the resident's family or friends may pay to hold the resident's bed in cases where a resident spends over 30 days on yearly visitation or spends over 10 days on a hospital stay. When the resident is not discharged from the facility, the payments shall not exceed 80 percent of the allowable audited costs for the facility, not to exceed the maximum reimbursement rate. When the resident is discharged, the facility may handle the holding of the reserved bed in the same manner as a private paying resident.

82.14(6) *Payment for out-of-state care.* Rescinded IAB 9/5/90, effective 11/1/90.

This rule is intended to implement Iowa Code section 249A.12 as amended by 2012 Iowa Acts, Senate File 2336, section 58.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0582C, IAB 2/6/13, effective 4/1/13]

441—82.15(249A) Billing procedures.

82.15(1) *Claims.* Claims for service for clients not enrolled with a managed care organization must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Such claims must be submitted electronically through IME's electronic clearinghouse.

a. A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system.

b. Adjustments to claims may be made electronically as provided for by the Iowa Medicaid enterprise.

82.15(2) Reserved.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.16(249A) Closing of facility. When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving Medicaid shall be approved by the resident's managed care organization or by the Iowa Medicaid enterprise for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.17(249A) Audits.

82.17(1) *Audits of financial and statistical report.* Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report, Form 470-0030, are reasonable and proper according to the rules set forth in 441—82.5(249A). These audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agents.

a. When a proper per diem rate cannot be determined, through generally accepted auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing fiscal period and if the situation is not remedied on the subsequent Financial and Statistical Report, Form 470-0030, the facility shall be suspended and eventually canceled from the intermediate care facility program, or

b. When a facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing fiscal period. The department may, after considering the seriousness of the exception, make the reduction.

82.17(2) *Auditing of proper billing and handling of patient funds.*

a. The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure that the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 82.9(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, such sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation which would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph "d" the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general's office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit which are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.18(249A) Out-of-state facilities. Payment will be made for care in out-of-state intermediate care facilities for persons with an intellectual disability. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

82.18(1) Out-of-state providers will be reimbursed at the same intermediate care facility rate they are receiving for their state of residence.

82.18(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).

82.18(3) Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at 80 percent of the rate paid to the facility by the Iowa Medicaid program. Out-of-state facilities with 15 or fewer beds shall be reimbursed at 95 percent of the rate paid to the facility by the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 0582C, IAB 2/6/13, effective 4/1/13]

441—82.19(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with an intellectual disability who has countable income for purposes of rule 441—75.16(249A) of less than \$50 per month shall receive a state-funded payment from the department for the difference between that countable income and \$50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code section 249A.30A.
 [ARC 0582C, IAB 2/6/13, effective 4/1/13]

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◊ Two or more ARCs

CHAPTER 87
FAMILY PLANNING PROGRAM

PREAMBLE

This chapter defines and structures the family planning program administered by the department pursuant to 2017 Iowa Acts, House File 653, section 90. The purpose of this program is to provide family planning services to individuals who are not enrolled in medical assistance under 441—Chapter 74 or 441—Chapter 75. The department is not receiving federal financial participation for expenditures under the family planning program. Therefore, this chapter shall remain in effect only as long as state funding is available.

The family planning program shall replicate the eligibility requirements and other provisions included in the Medicaid family planning network waiver, as approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services in effect on June 30, 2017, but shall provide for distribution of the family planning services program funds in accordance with this chapter.

Distribution of family planning program funds under this chapter shall be made in a manner that continues access to family planning services.

[ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17]

441—87.1(217) Definitions.

“*Applicant*” means a person who applies for assistance under the family planning program described in this chapter.

“*Authorized Title X agency*” means an agency or entity with an executed memorandum of understanding (MOU) with the Iowa department of human services authorizing the agency to perform point-of-service eligibility determinations for the family planning program.

“*Creditable qualifying quarters*” means all of the qualifying quarters of coverage as defined under Title II of the Social Security Act worked by a parent of an alien while the alien was under the age of 18, and qualifying quarters worked by a spouse of an alien during their marriage if the alien remains married to the spouse or was married to the spouse at the spouse’s death, except for quarters beginning after December 31, 1996, if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is credited.

“*Department*” means the Iowa department of human services.

“*Family planning services*” means pregnancy prevention and related reproductive health services.

[ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17]

441—87.2(217) Eligibility. Eligibility for the family planning program shall be determined according to the provisions of this rule.

87.2(1) Persons covered. Subject to funding as described in subrule 87.7(1) and to the requirements of subrules 87.2(2), 87.2(4), and 87.2(6), assistance for family planning services shall be available to the following individuals who are not enrolled in medical assistance pursuant to 441—Chapter 74 or 441—Chapter 75:

a. Women who were enrolled in medical assistance when their pregnancy ended and who are capable of bearing children but are not pregnant. Eligibility for these women extends for 12 consecutive months after the month when their 60-day postpartum period ends;

b. Women who are under the age of 55, who are capable of bearing children but are not pregnant, and who have household income that does not exceed 300 percent of the federal poverty level as determined pursuant to subrule 87.2(3);

c. Men who are under the age of 55, who are capable of fathering children, and who have household income that does not exceed 300 percent of the federal poverty level as determined pursuant to subrule 87.2(3).

87.2(2) *Furnishing of social security number.* As a condition of eligibility, except as provided by paragraph 87.2(2)“a,” all social security numbers issued to each individual (including children) for whom family planning services are sought must be furnished to the department.

a. The requirement of furnishing a social security number does not apply to an individual who:

- (1) Is not eligible to receive a social security number;
- (2) Does not have a social security number and may only be issued a social security number for a valid nonwork reason in accordance with 20 CFR § 422.104; or
- (3) Refuses to obtain a social security number because of a well-established religious objection.

For this purpose, a well-established religious objection means that the individual:

1. Is a member of a recognized religious sect or division of a sect; and
2. Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

b. If a required social security number has not been issued or is not known, the individual seeking coverage under the family planning program must apply for a social security number with the Social Security Administration or request the Social Security Administration to furnish the number.

87.2(3) *Determination of household income.* The department shall determine the countable household income of an individual applying under paragraph 87.2(1)“b” or “c” as follows:

a. Household composition. The household shall include the applicant or member, any dependent children, as defined below, living in the same home as the applicant or member, and any spouse living in the same home as the applicant or member, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act.

(1) *Definition of dependent children.* A dependent child is one under the age of 18 years or aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19.

(2) Reserved.

b. Earned income. All earned income that is received by a member of the household shall be counted except for earnings of a child who is a full-time student as defined in subparagraph 87.2(3)“a”(1). The following earned income, including but not limited to, shall be counted:

- (1) Salary.
- (2) Wages.
- (3) Tips.
- (4) Bonuses.
- (5) Commissions.
- (6) Income from Job Corps.
- (7) Earnings from self-employment defined as gross income less the allowable costs of producing the income.

c. Unearned income. The following unearned income of all household members shall be counted:

- (1) Unemployment insurance benefits.
- (2) Child support.
- (3) Alimony.
- (4) Social security and railroad retirement benefits.
- (5) Workers’ compensation and disability payments.
- (6) Benefits paid by the U.S. Department of Veterans Affairs to disabled members of the armed forces or survivors of deceased veterans.

d. Deemed income. Income deeming for a sponsored alien shall be determined pursuant to subrule 87.2(5).

e. Deductions. Deductions from income shall be made for any payments made by household members for the following:

- (1) Court-ordered child support, alimony, or spousal support paid to non-household members.
- (2) Twenty percent of nonexempt earnings.

(3) Child care expenses or expenses related to care for an incapacitated adult. This deduction shall not exceed \$200 per month for each child under the age of two and \$175 per month for each adult or child aged two or older.

87.2(4) Citizenship or alienage requirements.

a. To be eligible for the family planning program, a person must be one of the following:

- (1) A citizen or national of the United States.
- (2) A qualified alien residing in the United States before August 22, 1996.
- (3) A qualified alien under the age of 21.
- (4) A refugee admitted to the United States under Section 207 of the Immigration and Nationality Act (INA).
- (5) An alien who has been granted asylum under Section 208 of the INA.
- (6) An alien whose deportation is withheld under Section 243(h) or 241(b)(3) of the INA.
- (7) A qualified alien veteran who has an honorable discharge that is not due to alienage.
- (8) A qualified alien who is on active duty in the armed forces of the United States other than active duty for training.
- (9) A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in subparagraph 87.2(4) "a"(7) or 87.2(4) "a"(8), including a surviving spouse who has not remarried.
- (10) A qualified alien who has resided in the United States for a period of at least five years.
- (11) An Amerasian admitted as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V).
- (12) A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7).
- (13) A certified victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.

(14) An American Indian born in Canada to whom Section 289 of the INA applies or who is a member of a federally recognized Indian tribe as defined in 25 U.S.C. Section 450b(e).

(15) An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to December 20, 2010, or to Section 602(b)(8) of Public Law 111-8 as amended to December 20, 2010.

b. As a condition of eligibility, all applicants for the family planning program shall attest to their citizenship or alien status by signing the application form.

c. Except as provided in paragraph 87.2(4) "f," applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph 87.2(4) "b" shall present satisfactory documentation of citizenship or nationality as defined in paragraph 87.2(4) "d," "e," or "i." A reference to a form in paragraph 87.2(4) "d" or "e" includes any successor form. An applicant or member shall have a reasonable period to obtain and provide required documentation of citizenship or nationality.

(1) For the purposes of this requirement, the "reasonable period" begins on the date a written request for documentation or a notice pursuant to subparagraph 87.2(4) "i"(2) is issued to an applicant or member, whichever is later, and continues for 90 days.

(2) Family planning services shall be approved for new applicants and continue for members not previously required to provide documentation of citizenship or nationality until the end of the reasonable period to obtain and provide required documentation of citizenship or nationality. However, the receipt of family planning services pending documentation of citizenship or nationality is limited to one reasonable period of up to 90 days for each individual. An applicant or member who has already received benefits during any portion of a reasonable period shall not be granted coverage for a second reasonable period.

d. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

- (1) A United States passport.
- (2) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.
- (3) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.
- (4) A valid state-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the INA, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or
2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Documentation issued by a federally recognized Indian tribe showing membership or enrollment in or affiliation with that tribe.

(6) Another document that provides proof of United States citizenship or nationality and provides a reliable means of documentation of personal identity, as the Secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v).

e. Satisfactory documentation of citizenship or nationality may also be demonstrated by the combination of:

(1) Any identity document described in Section 274A(b)(1)(D) of the INA or any other documentation of personal identity that provides a reliable means of identification, as the Secretary of the U.S. Department of Health and Human Services finds by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(D)(ii); and

(2) Any one of the following:

1. A certificate of birth in the United States.
2. Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.
3. Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.
4. Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.
5. Another document that provides proof of United States citizenship or nationality, as the Secretary of the U.S. Department of Health and Human Services may specify pursuant to 42 U.S.C. Section 1396b(x)(3)(C)(v).

f. A person for whom an attestation of United States citizenship has been made pursuant to paragraph 87.2(4)“*b*” is not required to present documentation of citizenship or nationality for the family planning program if any of the following circumstances apply:

(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the federal Social Security Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the federal Social Security Act, Section 202 or 223, based on disability (as defined in Section 223(d)).

(3) The person is receiving supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act.

(4) The person is a child in foster care who is assisted by child welfare services funded under Part B of Title IV of the federal Social Security Act.

(5) The person is receiving foster care maintenance or adoption assistance payments funded under Part E of Title IV of the federal Social Security Act.

(6) The person has previously presented satisfactory documentary evidence of citizenship or nationality, as specified by the Secretary of the U.S. Department of Health and Human Services.

(7) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1396a(e)(4) as the newborn of a Medicaid-eligible mother.

(8) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1397ll(e) as the newborn of a mother eligible for assistance under a state children’s health insurance program (SCHIP) pursuant to Title XXI of the Social Security Act.

g. If no other identity documentation allowed by subparagraph 87.2(4)“*e*”(1) is available, identity may be documented by affidavit as described in this paragraph. However, affidavits cannot be used to document both identity and citizenship.

(1) For children under the age of 16, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by the child’s parent, guardian, or caretaker relative under penalty of perjury.

(2) For disabled persons who live in a residential care facility, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by a residential care facility director or administrator under penalty of perjury.

h. If no other documentation that provides proof of United States citizenship or nationality allowed by subparagraph 87.2(4) “*e*”(2) is available, United States citizenship or nationality may be documented using Form 470-4373 or 470-4373(S), Affidavit of Citizenship. However, affidavits cannot be used to document both identity and citizenship.

(1) Two affidavits of citizenship are required. The person who signs the affidavit must provide proof of citizenship and identity. A person who is not related to the applicant or member must sign at least one of the affidavits.

(2) When affidavits of citizenship are used, Form 470-4374 or 470-4374(S), Affidavit Concerning Documentation of Citizenship, or an equivalent affidavit explaining why other evidence of citizenship does not exist or cannot be obtained must also be submitted and must be signed by the applicant or member or by another knowledgeable person (guardian or representative).

i. In lieu of a document listed in paragraph 87.2(4) “*d*” or “*e*,” satisfactory documentation of citizenship or nationality may also be presented pursuant to this paragraph.

(1) Provision of an individual’s name, social security number, and date of birth to the department shall constitute satisfactory documentation of citizenship and identity if submission of the name, social security number, and date of birth to the Social Security Administration produces a response that substantiates the individual’s citizenship.

(2) If submission of the name, social security number, and date of birth to the Social Security Administration does not produce a response that substantiates the individual’s citizenship, the department shall issue a written notice to the applicant or member giving the applicant or member 90 days to correct any errors in the name, social security number, or date of birth submitted, to correct any errors in the Social Security Administration’s records, or to provide other documentation of citizenship or nationality pursuant to paragraph 87.2(4) “*d*” or “*e*.”

87.2(5) *Deeming of alien sponsor’s income.*

a. When an alien admitted for lawful permanent residence is sponsored by a person who executed an affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the income of the alien shall be deemed to include the income of the sponsor (and of the sponsor’s spouse if living with the sponsor). The amount deemed to the sponsored alien shall be the total countable income of the sponsor and the sponsor’s spouse, determined pursuant to paragraphs 87.2(3) “*b*” through “*d*.”

b. An indigent alien is exempt from the deeming of a sponsor’s income for 12 months after indigence is determined. An alien shall be considered indigent if:

- (1) The alien does not live with the sponsor; and
- (2) The alien’s gross income, including any income actually received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien’s household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor’s income for 12 months.

d. Deeming of the sponsor’s income does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title II of the INA.

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 creditable qualifying quarters as defined in rule 441—87.1(217).

(3) The sponsored alien or the sponsor dies.

(4) The sponsored alien is a child under the age of 21.

87.2(6) *Residency requirements.* Residency in Iowa is a condition of eligibility for the family planning services program.

a. Definition of resident. A resident of Iowa is one:

(1) Who is living in Iowa voluntarily with the intention of making that person’s home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis.

Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

(2) Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition, the child is a resident of the state in which the parent or caretaker is a resident.

b. Retention of residence. Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

87.2(7) *Investigation by quality control or the department of inspections and appeals.* As a condition of eligibility, an applicant or member shall cooperate with the department when the applicant's or member's case is selected by quality control or the department of inspections and appeals for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect family planning program eligibility. (See department of inspections and appeals rules in 481—Chapter 72.) Failure to cooperate shall serve as a basis for denial of an application or cancellation of family planning program eligibility. Once a person's eligibility is denied or canceled for failure to cooperate, the person may reapply but shall not be determined eligible until cooperation occurs.

87.2(8) *Funding contingency.* Initial and continuing eligibility for family planning services under this program is subject to the availability of funding appropriated for this purpose.

a. When appropriated funding is exhausted, ongoing eligibility shall be terminated and new applications shall be denied.

b. When appropriated funding becomes available, applications submitted thereafter will be considered on a first-come, first-served basis, based on the date of approval.

[ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17]

441—87.3(217) Enrollment.

87.3(1) *Application.* An individual who requests assistance for family planning services shall file an application Form 470-5485, Family Planning Program Application. A woman eligible under paragraph 87.2(1) "a" is not required to file an application for assistance under this program. The department will automatically redetermine eligibility upon loss of other Medicaid eligibility within 12 months after the month when the 60-day postpartum period ends.

87.3(2) *Place of filing.* An application may be filed at any department office or authorized Title X family planning agency.

87.3(3) *Information or verification needed to determine eligibility.* The department shall notify the applicant, authorized representative, or responsible person in writing of the information or verification required to establish eligibility. This notice shall be provided to the applicant, authorized representative, or responsible person personally or by mail or fax.

a. The department shall allow the applicant, authorized representative, or responsible person ten calendar days to supply the information or verification requested.

b. The department may extend the deadline for a reasonable period of time when the applicant, authorized representative, or responsible person is making reasonable efforts but is unable to secure the required information or verification.

c. If benefits are denied for failure to provide information or verification and the information or verification is provided within 14 calendar days of the effective date of the denial, the department shall complete the eligibility determination as though the information or verification were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant, authorized representative, or responsible person shall have until the next business day to provide the information.

87.3(4) *Annual review.* An individual who requests that assistance continue for family planning services shall complete Form 470-4071, Family Planning Program Review. The member must submit the completed review form before the end of the eligibility period to any location specified in subrule 87.3(2).

87.3(5) *Time limit for decision.* An application or review form shall be processed by the family planning agency with which the application was filed. A determination of eligibility shall be made within 45 days of receipt of the application or review form.

87.3(6) *Notice of decision.* The individual shall be notified in writing of the decision regarding eligibility for the family planning program.

[ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17]

441—87.4(217) *Effective date of eligibility.* Subject to the availability of funding appropriated for this purpose, assistance for family planning services under this program shall be effective on the first day of the month of application or the first day of the month in which all eligibility requirements are met, whichever is later. Assistance shall not be available under this program for any months prior to the month of application.

[ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17]

441—87.5(217) *Period of eligibility.* Eligibility for family planning services under this program shall be limited to a period of 12 months from the effective date of eligibility, or the duration of appropriated funding, whichever is less. A new application or annual redetermination of eligibility shall be required for benefits to continue beyond 12 months.

[ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17]

441—87.6(217) *Reporting changes.*

87.6(1) *Required changes to report.* An individual applying for or receiving family planning services under this program shall report the following changes within ten days from the date the change is known:

- a. Change in mailing address;
- b. No longer a resident of Iowa;
- c. A woman becomes pregnant;
- d. No longer capable of bearing or fathering children;
- e. Becomes Medicaid eligible, except women meeting criteria in paragraph 87.2(1)“a”; or
- f. Turns 55 years of age.

87.6(2) *Disregard of changes.* An individual found to be eligible upon application or annual redetermination of eligibility shall remain eligible for 12 months or the duration of appropriated funding, whichever is less, regardless of any change in income or household size.

[ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17]

441—87.7(217) *Funding of family planning services program.*

87.7(1) *Distribution of funds.* Distribution of family planning services program funds shall be made to eligible, approved, and participating family planning providers subject to rule 441—87.11(217). Eligible family planning providers shall not include any provider that performs abortions or that maintains or operates a facility where abortions are performed and must attest to this fact. Effective July 1, 2018, eligible family planning providers shall be interpreted to include a distinct location of a nonprofit health care delivery system, if the distinct location provides family planning services but does not perform abortions or maintain or operate as a facility where abortions are performed. For the purposes of this subrule, “nonprofit health care delivery system” means an Iowa nonprofit corporation that controls, directly or indirectly, a regional health care network consisting of hospital facilities and various ambulatory and clinic locations that provide a range of primary, secondary, and tertiary inpatient, outpatient, and physician services. For the purposes of this subrule, “abortion” does not include any of the following:

a. The treatment of a woman for a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death.

b. The treatment of a woman for a spontaneous abortion, commonly known as a miscarriage, when not all of the products of human conception are expelled.

87.7(2) Recovery. The department shall recover from a member all funds incorrectly expended to or on behalf of the member for family planning program services.

[ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17; ARC 4069C, IAB 10/10/18, effective 11/14/18]

441—87.8(217) Availability of services. Family planning services are payable for an individual enrolled in this program only when care is received at or authorized by a participating family planning provider.

87.8(1) Sterilization is a covered service subject to the limitations in 441—paragraphs 78.1(16) “a” through “i.”

87.8(2) Covered services shall not include abortion services.

[ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17]

441—87.9(217) Payment of covered services. Payment for family planning services covered under this chapter, including services authorized but not provided by a participating family planning provider, shall be made only to participating family planning providers on a fee schedule determined by the department. Family planning services program funds distributed in accordance with this rule shall not be used for direct or indirect costs, including but not limited to administrative costs or expenses, overhead, employee salaries, rent, and telephone and other utility costs, related to providing abortions as specified in subrule 87.7(1).

87.9(1) Fee schedule. The fee schedule shall include the amount of payment for each service and any limits on the service (e.g., a routine Pap smear is payable once annually).

87.9(2) Third-party payments. This program is the payer of last resort for services covered in this chapter. Any third-party payment received by the family planning agency or other provider of services plus any payments under this program cannot exceed the fee schedule allowance.

87.9(3) Supplementation. Payment made under this program shall be considered payment in full.

[ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17]

441—87.10(217) Submission of claims.

87.10(1) Family planning providers that participate in the program shall submit claims to the Iowa Medicaid enterprise for services rendered no later than 45 days from the last day of the month in which services were provided.

87.10(2) Following a successful review of the claim, the Iowa Medicaid enterprise shall make payments to the family planning provider subject to the availability of funding and the allocation of available funds under subrule 87.7(1).

[ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17]

441—87.11(217) Providers eligible to participate.

87.11(1) Providers must be enrolled with the Iowa Medicaid program, subject to rule 441—79.14(249A), and otherwise qualified to provide family planning services under Medicaid, subject to the limitations related to abortions, as specified above under subrule 87.7(1). Effective July 1, 2018, as a condition of eligibility as a provider under the family planning services program, each distinct location of a nonprofit health care delivery system shall enroll in the program as a separate provider, be assigned a distinct provider identification number, and complete an attestation that abortions are not performed at the distinct location. For the purposes of this subrule, “nonprofit health care delivery system” shall have the same meaning as provided under subrule 87.7(1).

87.11(2) Process for enrollment. Providers wishing to enroll under the state family planning program must complete the following steps:

a. Must complete enrollment with Iowa Medicaid enterprise.

b. Must complete Form 470-5484, Family Planning Program Provider Attestation, regarding nonprovision of abortions, pursuant to requirements referenced above under subrule 87.7(1).

c. Forms referenced in this subrule must be sent to Iowa Medicaid Enterprise, Provider Enrollment Unit, P.O. Box 36450, Des Moines, Iowa 50315.

[ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17; ARC 4069C, IAB 10/10/18, effective 11/14/18]

These rules are intended to implement Iowa Code section 217.41B as amended by 2018 Iowa Acts, Senate File 2418, section 83.

[Filed Emergency ARC 3199C, IAB 7/19/17, effective 7/1/17]

[Filed ARC 3389C (Notice ARC 3198C, IAB 7/19/17), IAB 10/11/17, effective 11/15/17]

[Filed ARC 4069C (Notice ARC 3910C, IAB 8/1/18), IAB 10/10/18, effective 11/14/18]

CHAPTER 51
HOSPITALS

[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.

“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.

“*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.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

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 main premises of the hospital.

51.2(5) The department shall recognize, in lieu of its own licensure inspection, the comparable inspections and inspection findings of The Joint Commission (TJC), the American Osteopathic Association (AOA), DNV GL – Healthcare (DNV GL), 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 TJC, AOA, DNV GL, or CIHQ are insufficient to address concerns identified as possible licensure issues.

51.2(6) Hospitals not accredited by TJC, AOA, DNV GL, 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. 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; ARC 2472C, IAB 3/30/16, effective 5/4/16]

481—51.3(135B) Quality improvement program.

51.3(1) 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:

- a. Assessing clinical patient care;
- b. Assessing nonclinical and patient-related services within the hospital;
- c. Developing remedial action as needed; and
- d. Ongoing monitoring and evaluating of the progress of remedial action taken.

51.3(2) The governing body shall ensure there is an effective hospitalwide patient-oriented quality improvement program.

51.3(3) 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(4) The quality improvement plan may include external, state, local, federal, and regional benchmarking activities designed to improve the quality of patient care. The quality improvement plan shall be written and may address the following:

- a. The program's objectives, organization, scope, and mechanisms for overseeing the effectiveness of monitoring, evaluation, and problem-solving activities;
- b. The participation from all departments, services (including services provided both directly and under contract), and disciplines;
- c. An assessment of participation through a quality improvement committee meeting on an established periodic basis;
- d. The coordination of quality improvement activities;
- e. The 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. An annual evaluation by the governing board of the effectiveness of the quality improvement program; and
- g. The 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.
[ARC 2472C, IAB 3/30/16, effective 5/4/16]

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, advanced registered nurse practitioners or pharmacists licensed under Iowa Code chapter 147, 148, 148C, 149, 152, 153, or 155 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 health care education or postgraduate training if the health care education 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.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

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 (TJC), the American Osteopathic Association (AOA), DNV GL – Healthcare (DNV GL), 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 age, race, creed, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression, 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; ARC 2472C, IAB 3/30/16, effective 5/4/16]

481—51.7(135B) Abuse.

51.7(1) Definitions.

"Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain or mental anguish. Neglect is a form of abuse and is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

"Child abuse" means the same as provided for in Iowa Code section 232.68.

"Dependent adult abuse" means the same as provided for in Iowa Code section 235E.1.

"Domestic abuse," as defined in Iowa Code section 236.2, means the commission of assault under any of the following circumstances:

1. The assault is between family or household members who resided together at the time of the assault;
2. The assault is between separated spouses or persons divorced from each other and not residing together at the time of the assault;
3. The assault is between persons who are parents of the same minor child, regardless of whether they have been married or have lived together at any time; or
4. The assault is between persons who have been family or household members residing together within the past year and are not residing together at the time of the assault.

"Elder abuse" means the same as provided for in Iowa Code section 235F.1.

"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 all forms of abuse or harassment.

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) Hospital response to 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) Hospital response to elder abuse. Each hospital shall establish and implement protocols with respect to victims of elder 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; and

(3) Education of appropriate emergency department staff to assist in the identification of victims of elder abuse.

b. The treatment records of victims of elder 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) A record of the treatment and intervention by health care provider personnel;

(3) 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

(4) The victim's statement of how the injury occurred.

51.7(5) Mandatory reporting of 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.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

481—51.8(135B) Organ, tissue and eye procurement. Each hospital licensed in accordance with Iowa Code chapter 135B shall have in place written policies and protocols for organ, tissue and eye donation. Hospitals shall be familiar with the revised uniform anatomical gift Act, Iowa Code chapter 142C, and shall develop policies and protocols for consent to organ, tissue and eye donation by either the patient or an appropriate person to consent on the patient's behalf consistent with that Act's provisions. Hospitals shall ensure that the specific organ, tissue and eye procurement requirements are met, as provided in 42 CFR 482.45 or 42 CFR 485.643.

This rule is intended to implement Iowa Code section 135B.7.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

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 nurses shall utilize the nursing process in the practice of nursing, consistent with accepted and prevailing practice. The nursing process is ongoing and includes:

a. Nursing assessments about the health status of an individual or group.

b. Formulation of a nursing diagnosis based on analysis of the data from the nursing assessment.

c. Planning of nursing care, which includes determining goals and priorities for actions that are based on the nursing diagnosis.

d. Nursing interventions implementing the plan of care.

e. Evaluation of the individual's or group's 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 hold an active Iowa license or hold an active license in another state and be recognized for licensure in this state pursuant to the nurse licensure compact in Iowa Code section 152E.1.

51.9(5) There shall be a director of nursing service with administrative and executive competency who shall hold an active Iowa license or hold an active license in another state and be recognized for licensure in this state pursuant to the nurse licensure compact in Iowa Code section 152E.1.

51.9(6) Nursing management shall have had preparation courses and experience in accordance with hospital policy commensurate with the responsibility of the specific assignment.

51.9(7) All unlicensed personnel performing patient-care service shall be under the supervision of a registered nurse. The duties of unlicensed personnel shall be defined in writing by the hospital, and unlicensed personnel 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.
[ARC 2472C, IAB 3/30/16, effective 5/4/16]

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 maintained for all patients and signed by the appropriate provider. These records shall be filed and stored in an accessible manner 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) Electronic records. In addition to the access provided in 481—subrule 50.10(2), an authorized representative of the department shall be provided unrestricted access to electronic records pertaining to the care provided to the patients of the hospital.

a. If access to an electronic record is requested by the authorized representative of the department, the hospital may provide a tutorial on how to use its particular electronic system or may designate an individual who will, when requested, access the system, respond to any questions or assist the authorized representative as needed in accessing electronic information in a timely fashion.

b. The hospital shall provide a terminal where the authorized representative may access records.

c. If the hospital is unable to provide direct print capability to the authorized representative, the hospital shall make available a printout of any record or part of a record on request in a time frame that does not intentionally prevent or interfere with the department's survey or investigation.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

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 rules in 657—Chapters 7, 8, 9, 10, 11, 20, 21, 22 and 40.

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 by signature or other secure electronic method by the prescribing practitioner within a period not to exceed 30 days following a patient's discharge.

When verbal 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 clinical situations 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 medical staff and the hospital's nursing and pharmacy leadership 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, authorized by signature or other secure electronic method 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.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

481—51.15(135B) Orders other than medication. All verbal orders must be authenticated by the ordering practitioner within a period not to exceed 30 days following a patient's discharge. When verbal or electronic mechanisms are used to transmit orders, the orders must be accepted only by personnel who are authorized to accept them by hospital policies and procedures in a manner consistent with federal and state law.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

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 Food Code 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.

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 ordered by the qualified health care practitioner, including a registered, licensed dietitian, and shall be planned, prepared, and served with supervision or consultation from the registered, licensed dietitian. Persons responsible for therapeutic diets shall have sufficient knowledge of food to make appropriate substitutions when necessary.

f. The patient’s likes, dislikes, food allergies, and other pertinent information shall be included with the patient’s diet information.

g. Menus.

(1) Menus for regular and therapeutic diets shall be nutritionally appropriate, meet the needs of patients, and be available.

(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; ARC 2472C, IAB 3/30/16, effective 5/4/16]

481—51.21 Reserved.

481—51.22(135B) Equipment for patient care. Hospital equipment shall be selected, maintained and utilized in accordance with the manufacturer's specifications and the needs of the patients.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

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 current rules for the control of communicable disease as provided by the Iowa department of public health and current Centers for Disease Control and Prevention (CDC) guidelines for isolation precautions.

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 staff, providing for proper isolation technique in order to prevent cross-infection.

51.24(2) Visitors. The hospital shall establish proper policies and procedures for the control of visitors to all services in the hospital.

51.24(3) Health assessments. Health assessments for all contracted or employed personnel who provide direct services shall be required at the commencement of employment and thereafter at least every four years.

a. “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 the 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.

b. The health assessment may be performed by the person’s primary care provider.

c. The health assessment shall include, at a minimum, vital signs and an assessment for infectious or communicable diseases.

d. 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; ARC 2472C, IAB 3/30/16, effective 5/4/16]

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.

a. 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:

(1) Surgical services under the direction of a qualified doctor of medicine or osteopathy.

(2) 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.

(3) Immediate availability of at least one registered nurse for the operating room suites to respond to emergencies.

(4) The qualifications and job descriptions of nursing personnel, surgical technicians, and other support personnel and continuing education required.

(5) Appropriate staffing for surgical services including physician and anesthesia coverage and other support personnel.

(6) Availability of ancillary services for surgical patients including, but not limited to: blood banking, laboratory, radiology, and anesthesia.

(7) 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.

(8) Housekeeping requirements.

(9) Safety practices.

(10) Ongoing quality assessment, performance improvement, and process improvement.

(11) Provisions for the pathological examination of tissue specimens either directly or through contractual arrangements.

(12) Appropriate preoperative teaching and discharge planning.

b. Hospitals may consider the most recent edition of the following publications in the development of policies and procedures: “Statement of Principles,” American College of Surgeons; and “Standards and Recommended Practices,” 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) A full operative report must be written or dictated within 24 hours 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).
[ARC 2472C, IAB 3/30/16, effective 5/4/16]

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 or outpatient settings.

This rule is intended to implement Iowa Code section 135B.7.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

481—51.29 Reserved.

481—51.30(135B) Emergency services.

51.30(1) 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(2) The hospital shall have written policies and procedures specifying the scope and conduct of patient care to be provided in the emergency service. The policies shall:

a. Specify the mechanism for providing physician coverage at all times.

b. Provide for training required of all personnel providing patient care in the emergency service.

c. 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.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

481—51.31 Reserved.

481—51.32(135B) Obstetric and neonatal services.

51.32(1) All hospitals providing obstetrical care 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.

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.

a. 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:

(1) Obstetric and neonatal services under the direction of a qualified doctor of medicine or osteopathy.

(2) Delineation of the privileges and qualifications of individuals authorized to provide obstetrical/gynecological service as set out in the hospital's medical staff bylaws.

(3) The qualifications of nursing personnel and continuing education required.

(4) Adequate staffing for obstetrical and newborn services.

(5) Location and arrangement of obstetric and newborn services.

(6) Infection control and disease prevention.

(7) Ongoing quality assessment.

b. Hospitals may consider the most recent edition of the following publications in the development of policies and procedures: 641—Chapter 150, Iowa Regionalized System of Perinatal Health Care, Iowa Administrative Code, and Guidelines for Perinatal Care, American Academy of Pediatrics, American College of Obstetrics and Gynecology.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

481—51.33 Reserved.

481—51.34(135B) Pediatric services.

51.34(1) All 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.

a. 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:

(1) Pediatric services under the medical direction of a qualified doctor of medicine or osteopathy.

(2) Delineation of the privileges and qualifications of individuals authorized to provide pediatric services as set out in the hospital's medical staff bylaws.

(3) The qualifications of nursing personnel and continuing education required, including care in the event of emergency situations.

(4) Adequate staffing and equipment for pediatric services including ancillary services. Staff participating in the care of pediatric patients shall have education appropriate for the care of pediatric patients.

(5) 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.

(6) Ongoing quality assessment.

(7) Written protocol for transfer of pediatric patients in the event the hospital does not have capability to provide care for these patients.

b. Hospitals may consider the most recent editions of the following publications in the development of policies and procedures: the American Academy of Pediatrics' Policy Reference Guide and policy statements which are published on a monthly basis in "Pediatrics" and the "Pediatric & Neonatal Dosage Handbook," American Pharmacists Association.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

481—51.35 Reserved.

481—51.36(135B) Psychiatric services.

51.36(1) Any hospital operating as a psychiatric hospital or operating a 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, doctors of osteopathy or advanced registered nurse practitioners certified in psychiatric or mental health nursing 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;

(2) Be an advanced registered nurse practitioner certified in psychiatric or mental health nursing;

or

(3) 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 by the interdisciplinary team for the continued appropriateness of the plan and for a determination of needed changes.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

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. Rescinded ARC 2472C, IAB 3/30/16, effective 5/4/16.

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) to provide direct or indirect services to patients of a hospital.

“*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 website, 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 website, 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; **ARC 2472C**, IAB 3/30/16, effective 5/4/16]

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, 2018 edition, published by the Facility Guidelines Institute.

b. Existing 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.

c. The design and construction of a hospital or off-site premises shall be in conformance with the provisions of 661—Chapter 205.

d. 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.

e. 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) *Variations.* The director of the department may grant variances to building and construction guidelines as contained in the Guidelines for Design and Construction of Hospitals, 2018 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; ARC 4070C, IAB 10/10/18, effective 11/14/18]

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.

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 (TJC), the American Osteopathic Association (AOA), DNV GL – Healthcare (DNV GL), 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; ARC 2472C, IAB 3/30/16, effective 5/4/16]

These rules are intended to implement Iowa Code chapter 135B.

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NATURAL RESOURCE COMMISSION[571]

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[Prior to 12/31/86, see Conservation Commission[290] Chs 17, 66, 67, and 75]

571—15.1(483A) Scope. The purposes of this chapter are to provide rules for license fees, sales, refunds and administration; implement the wildlife violator compact and penalties for multiple offenses; administer special licenses available for hunting and fishing; and describe and implement certification and education programs of the department of natural resources.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 4072C, IAB 10/10/18, effective 12/15/18]

DIVISION I
LICENSE SALES, REFUNDS AND ADMINISTRATION

571—15.2(483A) Definitions. For the purposes of this division, the following definitions shall apply:

“Administration fee” means the fee collected by the department to pay a portion of the cost of administering the sale of licenses through electronic means.

“Department” means the department of natural resources.

“Director” means the director of the department of natural resources.

“Immediate family member” means the spouse, a domestic partner, and all minor children of the licensee or person seeking a license.

“License” means any license or privilege issued by the department to an individual for hunting or fishing in the state of Iowa. Multiple types of licenses are described in these rules.

“License agent” means an individual, business, or governmental agency authorized to sell a license.

“Licensee” means the person who applies for and receives a license under these rules from the department.

“Nonresident” means a person who is not a resident as that term is defined in this rule.

“Principal and primary residence or domicile” means the one and only place where a person has a true, fixed, and permanent home, and to where, whenever the person is briefly and temporarily absent, the person intends to return. Relevant factors used to determine a person’s principal and primary residence or domicile include the following:

1. Proof of place of employment, which must include the address of the person’s place of employment or business, including the area or region where a majority of the person’s work is performed.

2. Physical address, which shall be the person’s 911 address(es) or the address of an immediate family member. A post office box or a forwarded address shall not be accepted by the department to verify the person’s principal and primary residence or domicile.

3. Utility records, which must include the person’s name and be associated with the physical address provided for as the person’s principal and primary residence or domicile. The types of records that may be submitted include rental and lease documents and telephone, cellular phone, electricity, water, sewer, cable or satellite television, and any other utility records.

4. Real estate records, which include legal documents showing ownership or leasehold interests of any and all real estate related to the physical address used by the department to verify the person’s principal and primary residence or domicile. These records should also provide the time period of such ownership or rental.

5. Vehicle registration(s) for any vehicles owned or leased by the person and immediate family members.

6. Portion of federal, state or local income tax returns filed during the relevant time period showing the address provided on those forms by the person.

7. Documentation of homestead tax exemption allowed to the person or immediate family member(s) for all states in which such exemption is allowed.

8. Documentation of any coinhabitants, other than the person’s immediate family members, who use the same principal and primary residence or domicile.

“*Resident*” means a natural person who meets any of the following criteria during each year in which the person claims status as a resident:

1. Has physically resided in this state at the person’s principal and primary residence or domicile for a period of not less than 90 consecutive days immediately before applying for or purchasing a resident license, tag, or permit under this chapter and has been issued an Iowa driver’s license or an Iowa nonoperator’s identification card. A person is not considered a resident under this rule if the person is residing in the state only for a special or temporary purpose including but not limited to engaging in hunting, fishing, or trapping.

2. Is a full-time student at either of the following:

- An accredited educational institution located in this state if the person resides in this state while attending the educational institution.

- An accredited educational institution located outside of this state, if the person is under the age of 25 and normally resides with at least one parent or legal guardian who maintains a principal and primary residence or domicile in this state.

3. Is a student who qualifies as a resident pursuant to paragraph “2,” second bulleted paragraph, only for the purpose of purchasing any resident license specified in Iowa Code section 483A.1 or 484A.2.

4. Is a resident under 18 years of age whose parent is a resident of this state.

5. Is a member of the armed forces of the United States who is serving on active duty, claims residency in this state, and has filed a state individual income tax return as a resident pursuant to Iowa Code chapter 422, division II, for the preceding tax year, or is stationed in this state.

“*Retail*” means the sale of goods or commodities to the ultimate consumer, as opposed to the sale of goods or commodities for further distribution or processing.

“*Wholesale*” means the sale of goods or commodities for resale by a retailer, as opposed to the sale of goods or commodities to the ultimate consumer.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 9004B, IAB 8/11/10, effective 9/15/10]

571—15.3(483A) Form of licenses. Every license shall contain a general description of the licensee. At the time of application, the applicant for a license must provide the applicant’s date of birth and either a social security number or a valid Iowa driver’s license number. The license shall be signed by the applicant and shall clearly indicate the privilege granted.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.4(483A) Administration fee. An administration fee of \$1.50 per privilege purchased shall be collected from the purchaser at the time of purchase, except upon the issuance of free landowner deer and turkey hunting licenses, free annual hunting and fishing licenses, free annual fishing licenses, free group home fishing licenses, and boat registrations, renewals, transfers, and duplicates. An administrative fee of \$3.65 will be collected from the purchaser at the time of boat registration, renewal, transfer, and duplicate purchases.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 8104B, IAB 9/9/09, effective 10/14/09; ARC 8465B, IAB 1/13/10, effective 2/17/10]

571—15.5(483A) Electronic license sales.

15.5(1) Designation as license agent. The director may designate a retail business establishment, an office of a governmental entity, or a nonprofit corporation as an agent of electronically issued licenses in accordance with the provisions of this rule. The provisions of 571—15.6(483A) shall not apply to a license agent engaging in, or applying to engage in, the electronic sale and issuance of licenses.

15.5(2) Application. Application forms to sell electronically issued licenses may be secured by a written or in-person request to the Licensing Section, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034. The following information must be provided on the application form:

- a. The legal name, address, and telephone number of the entity applying for designation;
- b. The hours open for business and general service to the public;
- c. A brief statement of the nature of the business or service provided by the applicant;

d. Type of Internet connection (dial up or high speed) used for accessing the electronic licensing system; and

e. A signature by an owner, partner, authorized corporate official, or public official of the entity applying for designation.

15.5(3) Application review.

a. The director shall approve or deny the application to sell electronically issued licenses based upon the following criteria:

- (1) The need for a license agent in the area;
- (2) The hours open for business or general service to the public;
- (3) The potential volume of license sales;
- (4) The apparent financial stability and longevity of the applicant;
- (5) The number of point-of-sale (POS) terminals available to the department; and
- (6) Type of Internet connection (dial up or high speed) used for accessing the electronic licensing system.

b. If necessary, the department may utilize a waiting list for license agent designation. The order of priority for the waiting list will be determined by the time of submittal of a complete and correct application and receipt of the required security deposit, as outlined in the application.

15.5(4) Issuance of electronic licensing equipment. Upon the director's approval of an application under this rule and designation of a license agent for electronic license sales, the equipment necessary to conduct such sales will be issued to the license agent by the department subject to the following terms and conditions:

a. Prior to the issuance of the electronic licensing equipment, the approved license agent shall furnish to the department an equipment security deposit in an amount to be determined by the department.

b. Prior to the issuance of the electronic licensing equipment, the approved license agent shall enter into an electronic license sales agreement with the department which sets forth the terms and conditions of such sales, including the authorized amounts to be retained by the license agent.

c. Prior to the issuance of the electronic licensing equipment, the approved license agent shall furnish to the department a signed authorization agreement for electronic funds transfer pursuant to subrule 15.5(5).

d. Electronic licensing equipment and supplies must be stored in a manner to provide protection from damage, theft, and unauthorized access. Any damage to or loss of equipment or loss of moneys derived from license sales is the responsibility of the license agent.

e. Upon termination of the agreement by either party, all equipment and supplies, as outlined in the agreement, must be returned to the department. Failure to return equipment and supplies in a usable condition, excluding normal wear and tear, will result in the forfeiture of deposit in addition to any other remedies available to the department by law.

15.5(5) License fees. All moneys received from the sale of licenses, less and except the agreed-upon service fee, must be immediately deposited and held in trust for the department.

a. All license agents must furnish to the department a signed authorization agreement for electronic funds transfer authorizing access by the department to a bank account for electronic transfer of license fees received by the license agent.

b. The amount of money due for accumulated sales will be drawn electronically by the department on a weekly basis. The license agent shall be given notice of the amount to be withdrawn at least two business days before the actual transfer of funds occurs. The license agent is responsible for ensuring that enough money is in the account to cover the amount due.

c. License agents may accept or decline payment in any manner other than cash, such as personal checks or credit cards, at their discretion. Checks or credit payments must be made payable to the license agent, not to the department. The license agent shall be responsible for ensuring that the license fee is deposited in the electronic transfer account, regardless of the payment or nonpayment status of any check accepted by the license agent.

15.5(6) Upon the termination of the electronic license sales agreement pursuant to subrule 15.5(7) or 15.5(8), the department may disconnect or otherwise block the license agent's access to the electronic licensing system.

15.5(7) Equipment shut down and termination. The department reserves the right to disconnect the license agent's access to the electronic licensing system or terminate the license agent's electronic license sales agreement for cause. Cause shall include, but is not limited to, the following:

- a. Failing to deposit license fees into the electronic transfer account in a sum sufficient to cover the amount due for accumulated sales;
- b. Charging or collecting any fees in excess of those authorized by law;
- c. Discriminating in the sale of a license in violation of state or federal law;
- d. Knowingly making a false entry concerning any license sold or knowingly issuing a license to a person who is not eligible for the license issued;
- e. Using license sale proceeds, other than the service fee, for personal or business purposes;
- f. Disconnecting or blocking access to the electronic licensing system for a period of 30 days or more; or
- g. Violating any of these rules or the terms of the electronic license sales agreement. Repeated violations of these rules may result in termination of the license agent's electronic license sales agreement.

15.5(8) Voluntary termination. A license agent may terminate its designation and the electronic license sales agreement at its discretion by providing written notice to the department. Voluntary termination shall become effective 30 days after the department's receipt of notice.
[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.6(483A) Paper license sales. Paper licenses shall be sold only in the event that the electronic licensing system is no longer available.

15.6(1) *Depository designation.* The director may designate a retail business establishment, an office of a governmental entity, or a nonprofit corporation as a depository for the sale of hunting and fishing licenses in accordance with the provisions of this rule.

15.6(2) *Application.*

a. An application form to act as a depository may be secured by a written or in-person request to the Licensing Section, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034. Requests for an application form may be made through department field staff or field officers. The applicant must provide the following information on the form:

- (1) The name of the retail business establishment, governmental entity, or nonprofit corporation, and location(s) and telephone numbers.
- (2) A general description of the type of retail business establishment, governmental entity, or nonprofit corporation.
- (3) The form of ownership if a retail business establishment. If a partnership, the full names and addresses of all partners must be provided. If a corporation, the date and state of incorporation must be provided.
- (4) If a governmental entity, the name and title of the responsible official.
- (5) If a nonprofit corporation, the date and state of incorporation.
- (6) The hours and days open to the public.
- (7) The contact information of the person signing the application.
- (8) The name, address, and telephone number of three credit references, including the bank used by the retail business establishment, governmental entity, or nonprofit corporation.

b. The application form contains a statement by which the applicant agrees to the terms and conditions as set forth in this rule. The application form must be signed by the owner if a sole proprietorship; by a partner if a partnership; by an authorized corporate official if a corporation; or by

the elected or appointed official administratively in charge of the governmental entity. The signature must be attested to by a notary public.

15.6(3) Security. The applicant under this rule must provide security, either a surety bond from an association or corporation whose business is assuring the fidelity of others and which has the authority by law to do business in this state, a collateral assignment of a certificate of deposit, or a letter of credit.

a. Condition of security. A surety bond required by this rule shall generally provide that the applicant render a true account of and turn over all moneys, license blanks, and duplicates when requested to do so by the director or an authorized representative and that the applicant comply with all applicable provisions of the application, the Iowa Administrative Code, and the Iowa Code.

b. Amount of security. All forms of security required by this rule shall be in the amount of \$5,000 each or a larger amount as jointly agreed to by the department and the depository.

c. Term of bond. The bond required by this rule shall run continuously from the date the application is approved.

d. Termination of bond. The surety or principal may terminate the bond at any time by sending written notice by certified mail, return receipt requested, to the Director, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034. The termination shall become effective 30 days after the receipt of the notice by the director.

e. Collateral assignment of a certificate of deposit and letters of credit. Collateral assignments of certificates of deposit and letters of credit shall be subject to the following terms and conditions:

(1) Certificates of deposit shall be assigned, in writing, to the department, and the assignment shall be recorded on the books of the bank issuing the certificate.

(2) Banks issuing these certificates shall waive all rights of setoff or liens which they have or might have against these certificates.

(3) Certificates of deposit shall be automatically renewed unless the director approves, in writing, release of the funds. Letters of credit shall be without reservation and shall remain in effect continuously, or as otherwise agreed to by the director.

(4) The director will release the certificates of deposit or approve the cancellation of a letter of credit upon termination of a license agent agreement if all licenses and moneys have been accounted for satisfactorily or if the depository provides a satisfactory surety bond in lieu thereof.

15.6(4) Multiple establishment locations. An application and security may be submitted for retail business establishments with multiple locations. For purposes of reporting and for determining the amount of the security, each application will be considered on a case-by-case basis and as mutually agreed upon by the depository and the director.

15.6(5) Approval of application and security. The director will approve the application upon the receipt of a satisfactory bond, collateral assignment of deposit, or letter of credit and a determination that the credit references are satisfactory. However, the director reserves the right not to approve any application received from a party whose depository agreement has previously been terminated by the department for cause. Upon approval by the director, the department will provide the depository with license blanks, reporting forms, and instructions.

15.6(6) Depository reporting standards. All depositories shall comply with the following reporting standards:

a. Monthly reports. A full and complete monthly sales report, including duplicate copies of the licenses sold and a check or other monetary instrument in the amount due, shall be remitted to the department the following month on a prescheduled due date. A depository that does not provide the monthly report to the department within 10 days after the due date shall be considered seriously delinquent. However, if the depository's office or business is operated on a seasonal basis, a monthly report is not required for any month that the office or business is not open to the public.

b. Annual report. An annual report for all sales for the calendar year and all unused license blanks for the year shall be remitted to the department by January 31 of each year. A depository will be considered seriously delinquent if the annual report is not received by February 15. An annual report shall also be submitted at the time a depository agreement is terminated for any reason during the

calendar year. This report must be received within 15 days after the director issues or, in the case of a voluntary termination, receives the notice of termination.

15.6(7) *Accountability.* The depositary shall be fully accountable to the state for all proceeds collected from the sale of licenses. This accountability shall not be diminished by reason of bankruptcy, fire loss, theft loss, or other similar reason.

15.6(8) *Probation.*

a. A depositary shall be placed on probation under any of the following circumstances:

(1) The depositary is seriously delinquent for the second time during any consecutive six-month period.

(2) The depositary fails to correct a serious delinquency within ten days.

(3) A check is returned by the bank due to insufficient funds.

b. Notice of probation shall be sent to the depositary by certified mail, return receipt requested.

c. The probation will be automatically canceled after six months of satisfactory performance by the depositary.

15.6(9) *Termination of depositary agreement.* A depositary may terminate the agreement at any time by notifying the director by certified mail, return receipt requested. The termination shall be effective 30 days after the receipt of the notice by the director and after the depositary has fully accounted for all moneys and unused license blanks. The director may terminate the depositary agreement and require an immediate and full accounting of all moneys and unused license blanks under any of the following circumstances:

a. The occurrence of a third serious delinquency during any consecutive six-month period.

b. When an insufficient funds check is received by the department, not correcting the deficiency within 10 days after proper notice by the director.

c. Failing to correct a serious delinquency within 15 calendar days.

d. Knowingly placing a date, other than the correct date, on any license.

e. Knowingly selling a resident license to a nonresident or selling a license to a person not qualified for such license.

f. Charging more than the statutory writing fee.

g. Refusing to sell a license to any individual by reason of creed, sexual orientation, gender identity, religion, pregnancy or public accommodation.

h. Canceling a bond, certificate of deposit, or letter of credit or allowing one to expire.

i. Failing to make a full and complete monthly sales report and monthly remittance.

j. Knowingly making a false entry on any license being sold or knowingly issuing any license to a person to whom issuance of that license is improper.

15.6(10) *Forms available from the department.* Copies of the forms required for application, bond, monthly reports, and collateral as assignment may be obtained by written or in-person request to the Licensing Section, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.7(483A) Lost or destroyed license blanks.

15.7(1) *Accountability for license blanks.* Whenever a depositary or county recorder requests to be relieved from accountability for license blanks that have been lost or destroyed, the depositary or county recorder (recorder) shall file a bond for the face value of such lost or destroyed license blanks and provide an explanation to the director.

15.7(2) *Explanation.*

a. The depositary or recorder shall submit a written statement in the form of an affidavit regarding the facts and circumstances surrounding the alleged loss or destruction. Pictures, drawings, or other pertinent information may be attached and referenced in the statement. The loss or destruction must relate to one or a combination of the following reasons:

(1) Loss or destruction by fire.

(2) Loss from theft.

- (3) Loss while in transit.
- (4) Loss from natural causes, including but not limited to floods, tornadoes, and severe storms.
- (5) Loss or accidental destruction during the course of normal business operations or facility maintenance and repair.

b. The statement must also include a specific description of the precautions and procedures normally utilized by the recorder or depository to prevent or to guard against the loss or destruction described, and a further statement as to why the precautions or procedures failed in this particular instance.

c. The director shall consider the written explanation as provided. The director shall also consider the past record of the depository or recorder regarding losses and destructions and the past record of the depository or recorder regarding prompt and accurate reporting. The director may direct department staff to further investigate the circumstances and facts.

(1) If the director determines that the depository or recorder exercised reasonable and prudent care, the director shall relieve the depository or recorder of accountability upon the filing of a bond.

(2) If the director determines that there was gross negligence by the depository or recorder and holds the depository or recorder accountable, the depository or recorder may file a request for a contested case proceeding as provided in 571—Chapter 7 of the Iowa Administrative Code.

15.7(3) Bond. The depository or recorder shall provide a bond in the amount of the face value of the lost or destroyed licenses. The bond shall be on a bond form provided by the department. The bond shall be conditioned to the effect that the depository or recorder agrees to surrender the subject licenses to the department in the event that they are located at any future time; or in the event of proof showing that any or all of the subject licenses have been issued, the depository, recorder, or sureties jointly and severally agree to pay the state the face value of all licenses covered by the bond.

a. For a face amount of \$500 or less, the personal bond of the depository or recorder is sufficient. One additional personal surety is required for a face amount up to \$1,000; and two personal sureties, in addition to the depository or recorder, are required if the face amount is more than \$1,000.

b. A corporate surety authorized to do business in Iowa may be provided in lieu of the personal sureties required, in addition to the depository or recorder.

c. The value assigned to a lost or destroyed blank license form shall be \$25. This amount will be paid by the depository to the department, except as relief from such payment is provided according to this rule.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.8(483A) Refund or change requests for special deer and turkey hunting licenses and general licenses.

15.8(1) Invalid applications. Deer and turkey hunting license applications that are received after the closing date for acceptance of applications and applications that are invalid on their face will be returned unopened to the applicant. Any license fee related to an application determined invalid by a computer analysis or other analysis after the application has been processed will be refunded to the applicant, less a \$10 invalid application fee to compensate for the additional processing cost related to an invalid application.

15.8(2) Death of licensee. The fee for a deer or turkey hunting license will be refunded to the licensee's estate when the licensee's death predates the season for which the license was issued and a written request from the licensee's spouse, executor or estate administrator is received by the department within 90 days of the last date of the season for which the license was issued.

15.8(3) National or state emergency. The fee for a deer or turkey hunting license will be refunded if the licensee is a member of the National Guard or a reserve unit and is activated for a national or state emergency which occurs during the season for which the license was issued. A written refund request must be received by the department within 90 days of the last date of the season for which the license was issued.

15.8(4) License changes. The department will attempt to change an applicant's choice of season or type of license if a written or telephonic request is received by the licensing section in sufficient time

(usually 20 days) before the license is printed and if the requested change does not result in disadvantage to another applicant. A change request made by telephone must be verified in writing by the requester before the change request will be honored. The department's ability to accommodate requests to change the season or license type is dependent on workload and processing considerations. If the department cannot accommodate a request to change a season or license type, the license will be issued as originally requested by the applicant. No refund will be allowed. The department will not change the name on the license from that submitted on the application.

15.8(5) Duplicate purchases of general hunting and fishing licenses. Upon a showing of sufficient documentation (usually a photocopy of the licenses) that more than one hunting or fishing license was purchased by or for a single person, the department will refund the amount related to the duplicate purchase. A written request for refund, with supporting documentation, must be received by the licensing section within 90 days of the date on the face of the duplicate licenses.

15.8(6) Other refund requests. Except as previously described in this rule, the department will not issue refunds for any licenses as defined in 571—15.2(483A).

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.9(483A) Proof of residency required. The department shall have the authority to require persons applying for or who have received resident licenses to provide additional information to determine the person's principal and primary residence or domicile and residency status. Whether a person was issued resident or nonresident licenses by the department in previous years shall not be a determining factor of residency. Persons required to provide additional information under this rule shall be notified in writing by the department and shall have 60 days to submit all required information to the department.

[ARC 9004B, IAB 8/11/10, effective 9/15/10]

571—15.10(483A) Residency status determination. Upon receipt of information requested from the person, the department may determine whether the person is a resident or a nonresident for purposes of these rules and Iowa Code chapter 483A. The department shall provide the person with written notice of the finding.

[ARC 9004B, IAB 8/11/10, effective 9/15/10]

571—15.11(483A) Suspension or revocation of licenses when nonresidents obtain resident licenses.

15.11(1) Suspension or revocation of license. If the department finds that a nonresident has obtained a resident license, the department shall provide written notice of intent to revoke and suspend hunting, fishing, or trapping licenses as provided in 571—Chapter 7. If the person requests a hearing, it shall be conducted in accordance with 571—Chapter 7. If the department finds that a nonresident has obtained a resident license fraudulently or through intentional misrepresentation, the person shall be guilty of a simple misdemeanor, punishable as a scheduled violation under Iowa Code section 805.8B.

15.11(2) Dates of suspension or revocation. The suspension or revocation shall be effective upon failure of the person to request a hearing within 30 days of the notice described in rule 571—15.10(483A) or upon issuance of an order affirming the department's intent to suspend or revoke the license after the hearing. The person shall immediately surrender all licenses and shall not apply for or obtain new licenses for the full term of the suspension or revocation.

15.11(3) Magistrate authority. Nothing in this chapter shall limit the magistrate's authority as described in Iowa Code section 483A.21 to suspend or revoke licenses.

[ARC 9004B, IAB 8/11/10, effective 9/15/10]

571—15.12(483A) Licenses—fees. Except as otherwise provided by law, a person shall not fish, trap, hunt, harvest, pursue, catch, kill, take in any manner, use, have possession of, sell, or transport all or a part of any wild animal, bird, game, turtle, or fish, the protection and regulation of which is desirable for the conservation of resources of the state, without first obtaining a license for that purpose and paying a fee as follows:

15.12(1) Residents.

- a. Fishing license, annual — \$20.
- b. Fishing license, three-year — \$60.
- c. Fishing license, seven-day — \$13.50.
- d. Fishing license, one-day — \$8.50.
- e. Third-line fishing permit, annual — \$12.
- f. Fishing license, lifetime, 65 years of age or older — \$59.50.
- g. Fishing license, lifetime, disabled veteran or POW — \$5.
- h. Paddlefish fishing license, annual — \$23.50.
- i. Trout fishing fee — \$12.50.
- j. Boundary waters sport trotline license, annual — \$24.
- k. Hunting license, annual — \$20.
- l. Hunting license, annual, including the wildlife habitat fee — \$33.
- m. Hunting license, three-year, including the wildlife habitat fee — \$99.
- n. Hunting license, lifetime, 65 years of age or older — \$59.50.
- o. Combination hunting and fishing license, annual, including the wildlife habitat fee — \$53.
- p. Combination hunting and fishing license, lifetime, disabled veteran or POW — \$5.
- q. Deer hunting license — \$30.
- r. First antlerless deer license — \$25.50.
- s. Additional antlerless deer license — \$12.
- t. Wildlife habitat fee — \$13.
- u. Migratory game bird fee — \$10.
- v. Wild turkey hunting license — \$26.50.
- w. Fur harvester license, annual — \$24.
- x. Fur harvester license, annual, including the wildlife habitat fee — \$37.
- y. Fur harvester license, annual, under 16 years of age — \$5.50.
- z. Fur harvester license, lifetime, 65 years of age or older — \$59.50.
- aa. Fur dealer license, annual — \$264.
- bb. Aquaculture unit license, annual — \$30.
- cc. Retail bait dealer license, annual — \$36.
- dd. Wholesale bait dealer license, annual — \$146.50.
- ee. Game breeder license, annual — \$18.
- ff. Taxidermy license, annual — \$18.

15.12(2) Nonresidents.

- a. Fishing license, annual — \$46.
- b. Fishing license, seven-day — \$35.50.
- c. Fishing license, three-day — \$18.50.
- d. Fishing license, one-day — \$10.
- e. Third-line fishing permit, annual — \$12.
- f. Paddlefish fishing license, annual — \$47.
- g. Trout fishing fee — \$15.50.
- h. Boundary waters sport trotline license, annual — \$47.50.
- i. Hunting license, annual — \$129.
- j. Hunting license, annual, including the wildlife habitat fee — \$142.
- k. Hunting license, annual, under 18 years of age — \$30.
- l. Hunting license, annual, under 18 years of age, including the wildlife habitat fee — \$43.
- m. Hunting license, five-day (not applicable to deer or wild turkey seasons) — \$75.
- n. Hunting license, five-day, including the wildlife habitat fee (not applicable to deer or wild turkey seasons) — \$88.
- o. Deer hunting license, antlered or any-sex deer — \$345.50.
- p. Deer hunting license, antlerless-deer-only, required with the purchase of an antlered or any-sex deer hunting license — \$146.50.
- q. Deer hunting license, antlerless-deer-only — \$263.50.

- r. Preference point issued under Iowa Code section 483A.7(3) “b” or 483A.8(3) “e” — \$58.50.
- s. Holiday deer hunting license issued under Iowa Code section 483A.8(6), antlerless-deer-only — \$88.
- t. Wildlife habitat fee — \$13.
- u. Migratory game bird fee — \$10.
- v. Wild turkey hunting license, annual — \$117.
- w. Fur harvester license, annual — \$232.
- x. Fur harvester license, annual, including the wildlife habitat fee — \$245.
- y. Fur dealer license, annual — \$586.50.
- z. Fur dealer license, one day, one location — \$292.50.
- aa. Location permit for fur dealer — \$66.
- bb. Aquaculture unit license, annual — \$66.
- cc. Retail bait dealer license, annual — \$146.50.
- dd. Wholesale bait dealer license, annual — \$292.50.
- ee. Game breeder license, annual — \$30.50.
- ff. Taxidermy license, annual — \$30.50.

[ARC 4072C, IAB 10/10/18, effective 12/15/18]

571—15.13 to 15.15 Reserved.

DIVISION II
MULTIPLE OFFENDER AND WILDLIFE VIOLATOR COMPACT

571—15.16(481A,481B,482,483A,484A,484B) Multiple offenders—revocation and suspension of hunting, fishing, and trapping privileges from those persons who are determined to be multiple offenders.

15.16(1) Definitions. For the purpose of this rule, the following definitions shall apply:

“*Department*” means the Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034.

“*License*” means any paid or free license, permit, or certificate to hunt, fish, or trap listed in Iowa Code chapters 481A, 481B, 482, 483A, 484A, 484B, and 716, including the authorization to hunt, fish, or trap pursuant to any reciprocity agreements with neighboring states.

“*Licensee*” means the holder of any license.

“*Multiple offender*” means any person who has equaled or exceeded five points for convictions in Iowa Code chapters 481A, 481B, 482, 483A, 484A, 484B, and 716 during a consecutive three-year period as provided in 15.16(3).

“*Revocation*” means the taking or cancellation of an existing license.

“*Suspension*” means to bar or exclude one from applying for or acquiring licenses for future seasons.

15.16(2) Record-keeping procedures. For the purpose of administering this rule, it shall be the responsibility of the clerk of district court for each county to deliver, on a weekly basis, disposition reports of each charge filed under Iowa Code chapters 456A, 481A, 481B, 482, 483A, 484A, 484B, and 716 to the department. Dispositions and orders of the court of all cases filed on the chapters listed in this subrule shall be sent to the department regardless of the jurisdiction or the department of the initiating officer.

a. *License suspensions.* In the event of a license suspension pursuant to Iowa Code section 481A.133, the clerk of court shall immediately notify the department.

b. *Entering information.* Upon receipt of the disposition information from the clerks of court, the department will, on a monthly basis, enter this information into a computerized system that is directly accessible by the department of public safety communications system for use by the department’s licensing section, and all state and local law enforcement officers. Direct access through the department of public safety communications system will be available as soon as practical and is dependent on the development of appropriate computer linkage by the department of public safety.

c. Disposition report information. Information from the disposition report that will be entered into a computerized system which includes but may not be limited to the following:

County of violation, name of defendant, address of defendant, social security or driver's license number, date of birth, race, sex, height, weight, date and time of violation, charge and Iowa Code section, officer name/C-number who filed charge, and date of conviction.

15.16(3) Point values assigned to convictions. Point values for convictions shall be assessed as stated in this subrule. Multiple citations and convictions of the same offense will be added as separate convictions:

- a.* Convictions of the following offenses shall have a point value of three:
- (1) Illegal sale of birds, game, fish, or bait.
 - (2) More than the possession or bag limit for any species of game or fish.
 - (3) Hunting, trapping, or fishing during the closed season.
 - (4) Hunting by artificial light.
 - (5) Hunting from aircraft, snowmobiles, all-terrain vehicles or motor vehicle.
 - (6) Any violation involving threatened or endangered species.
 - (7) Any violations of Iowa Code chapter 482, except sections 482.6 and 482.14.
 - (8) Any violation of nonresident license requirements.
 - (9) No fur dealer license (resident or nonresident).
 - (10) Illegal taking or possession of protected nongame species.
 - (11) The unlawful taking of any fish, game, or fur-bearing animal.
 - (12) Illegal taking, possession, or transporting of a raptor.
 - (13) Hunting, fishing, or trapping while under license suspension or revocation.
 - (14) Illegal removal of fish, minnows, frogs, or other aquatic wildlife from a state fish hatchery.
 - (15) Any fur dealer violations except failure to submit a timely annual report.
 - (16) Any resident or nonresident making false claims to obtain a license.
 - (17) Illegal taking or possession of hen pheasant.
 - (18) Applying for or acquiring a license while under suspension or revocation.
 - (19) For a repeat offense of acquiring a hunting license without hunter safety certification.
 - (20) Taking game from the wild—see Iowa Code section 481A.61.
 - (21) Violation of Iowa Code sections 483A.27(7) and 483A.27A.
 - (22) Any violation of Iowa Code section 716.8 while hunting deer.
- b.* Convictions of the following offenses shall have a point value of two:
- (1) Hunting, fishing, or trapping on a refuge.
 - (2) Illegal possession of fur, fish, or game.
 - (3) Chasing wildlife from or disturbing dens.
 - (4) Trapping within 200 yards of an occupied building or private drive.
 - (5) Possession of undersized or oversized fish.
 - (6) Snagging of game fish.
 - (7) Shooting within 200 yards of occupied building or feedlot.
 - (8) No valid resident license relating to deer, turkey, or paddlefish.
 - (9) Illegal importation of fur, fish, or game.
 - (10) Failure to exhibit catch to an officer.
 - (11) Trapping or poisoning game birds, or poisoning game animals.
 - (12) Violations pertaining to private fish hatcheries and aquaculture.
 - (13) Violations of the fur dealers reporting requirements.
 - (14) Violation of Iowa Code section 481A.126 pertaining to taxidermy.
 - (15) Loaded gun in a vehicle.
 - (16) Attempting to unlawfully take any fish, game, or fur-bearing animals.
 - (17) Attempting to take game before or after legal shooting hours.
 - (18) Wanton waste of fish, game or fur-bearing animals.
 - (19) Illegal discharge of a firearm pursuant to Iowa Code section 481A.54.
 - (20) Any violation of Iowa Code section 482.14 pertaining to commercial fishing.

- (21) Failure to tag deer, turkey, or paddlefish.
- (22) Applying for or obtaining more than the legal number of licenses allowed for deer or turkey.
- (23) Illegal transportation of game, fish or furbearers.
- (24) Violation of Iowa Code section 483A.27, except subsection (7).

c. All other convictions of provisions in Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B shall have a point value of one.

15.16(4) Length of suspension or revocation.

a. The term of license suspension or revocation shall be determined by the total points accumulated during any consecutive three-year period, according to the following: 5 points through 8 points is one year, 9 points through 12 points is two years, and 13 points or over is three years.

b. Any person convicted of a violation of any provision of Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B under the circumstances described in Iowa Code subsection 481A.135(2) shall have an additional suspension of one year. Any person convicted of a violation of any provision of Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B under the circumstances described in Iowa Code subsection 481A.135(3) shall have an additional suspension of two years. Any person convicted of a violation of any provision of Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B under the circumstances described in Iowa Code subsection 481A.135(4) shall have an additional suspension of three years. The foregoing provisions apply whether or not a person has been found guilty of a simple misdemeanor, serious misdemeanor or aggravated misdemeanor pursuant to Iowa Code subsections 481A.135(2), 481A.135(3) and 481A.135(4). If a magistrate suspends the privilege of a defendant to procure another license and the conviction contributes to the accumulation of a point total that requires the department to initiate a suspension, the term of suspension shall run consecutively up to a maximum of five years. After a five-year suspension, remaining time will be calculated at a concurrent rate.

15.16(5) Points applicable toward suspension or revocation. If a person pleads guilty or is found guilty of an offense for which points have been established by this rule but is given a suspended sentence or deferred sentence by the court as defined in Iowa Code section 907.1, the assigned points will become part of that person's violation record and apply toward a department suspension or revocation.

15.16(6) Notification of intent to suspend and revoke license. If a person reaches a total of five or more points, the department shall provide written notice of intent to revoke and suspend hunting, fishing, or trapping licenses as provided in 571—Chapter 7. If the person requests a hearing, it shall be conducted in accordance with 571—Chapter 7.

15.16(7) Dates of suspension or revocation. The suspension or revocation shall be effective upon failure of the person to request a hearing within 30 days of the notice described in 15.16(6) or upon issuance of an order affirming the department's intent to suspend or revoke the license after the hearing. The person shall immediately surrender all licenses and shall not apply for or obtain new licenses for the full term of the suspension or revocation.

15.16(8) Magistrate authority. This chapter does not limit the magistrate authority as described in Iowa Code section 483A.21.

15.16(9) Suspension for failure to comply with a child support order. The department is required to suspend or deny all licenses of an individual upon receipt of a certificate of noncompliance with child support obligation from the Iowa child support recovery unit pursuant to Iowa Code section 252J.8(4).

a. The receipt by the department of the certificate of noncompliance shall be conclusive evidence. Pursuant to Iowa Code section 252J.8(4), the person does not have a right to a hearing before the department to contest the denial or suspension action taken due to the department's receipt of a certificate of noncompliance with a child support obligation but may seek a hearing in district court in accordance with Iowa Code section 252J.9.

b. Suspensions for noncompliance with a child support obligation shall continue until the department receives a withdrawal of the certificate of noncompliance from the Iowa child support recovery unit.

c. After the department receives a withdrawal of the certificate of noncompliance, an individual may obtain a new license upon application and the payment of all applicable fees.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 2561C, IAB 6/8/16, effective 7/13/16]

571—15.17(456A) Wildlife violator compact. The department has entered into the wildlife violator compact (the compact) with other states for the uniform enforcement of license suspensions. The compact, a copy of which may be obtained by contacting the department's law enforcement bureau, is adopted herein by reference. The procedures set forth in this rule shall apply to license suspensions pursuant to the wildlife violator compact.

15.17(1) Definitions. For purposes of this rule, the following definitions shall apply:

"Compliance" with respect to a citation means the act of answering a citation through an appearance in a court or through the payment of all fines, costs, and surcharges, if any.

"Department" means the Iowa department of natural resources.

"Home state" means the state of primary residence of a person.

"Issuing state" means a participating state that issues a fish or wildlife citation to a person.

"License" means any license, permit, or other public document which conveys to the person to whom it was issued the privilege of pursuing, possessing, or taking any fish or wildlife regulated by statute, law, regulation, ordinance, or administrative rule of a participating state.

"Participating state" means any state which enacts legislation to become a member of the wildlife violator compact. Iowa is a participating state pursuant to Iowa Code section 456A.24(14).

15.17(2) Suspension of licenses for noncompliance. Upon the receipt of a valid notice of failure to comply, as defined in the compact, the department shall issue a notice of suspension to the Iowa resident. The notice of suspension shall:

a. Indicate that all department-issued hunting (including furbearer) or fishing licenses shall be suspended, effective 30 days from the receipt of the notice, unless the department receives proof of compliance.

b. Inform the violator of the facts behind the suspension with special emphasis on the procedures to be followed in resolving the matter with the court in the issuing state. Accurate information in regard to the court (name, address, telephone number) must be provided in the notice of suspension.

c. Notify the license holder of the right to appeal the notice of suspension within 30 days of receipt. Said appeal shall be conducted pursuant to 571—Chapter 7 but shall be limited to the issues of whether the person so notified has a pending charge in the issuing state, whether the person has previously received notice of the violation from the issuing state, and whether the pending charge is subject to a license suspension for failure to comply pursuant to the terms of the compact.

d. Notify the license holder that, prior to the effective date of suspension, a person may avoid suspension through an appearance in the court with jurisdiction over the underlying violations or through the payment of all fines, costs, and surcharges associated with the violations.

e. Indicate that, once a suspension has become effective, the suspension may only be lifted upon the final resolution of the underlying violations.

15.17(3) Reinstatement of licenses. Any license suspended pursuant to this rule may be reinstated upon the receipt of an acknowledgement of compliance from the issuing state, a copy of a court judgment, or a certificate from the court with jurisdiction over the underlying violations and the payment of applicable Iowa license fees.

15.17(4) Issuance of notice of failure to comply. When a nonresident is issued a citation by the state of Iowa for violations of any provisions under the jurisdiction of the natural resource commission which is covered by the suspension procedures of the compact and fails to timely resolve said citation by payment of applicable fines or by properly contesting the citation through the courts, the department shall issue a notice of failure to comply.

a. The notice of failure to comply shall be delivered to the violator by certified mail, return receipt requested, or by personal service.

b. The notice of failure to comply shall provide the violator with 14 days to comply with the terms of the citation. The violator may avoid the imposition of the suspension by answering a citation through an appearance in a court or through the payment of all fines, costs, and surcharges, if any.

c. If the violator fails to achieve compliance, as defined in this rule, within 14 days of receipt of the notice of failure to comply, the department shall forward a copy of the notice of failure to comply to the home state of the violator.

15.17(5) Issuance of acknowledgement of compliance. When a person who has previously been issued a notice of failure to comply achieves compliance, as defined in this rule, the department shall issue an acknowledgement of compliance to the person who was issued the notice of failure to comply.

15.17(6) Reciprocal recognition of suspensions. Upon receipt of notification from a state that is a member of the wildlife violator compact that the state has suspended or revoked any person's hunting or fishing license privileges, the department shall:

- a. Enter the person's identifying information into the records of the department.
- b. Deny all applications for licenses to the person for the term of the suspension or until the department is notified by the suspending state that the suspension has been lifted.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.18 to 15.20 Reserved.

DIVISION III
SPECIAL LICENSES

571—15.21(483A) Fishing license exemption for patients of substance abuse facilities.

15.21(1) Definition. For the purpose of this rule, the definition of "substance abuse facility" is identical to the definition of "facility" in Iowa Code subsection 125.2(9).

15.21(2) Procedure. Each substance abuse facility may apply to the department of natural resources for a license exempting patients from the fishing license requirement while fishing as a supervised group as follows:

- a. Application shall be made on a form provided by the department and shall include the name, address and telephone number of the substance abuse facility including the name of the contact person. A general description of the type of services or care offered by the facility must be included as well as the expected number of participants in the fishing program and the water bodies to be fished.
- b. A license will be issued to qualifying substance abuse facilities and will be valid for all patients under the care of that facility.
- c. Patients of the substance abuse facility must be supervised by an employee of the facility while fishing without a license pursuant to this rule. An employee of the substance abuse facility must have the license in possession while supervising the fishing activity of patients.
- d. Notwithstanding the provisions of this rule, each employee of the substance abuse facility must possess a valid fishing license while participating in fishing.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.22(481A) Authorization to use a crossbow for deer and turkey hunting during the bow season by handicapped individuals.

15.22(1) Definitions. For the purpose of this rule:

"Bow and arrow" means a compound, recurve, or longbow.

"Crossbow" means a weapon consisting of a bow mounted transversely on a stock or frame and designed to fire a bolt, arrow, or quarrel by the release of the bow string, which is controlled by a mechanical or electric trigger and a working safety.

"Handicapped" means a person possessing a physical impairment of the upper extremities that makes a person physically incapable of shooting a bow and arrow. This includes difficulty in lifting and reaching with arms as well as difficulty in handling and fingering.

15.22(2) Application for authorization card. An individual requesting use of a crossbow for hunting deer or turkey must submit an application for an authorization card on forms provided by the department. The application must include a statement signed by the applicant's physician declaring that the individual is not physically capable of shooting a bow and arrow. A first-time applicant must submit the authorization card application no later than ten days before the last day of the license application period for the season the person intends to hunt.

15.22(3) Authorization card—issuance and use. Approved applicants will be issued a card authorizing the individual to hunt deer and turkey with a crossbow. The authorization card must be

carried with the license and on the person while hunting deer and turkey and must be exhibited to a conservation officer upon request.

15.22(4) *Validity and forfeiture of authorization card.* A card authorizing the use of a crossbow for hunting deer and turkey will be valid for as long as the person is incapable of shooting a bow and arrow. If a conservation officer has probable cause to believe the person's handicapped status has improved, making it possible for the person to shoot a bow and arrow, the department may, upon the officer's request, require the person to obtain in writing a current physician's statement.

If the person is unable to obtain a current physician's statement confirming that the person is incapable of shooting a bow and arrow, the department may initiate action to revoke the authorization card pursuant to 571—Chapter 7.

15.22(5) *Restrictions.* Crossbows equipped with pistol grips and designed to be fired with one hand are illegal for taking or attempting to take deer or turkey. All projectiles used in conjunction with a crossbow for deer hunting must be equipped with a broadhead.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 2561C, IAB 6/8/16, effective 7/13/16]

571—15.23(483A) Free hunting and fishing license for low-income persons 65 years of age and older or low-income persons who are permanently disabled.

15.23(1) *Purpose.* Pursuant to Iowa Code subsection 483A.24(15), the department of natural resources will issue a free annual combination hunting and fishing license to low-income persons who meet the age status or permanently disabled status as defined.

15.23(2) *Definitions.*

“*Age status*” means a person who has achieved the sixty-fifth birthday.

“*Low-income person*” means a person who is a recipient of a program administered by the state department of human services for persons who meet low-income guidelines.

“*Permanently disabled*” means a person who meets the definition in Iowa Code section 483A.4.

15.23(3) *Procedure.* Each person shall apply to the department of natural resources for a license as follows:

a. Application shall be made on a form provided by the department and shall include the name, address, height, weight, color of eyes and hair, date of birth, and gender of the applicant. In addition, applicants shall include a copy of an official document such as a birth certificate if claiming age status, or a copy of an award letter from the Social Security Administration or private pension plan if claiming permanent disabled status. The application shall include an authorization allowing the department of human services to verify the applicant's household income if proof of income is provided through the department of human services.

b. The free annual hunting and fishing combination license will be issued by the department upon verification of program eligibility. The license issued under this rule will be valid until January 10 of the subsequent year. Proof of eligibility must be submitted each year in order to obtain a free license.

c. A person whose income falls below the federal poverty guidelines may apply for this license by providing either of the following:

(1) A current Notice of Decision letter. For purposes of this rule, a “current Notice of Decision letter” shall mean a letter from the department of human services dated in the month the application is received or dated in the five months immediately preceding the month the application is received that describes the applicant's monthly or annual household income.

(2) If a person does not have a Notice of Decision letter as described in subparagraph (1), a document shall be provided that states that the applicant's annual income does not exceed the federal poverty limit for the current year and lists income from all sources, including but not limited to any wages or compensation, social security, retirement income, dividends and interest, cash gifts, rents and royalties, or other cash income. In addition, the applicant shall provide documentation of such income by submitting a copy of the applicant's most recently filed state or federal income tax return to the department. In the event an applicant does not have a tax return that was filed within the last year because the applicant's income level does not require the filing of a tax return, the applicant shall so notify the department, shall provide to the department bank statements, social security statements or

other relevant income documentation identified by the department, and shall meet with the department to verify income eligibility under this rule.

Federal poverty guidelines are published in February of each year and will be the income standard for applicants from that time until the guidelines are available in the subsequent year. The guidelines will be shown on the application and will be available upon request from the department.

15.23(4) Revocation. Any license issued pursuant to rule 571—15.23(483A) may be revoked, in whole or in part, by written notice, if the director determines that a license holder had provided false information to obtain a license under this chapter or has violated any provision of this chapter and that continuation of the license is not in the public interest. Such revocation shall become effective upon a date specified in the notice. The notice shall state the extent of the revocation and the reasons for the action. Within 30 days following receipt of the notice of a revocation, the license holder may file a notice of appeal, requesting a contested case hearing pursuant to 561—Chapter 7. The notice of appeal shall specify the basis for requesting that the license be reinstated.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 8465B, IAB 1/13/10, effective 2/17/10]

571—15.24(483A) Free annual fishing license for persons who have severe physical or mental disabilities.

15.24(1) Purpose. Pursuant to Iowa Code subsection 483A.24(9), the department of natural resources will issue a free annual fishing license to Iowa residents 16 or more years of age who have severe mental or physical disabilities who meet the definition of “severe mental disability” or “severe physical disability” in 15.24(2).

15.24(2) Definitions. For the purposes of this rule, the following definitions apply:

“*Severe mental disability*” means a person who has severe, chronic conditions in all of the following areas which:

1. Are attributable to a mental impairment or combination of mental and physical impairments;
2. Result in substantial functional limitations 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, or economic self-sufficiency;
3. Reflect the person’s need for a combination and sequence of services that are individually planned and coordinated; and
4. Requires the full-time assistance of another person to maintain a safe presence in the outdoors.

“*Severe physical disability*” means a disability that limits or impairs the person’s mobility or use of a hand or arm and that requires the full-time assistance of another person or that makes the person dependant on a wheelchair for the person’s normal life routine.

15.24(3) Procedure. Each person shall apply to the department of natural resources for a license as follows:

a. Application shall be made on a form provided by the department and shall include the name, home address, home telephone number, height, weight, eye and hair color, date of birth, and gender of the applicant and other information as required. The license issued under this rule will be issued by the department upon verification of program eligibility and will be valid until January 10 of the subsequent year. Proof of eligibility must be submitted each year in order to obtain the license.

b. The application shall be certified by the applicant’s attending physician with an original signature and, based upon the definition of severe mental disability or severe physical disability as provided for in this rule, declare that the applicant has a severe mental or physical disability. A medical statement from the applicant’s attending physician specifying the applicant’s type of disability shall be on 8½" x 11" stationery of the attending physician or on paper inscribed with the attending physician’s letterhead. For purposes of this rule, the attending physician must be a currently practicing doctor of medicine, doctor of osteopathy, physician’s assistant or nurse practitioner.

15.24(4) Revocation. Any license issued pursuant to 571—15.24(483A) may be revoked, in whole or in part, by written notice, if the director determines that a license holder had provided false information to obtain a license under this chapter or has violated any provision of this chapter and that continuation of the license is not in the public interest. Such revocation shall become effective upon a date specified

in the notice. The notice shall state the extent of the revocation and the reasons for the action. Within 30 days following receipt of the notice of a revocation, the license holder may file a notice of appeal, requesting a contested case hearing pursuant to 561—Chapter 7. The notice of appeal shall specify the basis for requesting that the license be reinstated.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 8465B, IAB 1/13/10, effective 2/17/10]

571—15.25(483A) Transportation tags for military personnel on leave from active duty.

15.25(1) *Military transportation tags for deer and turkey.* The military transportation tag shall include the following information: name, birth date, current address of military person; species and sex of animal taken; date of kill; and weapon used. Only conservation officers of the department shall be authorized to issue military transportation tags.

15.25(2) *Annual limit for military transportation tags.* A person receiving a military transportation tag shall be limited to one military deer tag and one military turkey tag annually.

15.25(3) *Regulations apply to military personnel.* With the exception of the license requirement exemption set forth in Iowa Code section 483A.24(6), all hunting and fishing regulations shall apply to active duty military personnel.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.26(483A) Special nonresident deer and turkey licenses. The commission hereby authorizes the director to issue special nonresident deer and turkey licenses pursuant to the provisions of 561—Chapter 12.

[ARC 2398C, IAB 2/17/16, effective 3/23/16]

571—15.27(483A) Apprentice hunter designation.

15.27(1) A person who is 16 years of age or older and meets all the requirements of Iowa Code section 483A.27A may purchase, up to two times, a hunting license with an apprentice hunter designation on the license without first completing a hunter education course.

15.27(2) A hunting license with an apprentice hunter designation issued pursuant to Iowa Code section 483A.27A is valid from the date issued to January 10 of the succeeding calendar year.

[ARC 2561C, IAB 6/8/16, effective 7/13/16]

571—15.28 to 15.40 Reserved.

DIVISION IV
EDUCATION AND CERTIFICATION PROGRAMS

571—15.41(483A) Hunter education program. This division clarifies the term “hunting license” as used in Iowa Code section 483A.27 in relation to the hunter education course requirement, clarifies the need for exhibiting a hunter education course certificate when applying for a deer or wild turkey license, and explains the requirements for individuals who wish to demonstrate their knowledge of hunter education so as to be eligible to purchase an Iowa hunting license. For the purpose of this division, a hunting license, pursuant to Iowa Code sections 483A.1 and 483A.24, includes:

1. Hunting licenses for legal residents except as otherwise provided. (Iowa Code section 483A.1(1))
2. Hunting licenses for nonresidents. (Iowa Code section 483A.1(2))
3. Hunting preserve license.
4. Free annual hunting and fishing licenses for persons who are disabled or are 65 years of age or older and qualify for low-income status as defined in Iowa Code section 483A.24.
5. Veteran’s lifetime hunting and fishing license as defined in Iowa Code section 483A.24.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 2561C, IAB 6/8/16, effective 7/13/16]

571—15.42(483A) Testing procedures.

15.42(1) *General testing procedures.*

a. Upon completion of the required curriculum, each person shall score a minimum of 75 percent on the written or oral test provided by the department and demonstrate safe handling of a firearm. Based

on the results of the written or oral test and demonstrated firearm safe handling techniques as prescribed by the department, the volunteer instructor shall determine the persons who shall be issued a certificate of completion.

b. Notwithstanding paragraph 15.42(1)“*a*” above, a resident who is 18 years of age or older may obtain a certificate of completion without demonstrating the safe handling of a firearm.

15.42(2) Exemptions. The following groups of individuals do not need hunting licenses and therefore do not need to satisfactorily complete a hunter education course:

a. Landowners and tenants. Owners or tenants of land and their children when hunting on the land which they own or on which they are tenants.

b. Residents under 16. Residents of the state under 16 years of age accompanied by their parent or guardian or in the company of any other competent adult if the adult accompanying said minor possesses a valid hunting license, providing, however, there is one licensed adult accompanying each person under 16 years of age.

15.42(3) Deer and wild turkey license applications. Individuals are not required to exhibit a certificate showing satisfactory completion of a hunter education course only when applying for a deer or wild turkey license.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 2561C, IAB 6/8/16, effective 7/13/16]

571—15.43(321G,462A,483A) Volunteer bow and fur harvester education instructors, snowmobile and all-terrain vehicle (ATV) safety instructors, boating safety instructors and hunter education instructors. Rescinded ARC 2561C, IAB 6/8/16, effective 7/13/16.

571—15.44 to 15.50 Reserved.

DIVISION V

LICENSE REVOCATION, SUSPENSION, AND MODIFICATION DUE TO LIABILITIES OWED TO THE STATE

571—15.51(272D) Purpose and use. This rule is intended to help collect liabilities of the state or a state agency. This rule shall apply to all licenses issued, renewed or otherwise authorized by the department. [ARC 8465B, IAB 1/13/10, effective 2/17/10]

571—15.52(272D) Definitions. For purposes of this chapter, the following definitions shall apply:

“*Certificate of noncompliance*” means a document provided by the unit certifying the named person has outstanding liability placed with the unit and has not entered into an approved payment plan to pay the liability.

“*Department*” means the department of natural resources.

“*Liability*” means a debt or obligation placed with the unit for collection that is greater than \$1,000. For purposes of this chapter, “liability” does not include child support payments collected pursuant to Iowa Code chapter 252J.

“*License*” means a license, certification, registration, permit, approval, renewal or other similar authorization issued to a person by the department which evidences the admission to, or granting of authority to engage in, a profession, occupation, business, industry, or recreation, including those authorizations set out in Iowa Code chapters 321G, 321I, 455B, 455C, 455D, 456A, 459, 459A, 461A, 462A, 481A, 481B, 481C, 482, 483A, 484B and 484C.

“*Licensee*” means a person to whom a license has been issued by the department or who is seeking the issuance of a license from the department.

“*Notice of intent*” means a notice sent to a licensee indicating the department’s intent to suspend, revoke, or deny renewal or issuance of a license.

“*Obligor*” means a person with a liability placed with the unit.

“*Unit*” means the centralized collection unit of the department of revenue or the college student aid commission.

“*Withdrawal of a certificate of noncompliance*” means a document provided by the unit certifying that the certificate of noncompliance is withdrawn and that the department may proceed with issuance, reinstatement, or renewal of a person’s license.

[ARC 8465B, IAB 1/13/10, effective 2/17/10; ARC 9005B, IAB 8/11/10, effective 9/15/10]

571—15.53(272D) Requirements of the department.

15.53(1) Records. The department shall collect and maintain records of its licensees that must include, at a minimum, the following:

- a. The licensee’s first and last names.
- b. The licensee’s current known address.
- c. The licensee’s social security number.

The records shall be made available to the unit so that the unit may match to the records the names of persons with any liabilities placed with the unit for collections. The records must be submitted in an electronic format and updated on a quarterly basis.

15.53(2) Certificate of noncompliance. Upon receipt of a certificate of noncompliance from the unit, the department shall initiate its existing rules and procedures for the suspension, revocation, or denial of issuance or renewal of a person’s license.

15.53(3) Notice of intent. The department shall provide a notice of intent to a person of its intent to suspend, revoke or deny issuance or renewal of a license in accordance with Iowa Code chapter 272D or section 261.126, whichever is appropriate. The suspension, revocation, or denial shall be effective no sooner than 30 days following the issuance of the notice of intent to the person. The notice shall include all of the following:

- a. That the department has received a certificate of noncompliance from the unit and intends to suspend, revoke or deny issuance or renewal of a person’s license;
- b. That the person must contact the unit to schedule a conference or to otherwise obtain a withdrawal of a certificate of noncompliance;
- c. That the department will revoke, suspend or deny the person’s license unless a withdrawal of a certificate of noncompliance is received from the unit within 30 days from the date of the notice;
- d. That, in the event the department’s rules and procedures conflict with the additional rules and procedures under this action, the rules and procedures of this action shall apply;
- e. That mistakes of fact in the amount of the liability owed and the person’s identity may not be contested to the department; and
- f. That the person may request a district court hearing as outlined in rule 701—153.14(272D).

15.53(4) Withdrawal. Upon receipt of a withdrawal of a certificate of noncompliance from the unit, the department shall immediately reinstate, renew, or issue a license if the person is otherwise in compliance with the department’s requirements.

[ARC 8465B, IAB 1/13/10, effective 2/17/10; ARC 9005B, IAB 8/11/10, effective 9/15/10]

571—15.54(272D) No administrative appeal of the department’s action. Pursuant to Iowa Code sections 261.126 and 272D.8, a person does not have a right to a hearing before the department to contest the department’s action under this rule, but may request a court hearing pursuant to rule 571—15.55(272D).

[ARC 8465B, IAB 1/13/10, effective 2/17/10; ARC 9005B, IAB 8/11/10, effective 9/15/10]

571—15.55(272D) District court hearing. A person may seek review of the actions listed in rule 701—153.14(272D) and request a hearing before the district court by filing an application with the district court in the county in which the majority of the liability was incurred. The person must send a copy of the application to the unit by regular mail. The application must be filed no later than 30 days after the department issues its notice of intent.

15.55(1) Scheduling. The clerk of the district court shall schedule a hearing and mail a copy of the scheduling order to the person, the unit, and the department.

15.55(2) Certification. The unit shall certify a copy of its written decision and certificate of noncompliance, indicating the date of issuance, and the department shall certify a copy of the notice issued pursuant to subrule 15.53(3) to the court prior to the hearing.

15.55(3) Stay. Upon receipt from the clerk of court of a copy of a scheduling order and prior to the hearing, the department shall stay any action contemplated on the person's license pursuant to the notice of intent.

15.55(4) Hearing. The hearing on the person's application shall be scheduled and held within 30 days of the application being filed. However, if the person fails to appear at the scheduled hearing, the stay shall be lifted and the department shall continue its procedures pursuant to the notice of intent.

15.55(5) Scope of review. The district court's review shall be limited to demonstration of the amount of the liability owed or the identity of the person.

15.55(6) Findings. If the court finds the unit was in error either in issuing a certificate of noncompliance or in its failure to issue a withdrawal of a certificate of noncompliance, the unit shall issue a withdrawal of a certificate of noncompliance to the department. If the court finds the unit was justified in issuing a certificate of noncompliance or in not issuing a withdrawal of a certificate of noncompliance, a stay imposed under subrule 15.55(3) shall be lifted and the department shall proceed with the action as outlined in its notice of intent.

[ARC 8465B, IAB 1/13/10, effective 2/17/10]

These rules are intended to implement Iowa Code chapters 272D, 321G, 456A, 462A, 481A, 481B, 482, 483A, 484A, and 484B and Iowa Code section 261.126.

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EARLY HEARING DETECTION AND INTERVENTION (EHDI) PROGRAM

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[Prior to 7/29/87, Health Department[470], Ch 9]

641—9.1(135) Scope. The scope of this chapter is to describe the standards for outpatient diabetes self-management education programs and the procedures programs must follow for certification by the Iowa department of public health that will allow for third-party reimbursement.

641—9.2(135) Definitions. For the purpose of these rules, the following terms shall have the meaning set forth below.

“*AADE*” means the American Association of Diabetes Educators.

“*Accredited*” means that a program is currently accredited by the American Association of Diabetes Educators.

“*ADA*” means the American Diabetes Association.

“*Certification*” means the review and approval and assignment of a program site number of an outpatient diabetes education program which meets minimum standards.

“*Certified diabetes educator*” means a person currently certified by the National Certification Board for Diabetes Educators.

“*Department*” means the Iowa department of public health.

“*Diabetes mellitus*” includes the following:

1. “Type I diabetes” means insulin-dependent diabetes (IDDM) requiring lifelong treatment with insulin.

2. “Type II diabetes” means noninsulin-dependent diabetes often managed by food plan, exercise, weight control, and in some instances, oral medications or insulin.

3. “Gestational diabetes” means diabetes diagnosed during pregnancy.

4. “Impaired glucose tolerance” means a condition in which blood glucose levels are higher than normal, diagnosed by a physician, and treated with food plan, exercise or weight control.

5. “Secondary diabetes” means diabetes induced by drugs or chemicals as well as by pancreatic or endocrine disease and treated appropriately.

“*Director*” means the director of the Iowa department of public health.

“*Licensed dietitian*” means a person currently licensed to practice dietetics under Iowa Code chapter 152A.

“*Participant*” means a patient who is referred to, is active in, or has completed the educational diabetes program.

“*Pharmacist*” means a person currently licensed to practice pharmacy under Iowa Code chapter 155.

“*Physician*” means a person currently licensed to practice medicine and surgery, osteopathic medicine and surgery, or osteopathy under Iowa Code chapter 148.

“*Primary instructor*” means an instructor with major or broad teaching responsibility.

“*Professional health educator*” means a person having successfully completed a degree designated “health education” from an accredited college or university.

“*Program*” means an outpatient diabetes self-management education program in which instruction shall be provided which shall enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes.

“*Program coordinator*” means the person responsible for the direction and supervision of a program including, but not limited to, planning, arranging implementation, and assuring quality.

“*Program staff*” means the program coordinator, program physician, primary and supporting instructors, and advisory committee members.

“*Recognized*” means that a program is currently recognized by the American Diabetes Association.

“*Registered nurse*” means a person currently licensed to practice professional nursing under Iowa Code chapter 152.

“*Standards*” means the outpatient diabetes education program standards developed by the department.

“*Supporting instructor*” means an instructor who teaches only one or two specific topics of the program, on a voluntary or paid basis.

[ARC 9249B, IAB 12/1/10, effective 1/5/11; ARC 4074C, IAB 10/10/18, effective 11/14/18]

641—9.3(135) Powers and duties. The department shall be responsible for taking the following actions:

9.3(1) Develop minimum standards in coordination with the American Diabetes Association and the American Association of Diabetes Educators.

9.3(2) Annually review and update the standards as needed, and provide revised standards to programs and others.

9.3(3) Develop certification packages.

a. Certification packages shall be provided on request to programs and to the general public.

b. The package shall contain certification procedures, rules, and standardized forms.

c. The certification package is available from the Bureau of Chronic Disease Prevention and Management, Division of Health Promotion and Chronic Disease Prevention, Iowa Department of Public Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075.

9.3(4) Evaluate each application submitted and determine adequacy of program for certification.

9.3(5) Assign a program site number and an expiration date and issue a certificate to each program that meets the standards. A certificate shall be valid for four years from issuance unless specified otherwise on the certificate or unless sooner revoked.

9.3(6) Maintain a list of certified programs.

[ARC 9249B, IAB 12/1/10, effective 1/5/11; ARC 4074C, IAB 10/10/18, effective 11/14/18]

641—9.4(135) Application procedures for American Diabetes Association-recognized and American Association of Diabetes Educators-accredited programs. When a program is recognized by the American Diabetes Association or accredited by the American Association of Diabetes Educators, the program shall apply for certification by submitting the following to the department:

9.4(1) A copy of the Certificate of Recognition provided by ADA or the Certificate of Accreditation provided by AADE.

9.4(2) The name, address and telephone number for the program.

9.4(3) The names of the program coordinator, program physician, primary and supporting instructors, and advisory committee members.

9.4(4) Copies of current licenses for all Iowa-licensed professionals named in 9.4(3).

9.4(5) The name and a copy of both the Iowa licenses and continuing education hours of any pharmacist who serves as program staff. A pharmacist shall be a primary or supporting instructor or advisory committee member and shall meet the education requirements in 9.8(6), 9.8(7) or 9.8(8).

[ARC 9249B, IAB 12/1/10, effective 1/5/11; ARC 4074C, IAB 10/10/18, effective 11/14/18]

641—9.5(135) Renewal procedures for American Diabetes Association-recognized and American Association of Diabetes Educators-accredited programs. Programs shall renew their certification every four years, at least 30 days prior to the expiration date. To apply for renewal of certification, the ADA-recognized program or the AADE-accredited program shall submit the following to the department:

9.5(1) A copy of the new ADA Certificate of Recognition or AADE Certificate of Accreditation.

9.5(2) The name, address and telephone number for the program.

9.5(3) The names of the program coordinator, program physician, primary and supporting instructors, and advisory committee members.

9.5(4) Copies of current licenses for all Iowa-licensed professionals named in 9.5(3).

9.5(5) The name and a copy of both the Iowa licenses and continuing education hours of any pharmacist who serves as program staff. A pharmacist shall be a primary or supporting instructor or advisory committee member and shall meet the continuing education requirements in 9.9(7).

[ARC 9249B, IAB 12/1/10, effective 1/5/11; ARC 4074C, IAB 10/10/18, effective 11/14/18]

641—9.6(135) Application procedures for programs not recognized by the American Diabetes Association or accredited by the American Association of Diabetes Educators.

9.6(1) Each program shall apply for certification with the department.

9.6(2) Applications from programs not recognized by ADA or accredited by AADE shall provide the following information:

a. Name, address and telephone number for the program, program physician and program coordinator. The names of instructional staff and advisory committee members and copies of their current Iowa licenses shall also be included.

b. Identification of the target population, an estimate of the program caseload, estimated number of programs to be conducted annually, minimum and maximum class size, and a calendar identifying the hours per day and number of days per week scheduled in individual or group instruction to meet the minimum course requirements.

c. A description of goals and objectives, participant referral mechanism, and means of coordinating between the community, physicians, and program staff.

d. Evaluation methods designed by individual programs and samples of documents to be used.

e. A description of the curriculum designed to instruct the participant with diabetes how to achieve self-management competency. The curriculum shall cover the same content areas as are required by the ADA for recognition or the AADE for accreditation including:

(1) Diabetes overview: includes content about the diabetes disease process, pathophysiology and treatment/management options.

(2) Stress and psychological adjustment: includes developing personal strategies to address psychological issues, healthy coping, and problem solving.

(3) Family involvement and social support: includes strategies for safety and risk reduction and creating healthy environments and social supports.

(4) Nutrition: includes incorporating nutritional management (healthy eating) into lifestyle.

(5) Exercise and activity: includes incorporating physical activity (being active) into lifestyle.

(6) Medications: includes using medications safely and for maximum therapeutic benefit.

(7) Monitoring and use of results: includes monitoring blood glucose and other health indicators or parameters and interpreting and using the results for self-management decision making.

(8) Reducing risks: includes prevention, detection, and treatment of acute complications and chronic complications; foot, skin and dental care; immunizations; and kidney function.

(9) Behavior change strategies, goal setting, risk-factor reduction, and problem solving: includes personal goals and strategies to address risks and build positive habits.

(10) Preconception care, pregnancy, and gestational diabetes.

(11) Use of health care systems and community resources.

[ARC 9249B, IAB 12/1/10, effective 1/5/11; ARC 4074C, IAB 10/10/18, effective 11/14/18]

641—9.7(135) Diabetes program management for programs not recognized by the American Diabetes Association or accredited by the American Association of Diabetes Educators.

9.7(1) Pertinent information related to the recent medical history, physical examination, and test results performed by the participant's health care provider shall be provided when the participant is referred to the program. Program staff shall remain in contact with the participant's health care provider and shall make recommendations relative to the medical care and treatment of the participant's diabetes when appropriate.

9.7(2) When the participant completes the program, arrangements shall be made by program staff for optimal follow-up care.

9.7(3) Program staff members shall take an active role in the care of the participant's diabetes during the course of the program to optimize diabetes control. The program staff shall be prepared to make necessary recommendations to the referring health care provider in the participant's diabetes management which may include the following:

a. Changes in the insulin regimen.

b. Changes in the medications.

- c. Changes in the food plan.
- d. Changes in exercise.

9.7(4) Written materials supporting the program curriculum are to be made available to the participants. Educational materials from commercial sources shall be carefully evaluated by staff and be consistent with the program curriculum.

[ARC 9249B, IAB 12/1/10, effective 1/5/11]

641—9.8(135) Program staff for programs not recognized by the American Diabetes Association or accredited by the American Association of Diabetes Educators.

9.8(1) A program coordinator and a program physician shall be designated.

a. The program coordinator shall provide direction and supervision of the program, including, but not limited to, planning, arranging implementation, and assuring quality. If the program coordinator is an instructor, the program coordinator shall be a health care professional and meet the requirements for primary or supporting instructor.

b. The program physician shall provide medical direction for the program. The program physician shall maintain contact with the participant's attending physician and shall make recommendations relative to the medical care and treatment of the participant's diabetes where appropriate.

9.8(2) The program shall have an advisory committee composed of at least one physician, one registered nurse, one licensed dietitian and one pharmacist to oversee the program. It is recommended the advisory committee include an individual with behavioral science expertise, a consumer, and a community representative. The advisory committee shall participate in the annual planning process, including determination of target audience, program objectives, participant access mechanisms, instructional methods, resource requirements, participant follow-up mechanisms, and program evaluation.

9.8(3) The primary instructors shall be one or more of the following health care professionals: physicians, registered nurses, licensed dietitians, and pharmacists who are knowledgeable about the disease process of diabetes and the treatment of diabetes. If there is only one primary instructor, there shall be at least one supporting instructor. The supporting instructor shall be from one of the four professions listed as possible primary instructors, but a different profession from the single primary instructor.

9.8(4) The program may have additional supporting instructors including, but not limited to, dentist, exercise physiologist, health educator, ophthalmologist, pediatric diabetologist, podiatrist, psychologist, psychiatrist, or social worker.

9.8(5) The names of the program physician, program coordinator, all primary and supporting instructors, and advisory committee members shall be included with the program application, with copies of their current Iowa licenses.

9.8(6) All primary instructors shall show evidence of knowledge about the disease process of diabetes and the treatment and management of people with diabetes by documentation of one or more of the following:

a. Within the last four years, completion of a minimum of 32 hours of continuing education in diabetes, diabetes management, or diabetes education; or

b. Equivalent training or experience including, but not limited to, endocrinology fellowship training or masters level preparation in diabetes nursing/nutrition. Unsupervised teaching of patients is not an acceptable equivalent.

c. Current certification as a certified diabetes educator.

9.8(7) All supporting instructors shall show evidence of knowledge about the disease process of diabetes and the treatment and management of people with diabetes by documentation of completion of a minimum of 16 hours of continuing education in diabetes, diabetes management, or diabetes education within the last four years or have current certification as a certified diabetes educator.

9.8(8) The four professionals required in 9.8(2) to be on the advisory committee shall have completed eight hours of continuing education in diabetes within the past four years.

9.8(9) The program coordinator shall determine that each primary or supporting instructor has current licensure or registration required to practice in Iowa.

9.8(10) The program coordinator shall determine that new primary or supporting instructors, who join the program staff during a certification period, meet the requirements for initial certification in 9.8(6) or 9.8(7) within six months of when they join the program staff.

[ARC 9249B, IAB 12/1/10, effective 1/5/11; ARC 4074C, IAB 10/10/18, effective 11/14/18]

641—9.9(135) Renewal application procedures for programs not recognized by the American Diabetes Association or accredited by the American Association of Diabetes Educators. Every four years, programs shall provide the following information to the department at least 30 days prior to the expiration date.

9.9(1) Name, address and telephone number of the program, program physician and program coordinator, with names of instructional staff and advisory committee members and copies of current licenses for all Iowa-licensed professionals.

9.9(2) Identification of the target population, an estimate of program caseload, and the number of participants served in the certification period.

9.9(3) A description of goals and objectives, participant referral mechanism, and means of coordinating between the community, physicians, and program staff.

9.9(4) A description of the program evaluation process.

9.9(5) A description of any changes from the previous application.

9.9(6) A list of new program staff by name, license number or registration number, and position with the program. New staff who will serve as primary instructors shall submit documentation of their training in diabetes as addressed in 9.8(6). New staff serving as supporting instructors shall submit documentation of their training as addressed in 9.8(7).

9.9(7) Documentation of continuing education hours accrued since the previous application for current staff and new staff.

a. All primary instructors shall complete a minimum of 24 hours of continuing education in diabetes, diabetes management, or diabetes education within the past four years.

b. All supporting instructors shall complete a minimum of 12 hours of continuing education in diabetes, diabetes management, or diabetes education within the past four years.

c. The four professionals required in 9.8(2) to be on the advisory committee shall complete a minimum of seven hours of continuing education in diabetes within the past four years.

[ARC 9249B, IAB 12/1/10, effective 1/5/11; ARC 4074C, IAB 10/10/18, effective 11/14/18]

641—9.10(135) Annual report. Summary data shall be completed annually by each program and sent to the department. The data shall include but not be limited to the number of times the program was presented, the number of outpatients that participated, and a summarized description of program participants including type of diabetes, age, race and sex.

[ARC 9249B, IAB 12/1/10, effective 1/5/11]

641—9.11(135) Enforcement.

9.11(1) The department may annually or more frequently conduct on-site visits of certified programs.

9.11(2) The department shall furnish a written report of each visit to the program coordinator.

9.11(3) Programs determined by the department to no longer meet the minimum standards for certification shall be given 30 days following receipt of the department's notification of deficiencies to submit a plan of correction.

9.11(4) Notification of cancellation shall be provided to the Iowa insurance division of the Iowa department of commerce and the public.

641—9.12(135) Complaints.

9.12(1) The department shall accept complaints of alleged problems relating to certified outpatient diabetes self-management programs. The information shall state in a reasonably specific manner the basis of the complaints and be presented in writing, in person or by telephone to: Bureau of Chronic

Disease Prevention and Management, Division of Health Promotion and Chronic Disease Prevention, Iowa Department of Public Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075; (515)281-5616.

9.12(2) The department shall, within 20 working days of the receipt of the complaint, contact the program coordinator for initial evaluation of the specific matters alleged in the complaint. The program shall receive a written report of the results of department activities relating to the complaint investigation. The complainant shall be promptly informed of the results of the investigation or any action taken by the department.

[ARC 9249B, IAB 12/1/10, effective 1/5/11]

641—9.13(135) Appeal process.

9.13(1) Denial. Programs shall receive written notice by certified mail, return receipt requested, setting forth the reason(s) for denial. The denial shall become effective 30 days after receipt by the aggrieved party unless the grievant within that 30-day period gives written notice to the department requesting a hearing in which case the notice shall be deemed to be suspended.

9.13(2) Revocation. Programs shall receive written notice by certified mail, return receipt requested, setting forth the reason(s) for revocation. The revocation shall become effective 30 days after receipt by the aggrieved party unless the grievant within that 30-day period gives written notice to the department requesting a hearing in which case the notice shall be deemed to be suspended.

9.13(3) Contested case. Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the department of inspections and appeals pursuant to the rule adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

641—9.14(135) Formal contest.

9.14(1) Hearing. The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10.

9.14(2) Decision of administrative law judge. When the administrative law judge makes a proposed decision and order, it shall be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken as provided in 9.14(3).

9.14(3) Appeal to director. Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

9.14(4) Record of hearing. Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

- a. All pleadings, motions and rules.
- b. All evidence received or considered and all other submissions by recording or transcript.
- c. A statement of all matters officially noticed.
- d. All questions and offers of proof, objections and rulings thereon.
- e. All proposed findings and exceptions.
- f. The proposed decision and order of the administrative law judge.

9.14(5) Decision of director. The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by certified mail, return receipt requested, or by personal service.

9.14(6) Exhausting administrative remedies. It is not necessary to file an application or a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has

exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

9.14(7) *Petition for judicial review.* Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the director by certified mail, return receipt requested, or by personal service. The address is: Iowa Department of Public Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075.

[ARC 9249B, IAB 12/1/10, effective 1/5/11]

These rules are intended to implement Iowa Code section 135.11.

[Filed 5/17/85, Notice 11/7/84—published 6/5/85, effective 7/10/85]¹

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[Filed ARC 4074C (Notice ARC 3898C, IAB 7/18/18), IAB 10/10/18, effective 11/14/18]

¹ Objection to 9.6(2) filed 7/11/85, IAB 7/31/85.

² See IAB, Inspections and Appeals Department.

CHAPTER 76
MATERNAL AND CHILD HEALTH PROGRAM

641—76.1(135) Program overview. The maternal and child health (MCH) programs are operated by the Iowa department of public health as the designated state agency pursuant to an agreement with the federal government. The majority of the funding available is from the Title V MCH block grant, administered by the Health Resources and Services Administration (HRSA) within the United States Department of Health and Human Services (DHHS).

76.1(1) Purpose. The purpose of the program is to promote the health of mothers, children, and youth by ensuring or providing access to quality maternal and child health care services (especially for low-income families or families with limited availability of health care services); to reduce infant mortality and the incidence of preventable diseases and handicapping conditions; to increase the number of children appropriately immunized against disease; and to facilitate the development of community-based systems of health care for children, youth and their families. The program provides and promotes family-centered, community-based coordinated care, including care/service coordination for children and youth with special health care needs.

76.1(2) Services.

a. The department's bureau of family health (BFH) enters into contracts with selected private nonprofit or public agencies for the assurance of access to prenatal and postpartum care for women, preventive and primary child health care services, and services to children and youth with special health care needs.

b. The department's bureau of oral and health delivery systems (OHDS) collaborates with BFH to develop oral health programs to reduce barriers to oral health care and reduce dental disease through prevention.

c. The children and youth with special health care needs program is administered by the Child Health Specialty Clinics (CHSC) at the University of Iowa. The department contracts with the University of Iowa department of pediatrics' CHSC to provide services for children and youth with special health care needs. In accordance with the MCH Title V Block Grant Program administered by DHHS, HRSA, and MCHB, the CHSC shall ensure that public health funds will be used to cover the cost of services only after all other sources of reimbursement have been exhausted.

76.1(3) MCH advisory council. The MCH advisory council assists in developing the state plan for MCH, assessing need, prioritizing services, establishing objectives, and encouraging public support for MCH and family planning programs. In addition, the council advises the director regarding health and nutrition services for women and children, supports the development of special projects and conferences and advocates for health and nutrition services for women and children.

[ARC 0364C, IAB 10/3/12, effective 11/7/12; ARC 4075C, IAB 10/10/18, effective 11/14/18]

641—76.2(135) Adoption by reference. Federal requirements contained in the Omnibus Reconciliation Act of 1989 (Public Law 101-239), Title V MCH block grant shall be the rules governing the Iowa MCH program and are incorporated by reference herein. Copies of the federal legislation adopted by reference are available from Chief, Bureau of Family Health, Iowa Department of Public Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075.

[ARC 0364C, IAB 10/3/12, effective 11/7/12]

641—76.3(135) Rule coverage. These rules cover agencies contracting with the department to provide community-based MCH public health care services and to receive funds from the department for that purpose. The contract agencies conduct essential public health care services directed toward MCH populations consistent with the state's Title V MCH block grant state plan. The state plan is developed and administered collaboratively by BFH and OHDS of the department and CHSC.

[ARC 0364C, IAB 10/3/12, effective 11/7/12]

641—76.4(135) Definitions.

“*Applicant*” means a private nonprofit or public agency that seeks a contract with the department to provide MCH services.

“*BFH*” means the bureau of family health.

“*Care/service coordination*” or “*care coordination*” means a comprehensive, family-centered approach that proactively engages and links clients and families to needed health care services, including medical, dental, emotional, behavioral, and health education services. Care coordination encompasses a specific set of activities that promote a client’s potential for optimal health and facilitate quality outcomes. By working with the client, family, and other involved disciplines, a care coordinator can promote seamless access and a holistic approach to service provision. Care coordination incorporates the following:

1. Meaningful assessment of needs and concerns.
2. Shared development of care plans.
3. Mobilization of agency and community resources.
4. Continued monitoring and follow-up.
5. Clear and transparent communication.
6. Complete documentation.

“*Chairperson*” means the chairperson of the MCH advisory council, who has been elected by the majority of the council’s members.

“*Children and youth with special health care needs*” or “*CYSHCN*” means children and youth with chronic physical, developmental, behavioral, or emotional conditions that require health and related services of a type or amount beyond that required by children and youth generally.

“*CHSC*” means Child Health Specialty Clinics, a statewide program for children and youth with special health care needs authorized under Title V of the Social Security Act.

“*Client*” means an individual who receives MCH services through a contract agency.

“*CMS*” means the DHHS Centers for Medicare and Medicaid Services.

“*Contract agency*” means a private nonprofit or public agency that has a contract with the department to provide MCH services and receives funds from the department for that purpose.

“*Core public health functions*” means the functions of community health assessment, policy development, and assurance.

1. Assessment: regular collection, analysis, interpretation, and communication of information about health conditions, risks, and assets in a community.

2. Policy development: development, implementation, and evaluation of plans and policies, for public health in general and priority health needs in particular, in a manner that incorporates scientific information and community values and is in accordance with state public health policy.

3. Assurance: ensuring, by encouragement, regulation, or direct action, that programs and interventions that maintain and improve health are carried out.

“*Council*” or “*MCH advisory council*” means the maternal and child health advisory council.

“*Dental home*” means a network of individualized care based on risk assessment, which includes oral health education, dental screenings, preventive services, diagnostic services, treatment services, and emergency services.

“*Department*” means the Iowa department of public health.

“*DHHS*” means the United States Department of Health and Human Services.

“*DIA*” means the Iowa department of inspections and appeals.

“*Direct health services*” means those services generally delivered one-on-one between a health professional and a client in an office or clinic.

“*Director*” means the director of the Iowa department of public health.

“*Enabling services*” means services that are designed to help families gain access to health care. Enabling services include but are not limited to outreach, informing/reinforming, and care coordination services to link women, children, and families to needed health care services.

“*EPSDT*” means the Early and Periodic Screening, Diagnosis, and Treatment program which provides for regular preventive health care services for children aged 0 to 21 as authorized by Title XIX of the Social Security Act.

“Essential public health services” means those activities carried out by public health entities and their contractors that fulfill the core public health functions in the promotion of maternal and child health.

“Family,” for the purpose of establishing eligibility, means a group of two or more persons related by birth, marriage or adoption or residing together and functioning as one socioeconomic unit. For the purpose of these rules, a pregnant woman is considered as two individuals when calculating the number of individuals in the family. If a pregnant woman is expecting multiple births, the family size is thereby increased by the number expected in the multiple birth.

“Family planning” means the promotion of reproductive and family health by the prevention of and planning for pregnancy, and reproductive health education.

“Gap filling” means direct health care services supported by Title V staff or resources that are not otherwise accessible in the community.

“HAWK-I” means healthy and well kids in Iowa and is the child health insurance program in Iowa as authorized in Title XXI of the Social Security Act.

“Health care services” means services provided through MCH contract agencies.

“Health professional” means an individual who possesses specialized knowledge in a health or social science field or is licensed to provide health care.

“HRSA” means the Health Resources and Services Administration with the United States Department of Health and Human Services.

“Infrastructure building” means activities that support developing and maintaining comprehensive health care service systems. These activities include but are not limited to needs assessment, data collection, strategic planning, working with community partners, developing protocols, quality assurance, and training.

“I-Smile™ program” means the department program implemented through public and private nonprofit agencies and private health care providers to increase access to dental care for children and to ensure a dental home.

“Maternal and child health services” means services provided through local contract agencies to meet the needs of the client. The types of services provided include infrastructure building, population-based services, enabling services, and direct health care services.

“Medicaid” means the Medicaid program authorized by Title XIX of the Social Security Act and funded through the Iowa department of human services from the DHHS.

“Medical home” means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the client, the personal provider, and other health care professionals, and where appropriate, the client’s family; utilizes the partnership to access all medical and nonmedical health-related services needed by the client and the client’s family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the characteristics specified in Iowa Code section 135.158.

“MIECHV” means the Maternal, Infant and Early Childhood Home Visiting program.

“OHDS” means the bureau of oral and health delivery systems.

“OMB” means the United States Department of the Treasury, Office of Management and Budget.

“Performance measures” means National Performance Measures (NPM) and State Performance Measures (SPM) required through the HRSA, Maternal and Child Health Bureau (MCHB), Title V MCH Block Grant.

“Physician” means a person currently licensed to practice under Iowa Code chapter 148.

“Population-based services” means services that include preventive personal health care services for groups of individuals (rather than one-on-one). Payer status of the individuals is not assessed, and services are not billed. Population-based services may be provided to an entire community, county, or region. Examples include but are not limited to mass immunizations, classroom oral health education, and the use of media for health promotion and education.

“Prenatal and postpartum care” means those types of services as recognized by the American College of Obstetricians and Gynecologists.

“Presumptive eligibility determination” means temporary Medicaid eligibility that pays for medical services while a formal Medicaid decision is being made by the Iowa department of human services. Presumptive eligibility is available for children, youth, and pregnant women.

“Program income” means gross income earned by the MCH contract agency resulting from activities related to fulfilling the terms of the contract. “Program income” includes but is not limited to such income as fees for services, third-party reimbursements, and proceeds from sales of tangible, personal or real property.

“Title V” means Title V of the Social Security Act and the federal requirements contained in the Omnibus Reconciliation Act of 1989 (Public Law 101-239) which address the MCH and CYSHCN programs.

“Title X” means the program authorized in the federal regulations found in 42 CFR Subpart A, Part 59, published in the Federal Register on June 3, 1980, and the Program Guidelines for Project Grants for Family Planning Services.

“Title XIX” means the Medicaid program authorized in the Social Security Act and funded through the Iowa department of human services from the DHHS.

“Title XXI” means the child health insurance program authorized in the Social Security Act and implemented in Iowa as the HAWK-I program as administered by the Iowa department of human services.

“WIC” means the Special Supplemental Nutrition Program for Women, Infants and Children, funded through the department from the United States Department of Agriculture.
[ARC 0364C, IAB 10/3/12, effective 11/7/12; ARC 4075C, IAB 10/10/18, effective 11/14/18]

641—76.5(135) MCH services. Maternal and child health services provided by contract agencies, as outlined in the annual application and contract for services, shall align with the MCH pyramid or model provided by the DHHS, HRSA, state policy manuals, and interagency agreements.
[ARC 0364C, IAB 10/3/12, effective 11/7/12; ARC 4075C, IAB 10/10/18, effective 11/14/18]

641—76.6(135) Client eligibility criteria. The certification process to determine eligibility for direct health care under the program shall include the following requirements:

76.6(1) Age.

- a. Maternal health program—no age restrictions.
- b. Child health program—birth through 21 years of age.
- c. CYSHCN program—birth through 21 years of age.

76.6(2) Income.

a. Income guidelines will be the same as those established for the state’s Title XXI program. Guidelines are published annually by DHHS. Department income guidelines will be adjusted following any change in DHHS guidelines.

b. Income information will be provided by the individual.

c. Proof of Title XIX, Title XXI (HAWK-I), or WIC eligibility will automatically serve in lieu of an application.

d. All income of family members as defined by DHHS poverty guidelines will be used in calculating the individual’s gross income for purposes of determining initial and continued eligibility.

e. Income will be calculated as follows:

(1) Annual income will be estimated based on the individual’s income for the past three months unless the individual’s income will be changing or has changed, or

(2) In the case of self-employed families the past year’s income tax return (adjusted gross income) will be used in estimating annual income unless a change has occurred.

(3) Terminated income will not be considered.

f. Individuals will be screened for eligibility for Title XIX, Title XXI (HAWK-I), and WIC. If an individual’s income falls within the eligibility guidelines for Title XIX, Title XXI (HAWK-I), or WIC, the individual may be referred to the Iowa department of human services or other enrollment source to apply for coverage. Children, youth and pregnant women shall be considered for Title XIX presumptive eligibility.

g. An individual whose income is above the poverty level established by Title XXI and below 302 percent of the federal poverty guidelines will qualify for services on a sliding fee scale, as determined by the local agency's cost for the service. The department provides annual guidelines based on poverty levels established annually by DHHS. An individual whose income is at or above 302 percent will qualify for services at full fee.

h. Eligibility determinations must be performed at least once annually. Should the individual's circumstances change in a manner which affects third-party coverage or Title XIX/Title XXI eligibility, eligibility determinations shall be completed more frequently.

76.6(3) Residency. Individuals must be currently residing in Iowa.

76.6(4) Pregnancy. An individual applying for the prenatal program shall have verification of pregnancy by an independent health provider, the maternal health contract agency, a family planning (Title X) agency, or a positive home pregnancy test.

76.6(5) Children and youth with special health care needs. An individual applying for CHSC services shall be determined to have a special health care need as defined by the federal MCHB. Care/service coordination, family support or other non-clinic services are provided at no charge to the family. Clinic services are provided without charge to families with adjusted gross incomes below 185 percent of the federal poverty guidelines. Families above this threshold are responsible for payment according to a sliding fee scale based on tax exemptions, adjusted gross income, and extenuating circumstances.

[ARC 0364C, IAB 10/3/12, effective 11/7/12; ARC 4075C, IAB 10/10/18, effective 11/14/18]

641—76.7(135) Client application procedures for MCH services.

76.7(1) A person or the parent or guardian of a minor desiring direct health services other than those provided to children and youth with special health care needs may apply to a contract agency using a Health Services Application, Form 470-2927 or 470-2927(S). Individuals requesting presumptive eligibility must complete the Application for Health Coverage and Help Paying Costs, Form 470-5192, or the alternate form authorized by the HAWK-I board.

76.7(2) The contract agency shall verify the following information to receive services under the Title V MCH program:

- a. The information requested on the application form under "Household Information."
- b. Income information for all family members or proof of eligibility for Title XIX (Medicaid), Title XXI (HAWK-I), or WIC.
- c. Information about health insurance coverage.
- d. The signature of the individual or responsible adult, dated and witnessed.

76.7(3) If an individual has completed a Health Services Application, Form 470-2927, within the last year and the form accurately documents the current financial and family status, the MCH contract agency shall accept a copy of that application and determine eligibility without requiring completion of any other application form.

76.7(4) If an individual indicates on the Health Services Application, Form 470-2927, that the individual also wishes to apply for WIC or Medicaid or HAWK-I, the contract agency shall forward the appropriate copy to the indicated agency within two working days.

76.7(5) The contract agency shall determine the eligibility of the family and the percent of the cost of care that is the family's responsibility. The individual shall be informed in writing of eligibility status prior to incurring costs for care.

76.7(6) Once an individual has been determined to be eligible, the individual shall report any changes in income, family composition, or residency to the contract agency within 30 days from the date the change occurred.

76.7(7) A family seeking direct health care or care/service coordination services, or family support for a child or youth with special health care needs shall follow CHSC policies and procedures. Insurance status and eligibility for the sliding fee scale are determined during the client registration process.

[ARC 0364C, IAB 10/3/12, effective 11/7/12; ARC 4075C, IAB 10/10/18, effective 11/14/18]

641—76.8(135) Right to appeal—client.

76.8(1) *Right of appeal.* Individuals applying for MCH services and clients receiving MCH services shall have the right to appeal whenever a decision or action of the department or contract agency results in the denial of participation, suspension, or termination from the approved MCH program. Notification of the denial of participation, suspension or termination shall be made in writing and shall state the basis for the action. All hearings shall be conducted in accordance with these rules.

76.8(2) *Notification of appeal rights and right to hearing.* Individuals applying for MCH services shall be notified of the right to appeal and the procedures for requesting a hearing at the time of application for MCH services. Information about the appeal and hearing process shall be provided in writing and shall be immediately available at MCH centers. A health professional shall be available to explain the method by which an appeal or hearing is requested and the manner in which the appeal and hearing will be conducted.

76.8(3) *Request for hearing.* A request for a hearing is a written expression by an individual or the individual's parent, guardian, or other representative that an opportunity to present the individual's case is desired. The request shall be filed with the contract agency within 60 days from the date the individual receives notice of the decision or action which is the subject of appeal.

76.8(4) *Receipt of benefits during appeal.* Individual applicants, who are denied program benefits due to a finding of ineligibility, shall not receive benefits during the administrative appeal period. Clients who are involuntarily suspended or terminated from the MCH program shall continue to receive program benefits during the administrative appeal period.

76.8(5) *Hearing officer.* The hearing officer shall be impartial, shall not have been directly involved in the initial determination of the action being contested, and shall not have a personal stake in the decision. Hearing officers may be contract agency directors, health professionals, community leaders, or any impartial citizen. If prior to the hearing the appealing party objects to a contract agency director serving as the hearing officer in a case involving the director's own agency, another hearing officer shall be selected and, if necessary, the hearing shall be rescheduled as expeditiously as possible. Contract agencies may seek the assistance of the Chief, Bureau of Family Health, Iowa Department of Public Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075, in the appointment of a hearing officer.

76.8(6) *Notice of hearing.* The hearing officer shall schedule the time, place and date of the hearing as expeditiously as possible. Parties shall receive notice of the hearing at least ten days in advance of the scheduled hearing. The hearing shall be accessible to the party requesting the hearing. The hearing shall be scheduled within three weeks from the date the contract agency received the request for a hearing or as soon as possible thereafter, unless a later date is agreed upon by the parties.

76.8(7) *Conduct of hearing.* The party requesting the hearing or the party's representative shall have the opportunity to:

- a. Examine, prior to and during the hearing, the documents and records presented to support the decision under appeal;
- b. Be represented by an attorney or other person at the party's own expense;
- c. Bring witnesses;
- d. Question or refute any testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses;
- e. Submit evidence to establish all pertinent facts and circumstances in the case; and
- f. Advance arguments without undue interference.

76.8(8) *Decision.* Decisions of the hearing officer shall be in writing and shall be based on evidence presented at the hearing. The decision shall summarize the facts of the case, specify the reasons for the decision, and identify the supporting evidence and pertinent regulations or policy. The decision shall be issued within 90 days of the receipt of the request for the hearing, unless a longer period is agreed upon by the parties.

76.8(9) *Appeal of decision to the department.* A party receiving an unfavorable decision may file an appeal with the department. Such appeals must be filed in writing within ten working days of the mailing date of the hearing decision. Appeals shall be sent to the Contract Administrator, Division

of Administration and Professional Licensure, Iowa Department of Public Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075.

76.8(10) *Contested case.* Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the DIA pursuant to the rules adopted by the DIA regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information, which may be provided by the aggrieved party, shall also be provided to the DIA.

76.8(11) *Hearing.* Parties shall receive notice of the hearing in advance. The administrative law judge shall schedule the time, place and date of the hearing so that the hearing is held as expeditiously as possible. The hearing shall be conducted according to the procedural rules of the DIA found in 481—Chapter 10, Iowa Administrative Code.

76.8(12) *Decision of administrative law judge.* The administrative law judge's decision shall be issued within 60 days from the date of request for hearing. When the administrative law judge makes a proposed decision and order, it shall be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final decision without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken as provided in subrule 76.8(13).

76.8(13) *Appeal to the director.* Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

76.8(14) *Record of hearing.* Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

- a. All pleadings, motions and rules.
- b. All evidence received or considered and all other submissions by recording or transcript.
- c. A statement of all matters officially noticed.
- d. All questions and offers of proof, objections and rulings thereon.
- e. All proposed findings and exceptions.
- f. The proposed decision and order of the administrative law judge.

76.8(15) *Decision of director.* An appeal to the director shall be based on the record of the hearing before the administrative law judge. The decision and order of the director becomes the department's final decision upon receipt by the aggrieved party and shall be delivered by certified mail, return receipt requested, or by personal service.

76.8(16) *Exhausting administrative remedies.* It is not necessary to file an application for the rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final decision of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

76.8(17) *Petition for judicial review.* Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the director by certified mail, return receipt requested, or by personal service. The address is Director, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

76.8(18) *Benefits after decision.* If a final decision is in favor of the person requesting a hearing and benefits were denied or discontinued, benefits shall begin immediately and continue pending further review should an appeal to district court be filed. If a final decision is in favor of the contract agency, benefits shall be terminated, if still being received, as soon as administratively possible after the issuance of the decision. Benefits denied during an administrative appeal period may not be awarded retroactively following a final decision in favor of a person applying for MCH services.

[ARC 0364C, IAB 10/3/12, effective 11/7/12]

641—76.9(135) Grant application procedures for community-based contract agencies. Private nonprofit or public agencies seeking to provide community-based Title V MCH public health services shall submit an application to the department during the competitive year to administer MCH services for a specified project period, as defined in the request for proposal, with an annual continuation application. The contract period shall be from October 1 to September 30 annually. After a notice of award is made by the department, all materials submitted as part of the grant application are considered public records in accordance with Iowa Code chapter 22. Notification of the availability of funds and grant application procedures will be provided in accordance with the department rules found in 641—Chapter 176.

Contract agencies are selected on the basis of the grant applications submitted to the department. The department will consider only applications from private nonprofit or public agencies. In the event that competitive proposals receive an equal number of points, two department division directors and the respective bureau chief administering the program may conduct a second review utilizing the same scoring process.

[ARC 0364C, IAB 10/3/12, effective 11/7/12; ARC 4075C, IAB 10/10/18, effective 11/14/18]

641—76.10(135) Funding levels for community-based contract agencies. The amount of Title V MCH funds available to each contract agency on an annual basis shall be determined by the department using a methodology based upon dollars available, number of clients enrolled, and selected needs criteria. [ARC 0364C, IAB 10/3/12, effective 11/7/12]

641—76.11(135) Contract agency performance. Contract agencies are required to provide services in accordance with these rules.

76.11(1) Performance measures. Contract agencies must report on activities and progress toward meeting NPM, SPM, and other performance measures identified by the department.

76.11(2) Contract agency review. The department shall review contract agency operations through the use of reports and documents submitted, state-generated data reports, chart audits, on-site and clinic visits for direct care services as applicable for evaluation and technical assistance.

76.11(3) Exception. Rescinded IAB 10/3/12, effective 11/7/12.
[ARC 0364C, IAB 10/3/12, effective 11/7/12]

641—76.12(135) Reporting. Completion of grant applications, budgets, expenditure reports, annual progress reports, and data forms shall be performed by contract agencies in compliance with the contract with the department.

641—76.13(135) Fiscal management. All contract agencies are required to meet fiscal management policies.

76.13(1) Last pay. Title V MCH funds are considered last pay. Title XIX and other third-party payers are to be billed first if other resources cover the service.

76.13(2) Program income. Program income may be used for allowable costs of the MCH contract agency. A spending plan must be approved by the department for use of program income in excess of 5 percent above the amount approved in the program budget. Program income must be used before the funds received from the department are used. Excess program income may be retained to build a three-month operating capital.

76.13(3) Advances. A contract agency may request an advance of up to one-sixth of its contract at the beginning of a contract year. The amount of any advance will be deducted prior to the end of the fiscal year.

76.13(4) Local share. Community-based contract agencies are required to match the Title V MCH funds received from the department at a minimum rate of one dollar of local match for every four dollars received from the department. Sources that may be used for match are reimbursement for service from third parties such as insurance and Title XIX, client fees, local funds from nonfederal sources, or in-kind contributions. In-kind contributions must be documented in accordance with generally accepted accounting principles.

76.13(5) Subcontracts. Contract agencies may subcontract a portion of the project activity to another entity provided such subcontract is approved by the department. Subcontract agencies must follow the same rules, procedures, and policies as required of the contract agency by these rules and contract with the department. The contract agency is responsible for ensuring the compliance of the subcontract. Subcontract agencies may not subcontract these project activities with other entities.
[ARC 0364C, IAB 10/3/12, effective 11/7/12]

641—76.14(135) Audits. Every two years, each contract agency shall undergo financial audit of the MCH program. The audit shall be conducted in compliance with OMB Circular A-133 Audits of States, Local Governments, and Non-Profit Organizations. Each audit shall cover all unaudited periods through the end of the previous grant year. The department's audit guide should be followed to ensure an audit which meets federal and state requirements.

641—76.15(135) Diagnosis and therapeutic services for children. Rescinded IAB 2/6/02, effective 3/13/02.

641—76.16(135) Denial, suspension, revocation or reduction of contracts with contract agencies. The department may deny, suspend, revoke or reduce contracts with contract agencies in accord with applicable federal regulations or contractual relationships. Notice of such action shall be in writing.

641—76.17(135) Right to appeal—contract agency. Community-based contract agencies may appeal the denial of a contract or the suspension, revocation or reduction of an existing contract.

76.17(1) Appeal. The appeal shall be made in writing to the department within ten days of receipt of notification of the adverse action. Notice is to be addressed to the Contract Administrator, Division of Administration and Professional Licensure, Iowa Department of Public Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075.

76.17(2) Contested case. Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the DIA pursuant to the rules adopted by the DIA regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information, which may be provided by the aggrieved party, shall also be provided to the DIA.

76.17(3) Hearing. Parties shall receive notice of the hearing in advance. The administrative law judge shall schedule the time, place and date of the hearing so that the hearing is held as expeditiously as possible. The hearing shall be conducted according to the procedural rules of the DIA found in 481—Chapter 10.

76.17(4) Decision of administrative law judge. The administrative law judge's decision shall be issued within 60 days from the date of request for hearing. When the administrative law judge makes a proposed decision and order, it shall be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final decision without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken as provided in subrule 76.17(5).

76.17(5) Appeal to the director. Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

76.17(6) Record of hearing. Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

- a. All pleadings, motions and rules;
- b. All evidence received or considered and all other submissions by recording or transcript;
- c. A statement of all matters officially noticed;
- d. All questions and offers of proof, objections and rulings thereon;

- e.* All proposed findings and exceptions; and
- f.* The proposed decision and order of the administrative law judge.

76.17(7) *Decision of director.* An appeal to the director shall be based on the record made at the hearing. The decision and order of the director becomes the department's final decision upon receipt by the aggrieved party and shall be delivered by certified mail, return receipt requested, or by personal service.

76.17(8) *Exhausting administrative remedies.* It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final decision of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A. Petition for judicial review must be filed within 30 days after decision becomes final.

[ARC 0364C, IAB 10/3/12, effective 11/7/12]

641—76.18 to 76.20 Reserved.

MATERNAL AND CHILD HEALTH ADVISORY COUNCIL

641—76.21(135) Purpose. The MCH advisory council assists in the development of the state plan for MCH, including children and youth with special health care needs and family planning. The council assists with assessment of need, prioritization of services, establishment of objectives, and encouragement of public support for MCH and family planning programs. In addition, the council advises the director regarding health and nutrition services for women and children, supports the development of special projects and conferences, and advocates for health and nutrition services for women and children.

[ARC 0364C, IAB 10/3/12, effective 11/7/12]

641—76.22(135) Mission. The mission of the MCH advisory council is to assist the department in improving coordination of and promoting an integrated health system serving children and families in Iowa. Areas of emphasis include Title V MCH and any other programs in the department that address the well-being of children and families.

[ARC 0364C, IAB 10/3/12, effective 11/7/12]

641—76.23(135) Membership. Membership of the MCH advisory council shall include representatives of professional groups, agency representatives, legislators, and individuals with an interest in promoting health services for women and children.

76.23(1) Appointments to the council shall be made by the director.

- a.* Each appointment shall be for a term of three years, commencing on July 1.
- b.* No member shall serve more than two full consecutive terms (this provision may be waived by the director in exceptional cases).
- c.* In order to ensure that one third of the council rotates each year, staggered terms shall be initiated in June. For terms expiring during the calendar year, appointments and reappointments shall be staggered, resulting in a council with approximately one third of the terms of membership expiring in each year.

- d.* The goal is to attempt to implement a gender-balanced council membership.

- e.* The number of members shall not be fewer than 15 or more than 25.

76.23(2) The council shall be composed of the following categories:

- a.* Required members.

- (1) The chair (or designee) of the department's perinatal advisory committee.
- (2) The chair (or designee) of the congenital and inherited disorders advisory committee.
- (3) With approval of the director:
 - 1. A representative chosen by the Iowa State Association of Counties.
 - 2. A representative chosen by the Iowa Dental Association.
 - 3. A representative chosen by the Iowa Dietetic Association.

4. A representative chosen by the American Academy of Family Physicians, Iowa chapter.
5. A representative chosen by the American Academy of Pediatrics, Iowa chapter.
6. A representative chosen by the American College of Obstetricians and Gynecologists, Iowa chapter.

7. A representative chosen by the state board of health.

(4) Three family representatives, appointed by the director, may represent parents with children and youth with special health care needs, parents with children participating in Medicaid or HAWK-I, or parents with children participating in child care or early childhood education.

b. Discretionary members. A maximum of 13 additional members from among the following may be appointed by the director:

- (1) Adolescent health.
- (2) Women's health.
- (3) Insurance (private sector).
- (4) Child care.
- (5) Legal services.
- (6) Child advocate.
- (7) Social service.
- (8) Infant mortality prevention.
- (9) University extension services.
- (10) Voluntary agency.
- (11) Children's mental health.
- (12) Youth.
- (13) Child health.
- (14) Adult mental health.
- (15) Substance abuse.
- (16) Domestic violence or sexual violence services, or both.
- (17) Juvenile justice.
- (18) Oral health.

c. Ex officio members. The following may serve as ex officio, nonvoting members of the council:

- (1) One state senator and one state representative.
- (2) A representative from a local maternal and child health contract agency.
- (3) A representative of the department of education, division of learning and results.
- (4) A representative of the department of human services, Iowa Medicaid enterprise.
- (5) A representative of the department of human services, division of adult, children and family services, bureau of child care and community services.
- (6) Director (or designee) of Child Health Specialty Clinics.
- (7) The chair (or designee) of the early childhood Iowa board.

76.23(3) Vacancies shall be filled in the same manner in which the original appointments were made for the balance of the unexpired term. The nominations committee will make recommendations to the director for appointments.

[ARC 0364C, IAB 10/3/12, effective 11/7/12; ARC 4075C, IAB 10/10/18, effective 11/14/18]

641—76.24(135) Officers.

76.24(1) Officers of the council shall be a chairperson and a vice chairperson who shall be elected by the members at the last scheduled meeting of each fiscal year.

- a. The term of elected office shall be one year.
- b. A member shall not serve as chairperson for more than three full consecutive years.
- c. Vacancies in the office of chairperson shall be filled by elevation of the vice chairperson.
- d. Vacancies in the office of vice chairperson shall be filled by election at the next meeting after the vacancy occurs.

76.24(2) Duties of officers.

- a. The chairperson shall:

- (1) Preside at all meetings of the council,
- (2) Represent the council at appropriate or designated meetings,
- (3) Appoint such committees as deemed necessary, and
- (4) Designate the chairperson of ad hoc committees.

b. The vice chairperson shall:

(1) Perform the duties of the chairperson if the chairperson is absent or unable to act. When so acting, the vice chairperson shall have all the powers of and be subject to all restrictions upon the chairperson.

(2) Perform such other duties as may be assigned by the chairperson.

(3) Represent the council at designated meetings at the request of the chairperson.

[ARC 0364C, IAB 10/3/12, effective 11/7/12]

641—76.25(135) Duties of the council. The council shall perform the following duties:

76.25(1) Review the state's maternal, child, and adolescent health needs and the adequacy of health care services, programs, and providers to meet those needs.

76.25(2) Review local health statistics and program data to assess improvement in the overall health status of women and children.

76.25(3) Represent the concerns of consumers and local service providers in their relationship with the department programs and initiatives and other state agency initiatives.

76.25(4) Provide input and feedback in the development of the MCH state plan, the I-Smile™ program, family planning grant application and programming objectives, MIECHV state plan, and the WIC state plan, including the assessment of need, the prioritization of services and the establishment of objectives.

76.25(5) Identify potential collaborative partners to help achieve the mission and goals of the MCH advisory council and the department.

76.25(6) Disseminate information and report back to representative consumer groups and local providers regarding department programs, initiatives, services, and state plans.

[ARC 0364C, IAB 10/3/12, effective 11/7/12]

641—76.26(135) Meetings.

76.26(1) Meetings of the council will be held as necessary and at the call of the director or the chairperson. There shall be a minimum of four meetings per year.

a. At the last scheduled meeting of the fiscal year, the regular meetings for the following year will be scheduled.

b. Notice of meetings will be sent at least two weeks prior to the meeting date.

c. Materials for the meeting will be sent at least one week prior to the meeting date.

76.26(2) All meetings are open to the public in accordance with the open meetings law, Iowa Code chapter 21.

76.26(3) A majority of the required and discretionary membership shall constitute a quorum.

76.26(4) At all meetings of the council, the act of the majority of the members present at the meeting shall be the act of the council.

76.26(5) Meeting attendance.

a. Attendance shall be expected at all meetings unless circumstances prohibit attendance.

b. Participation by telephone or other means is permissible so long as arrangements can be made by the department for such participation.

c. Three unexcused absences per fiscal year shall result in termination of membership as determined by the director or the director's designee.

76.26(6) The council shall maintain information sufficient to indicate the results of each vote. If necessary, members may be polled telephonically or electronically.

76.26(7) Subcommittees shall meet as necessary.

[ARC 0364C, IAB 10/3/12, effective 11/7/12]

641—76.27(135) Executive committee.

76.27(1) The executive committee shall be composed of the chairperson and vice chairperson, assisted by two members appointed by the chairperson at the beginning of the fiscal year.

76.27(2) The executive committee will meet as necessary to act on behalf of the full council to develop a recommendation when the council is not in session.

76.27(3) The executive committee may request staff support and assistance from department management.

[ARC 0364C, IAB 10/3/12, effective 11/7/12]

641—76.28(135) Committees. The council may designate one or more committees to perform such duties as may be deemed necessary.

76.28(1) The chairperson appoints the nominations committee, which will submit a slate of potential members and officers.

76.28(2) Additional committees or ad hoc committees may be formed as needed.

76.28(3) Committees should be utilized whenever possible to review particular substantive areas by previewing recommendations, framing issues for the larger group and presenting on issues that need to be addressed by the council.

[ARC 0364C, IAB 10/3/12, effective 11/7/12]

These rules are intended to implement Iowa Code subsection 135.11(17).

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CHAPTER 110
CENTER FOR RURAL HEALTH
AND PRIMARY CARE

641—110.1(135) Purpose and scope. The following rules developed by the department of public health govern the organization of the center for rural health and primary care within the bureau of oral and health delivery systems of the department of public health.

[ARC 4076C, IAB 10/10/18, effective 11/14/18]

641—110.2(135,135B) Definitions.

“Center for rural health and primary care” means the department of public health administrative entity that is responsible for provision of technical planning assistance to rural communities and counties, administration of a comprehensive primary care provider recruitment and retention endeavor, coordination of services to provide research of rural occupational health injuries and hazards, and coordination with the following: the center for agricultural health and safety, the center for health effects of environmental contamination, and the department of agriculture and land stewardship.

“Center for rural health and primary care advisory committee” means a group of individuals appointed by the governor, department directors and the Iowa legislature whose purpose is to provide advice and make recommendations on rural health issues to the center for rural health and primary care, department of public health.

“Community health services assessment and developmental plan” means a comprehensive health services assessment and plan which has been developed through a communitywide collaborative effort of public and private entities, including citizens at large, located in rural communities.

“Department” means the Iowa department of public health.

“Director” means the director of the department of public health.

“Health care workforce and community support grant program” means a program that provides assistance in the form of a forgivable loan, grant, or other nonfinancial assistance to communities to support the effort of a community and that is part of the community’s long-term community health services assessment and developmental plan.

“Primary care health professional” means an individual who is providing primary health services and is licensed to practice in the state of Iowa.

“Primary care provider loan repayment program” means a loan repayment for qualifying loans to eligible health professionals who choose to establish practices in designated health professional shortage areas of the state.

“Primary care provider recruitment and retention endeavor” or *“PRIMECARRE”* means a comprehensive primary health care initiative which promotes and assists local efforts in developing health care provider recruitment and retention programs and which includes a health care workforce and community support grant program and a primary care provider loan repayment program.

“Primary health services” means health services regarding family practice, internal medicine, pediatrics, obstetrics and gynecology, dentistry, or mental health that are provided by physicians or other health professionals.

[ARC 4076C, IAB 10/10/18, effective 11/14/18]

641—110.3(135) Responsibilities of the center.

110.3(1) The center for rural health and primary care shall provide technical planning assistance to rural communities and counties exploring innovative means of delivering rural health services through community health services assessment, planning, and implementation, including but not limited to hospital conversions, cooperative agreements among hospitals, physician and health practitioner support, recruitment and retention of primary health care providers, public health services, emergency medical services, medical assistance facilities, rural health care clinics, and alternative means which may be included in the long-term community health services assessment and developmental plan.

110.3(2) The center for rural health and primary care shall encourage collaborative efforts of the local boards of health, hospital governing boards, and other public and private entities located in rural communities to adopt a long-term community health services assessment and developmental plan.

110.3(3) The center for rural health and primary care shall provide technical assistance to assist rural communities in improving Medicare reimbursements or establishing additional sources of funding through initiatives such as rural health clinics, distinct part skilled nursing facility beds, and the swing-bed program.

110.3(4) The center for rural health and primary care shall coordinate services to provide research for the following:

- a. Examination of the prevalence of rural occupational health injuries in the state.
- b. Assessment of training and continuing education available through local hospitals and others relating to diagnosis and treatment of diseases associated with rural occupational health hazards.
- c. Determination of continuing education support necessary for rural health practitioners to diagnose and treat illnesses caused by exposure to rural occupational health hazards.
- d. Determination of the types of actions that can help prevent agricultural accidents, surveillance and reporting of disabilities suffered by persons engaged in agricultural-related injuries and diseases in the state.

e. Identifying causal factors associated with agricultural-related injuries and diseases and indicating the effectiveness of intervention programs designed to reduce injuries and diseases.

110.3(5) The center for rural health and primary care shall cooperate with the center for agricultural health and safety, the center for health effects of environmental contamination and the department of agriculture and land stewardship to coordinate programs to the extent practicable.

110.3(6) The center for rural health and primary care shall administer grants for farm safety education efforts directed to rural families for the purpose of preventing farm-related injuries to children.

110.3(7) The center for rural health and primary care shall administer the PRIMECARRE.

a. PRIMECARRE shall include the following:

- (1) A health care workforce and community support grant program.
- (2) A primary care provider loan repayment program.

b. PRIMECARRE shall promote and accommodate local creativity in efforts to recruit and retain health care professionals to provide services in the locality. The focus shall be on developing health care provider recruitment and retention programs.

c. The center for rural health and primary care may enter into an agreement with the college student aid commission for the administration of the center's grant and loan repayment program.

[ARC 4076C, IAB 10/10/18, effective 11/14/18]

641—110.4(135) Advisory committee to the center for rural health and primary care.

110.4(1) The purpose of the advisory committee is to provide advice and make recommendations on rural health issues to the center for rural health and primary care, department of public health.

110.4(2) The advisory committee may provide the expertise and technical assistance necessary to review and recommend policies pertinent to rural health issues, as well as guidelines for grants and other programs of the center for rural health and primary care.

110.4(3) The advisory committee may evaluate new care delivery concepts arising to meet the needs of the rural population.

[ARC 4076C, IAB 10/10/18, effective 11/14/18]

641—110.5(135) Organization. The advisory committee to the center for rural health and primary care shall consist of one representative, approved by the respective agency, of each of the following agencies: the department of agriculture and land stewardship, the department of public health, the department of inspections and appeals, a national or regional institute for rural health policy, the institute of agricultural medicine and occupational health, and the Iowa state association of counties. The governor shall appoint two representatives of consumer groups active in rural health issues and a representative of each of two farm organizations active within the state, a representative of an agricultural business in the state, a practicing rural family physician, a practicing rural physician assistant, a practicing rural advanced

registered nurse practitioner, and a rural health practitioner who is not a physician, physician assistant, or advanced registered nurse practitioner, as members of the advisory committee. The advisory committee shall also include as members two state representatives, one appointed by the speaker of the house of representatives and one by the minority leader of the house, and two state senators, one appointed by the majority leader of the senate and one by the minority leader of the senate.

[ARC 4076C, IAB 10/10/18, effective 11/14/18]

641—110.6(135) Meetings.

110.6(1) Meetings. The advisory committee shall meet at least semiannually to conduct its business. Meetings can be scheduled as business requires, but notice to committee members must be at least five working days prior to the meeting date. The administrative head of the center for rural health and primary care and the director of the center for agricultural health and safety shall attend these meetings.

110.6(2) Quorum. A majority of the total membership shall constitute a quorum. Action can be taken by a vote of the majority of the membership.

110.6(3) Vacancies. Vacancies will be filled in the same manner as is prescribed in the Iowa Code. In the case of a vacancy, the chairperson will notify the agency of the need to appoint another representative.

110.6(4) Term of appointment. Unless otherwise specified by law, term of appointment is for two years with no more than three consecutive terms, excepting the department of public health representative. Exceptions for individual reappointment from organizations represented shall be determined by the director of public health.

110.6(5) Subcommittees. The advisory committee for the center for rural health and primary care may designate one or more subcommittees to have such powers and perform such duties as may be deemed necessary by the committee.

[ARC 4076C, IAB 10/10/18, effective 11/14/18]

641—110.7 to 110.10 Reserved.

PRIMECARRE HEALTH CARE WORKFORCE AND COMMUNITY SUPPORT GRANT PROGRAM

641—110.11(135) Purpose. The purpose of the PRIMECARRE health care workforce and community support grant program is to support community efforts which are part of the community's long-term community health services assessment and developmental plan. The application process is based upon the department's strategic plan. A community or region applying for assistance must complete a community health services assessment and adopt a long-term developmental plan. The community may request assistance with the assessment from the department. The community's or region's plan shall include, to the extent possible, a clear commitment to informing high school students of the health care opportunities which may be available to such students. The grant assistance may be in the form of a forgivable loan, grant, or other nonfinancial assistance as deemed appropriate by the center for rural health and primary care. Grants or other assistance provided by the center are intended to promote and accommodate local creativity in efforts to recruit and retain health care professionals to provide services in the locality. Notice of the availability of these public funds shall be published in the Iowa Administrative Bulletin in accordance with 641—Chapter 176.

110.11(1) Eligibility. The following requirements must be met in order to be eligible for the program:

a. The community or region must have illustrated efforts to meet the health care provider needs of the locality and surrounding area.

b. The community or region must have completed a community health services assessment and adopted a long-term developmental plan as established herein.

c. Participation in a community health services assessment process shall be documented by the community or region.

110.11(2) Funding. Grants awarded under the program shall be awarded to rural, underserved areas or special populations as identified by the department's strategic plan or evidence-based documentation.

110.11(3) Use of funds. Funds may be used for the following:

a. The procurement of clinical equipment, clinical facilities, and telecommunications facilities.

- b. Support for locum tenens arrangements and primary care provider mentor programs.
- c. Other capacity-building activities as they relate to recruitment and retention of primary health care providers.

110.11(4) Matching funds. Applications submitted may contain a commitment of matching funds for the grant assistance.

110.11(5) Application process. Applicants for grant funds must complete application forms provided by the department. Application materials shall be made available by the department at least 45 days prior to the application due date. Grant applications will be issued in accordance with 641—Chapter 176.

110.11(6) Selection criteria and review process. Selection criteria will be based on illustrated efforts to meet the health care provider needs of the locality and surrounding area. Selection criteria and the process for evaluation of applications shall be described in the application materials provided by the department. A competitive grant application review committee shall be appointed by the administrative head of the center for rural health and primary care. Grants will be awarded according to review criteria developed by the center, in accordance with 641—Chapter 176.

110.11(7) Notice of grant award. The department shall notify all applicants of the decision of grant awards.

110.11(8) Appeals. Applicants with a denied request for funding may appeal the decision of grant awards. The appeal shall be made in writing to the director, Iowa department of public health, within 10 days of the notification date of the grant awards decision. The appeal shall be mailed by certified mail, return receipt requested, or delivered by personal service. The decision of the director of public health becomes the department's final action and shall be sent by certified mail, return receipt requested, or delivered by personal service within 14 days of the receipt of the appeal.

110.11(9) Grantee oversight. The department shall monitor the use of funds granted to communities to ensure accountability and conformance with legislative intent. Oversight processes shall be described in the application materials provided by the department.

[ARC 4076C, IAB 10/10/18, effective 11/14/18]

641—110.12 to 110.15 Reserved.

PRIMECARRE PRIMARY CARE PROVIDER LOAN REPAYMENT PROGRAM

641—110.16(135) Purpose. A primary care provider loan repayment program is established to increase the number of health professionals practicing primary care in federally designated health professional shortage areas of the state. If sufficient state funds are available, applications will be considered for loan repayment for primary care providers practicing in communities not located in federally designated shortage areas. Under the program, loan repayment may be made to a recipient for educational loans incurred while completing an accredited health education program directly related to obtaining credentials necessary to practice the recipient's health profession. Notice of the availability of these public funds shall be published in the Iowa Administrative Bulletin in accordance with 641—Chapter 176.

110.16(1) Health care professional eligibility. The following requirements must be met by health care professionals in order to be eligible for the program:

- a. The status of the health care professional's citizenship must meet requirements of the National Health Service Corps loan repayment program.
- b. The health care professional must be licensed or certified to practice in the state of Iowa as a primary care health professional as defined in 641—110.2(135) and approved by the state for purposes of program priorities and requirements. Physicians must have completed a primary care residency and be board-eligible or board-certified.
- c. The health care provider must possess evidence of a contractual agreement to practice full time at a site in a designated shortage area within the state and approved by the state for the minimum number of years required by federal programs providing support for the program.

- d.* The health care provider shall provide one year of obligated service in exchange for each year of loan repayment, unless federal requirements otherwise require.
- e.* The health care provider must agree to comply with all contract provisions and the rules and regulations as promulgated by the department.
- f.* The health care provider must possess a license that is not restricted by a medical regulatory authority of any jurisdiction of the United States, other nations, or territories.
- g.* The health care professional must be eligible under Section 338B of the Public Health Service Act as amended November 16, 1990, by Public Law 101-597.
- h.* The health care provider must agree to provide full-time primary health care services at a clinical site in a designated health professional shortage area.
- i.* The health care provider must agree not to discriminate on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made pursuant to the program established in Title XVIII (Medicare) of the Social Security Act, or pursuant to the program established in Title XIX (Medicaid) of such Act.
- j.* The health care provider must agree to accept assignment under Section 1842(b)(3)(B)(ii) of the Social Security Act for all services for which payment may be made under Part B of Title XVIII and to enter into an appropriate agreement with the state agency that administers the state plan for medical assistance under Title XIX of such Act to provide service to individuals entitled to medical assistance under the plan.
- k.* The health care provider must complete an application form provided by the Iowa department of public health.

110.16(2) *Site eligibility.* The following requirements must be met in order to be eligible for placement of a health professional qualified under the PRIMECARRE loan repayment program:

- a.* The site must be located in a designated health professional shortage area in the state.
- b.* The site must agree to accept Medicare/Medicaid assignment.
- c.* The site must have a sliding fee schedule in place that is based upon the ability to pay.
- d.* The site must have completed a community health services assessment and adopted a long-term developmental plan.
- e.* The site must be part of a system of care. For the purpose of receiving federal assistance, a system of care is defined as a service continuum that includes comprehensive primary care for all regardless of ability to pay, and appropriate arrangements for secondary and tertiary care, including a referral system and arrangements for call coverage.
- f.* The site must complete an application form provided by the department.
- g.* The site must agree to report to the department those individuals unable to fulfill the contract.

110.16(3) *Federal grant requirements.* Use of federal grant dollars for loan repayment contracts requires that eligibility be determined as authorized by federal grant requirements.

110.16(4) *Funding limitations.* Loan repayment contracts provided under this program shall be determined annually, based upon the legislative appropriation for the PRIMECARRE initiative and other sources of funds.

110.16(5) *Other sources of funds.* The department of public health shall seek participation in federal programs supporting repayment of loans of health care providers and acceptance of gifts, grants, and other aid or amounts from any person, association, foundation, trust, corporation, governmental agency, or other entity for the purposes of the program.

110.16(6) *Review process.* The department of public health shall establish a review committee which will review all applications and make recommendations for loan repayment contracts. The department shall provide the review committee with a methodology for prioritization of federal shortage areas and eligible nonfederal shortage areas to be utilized in the application review process. The department shall provide the review committee with the criteria and scoring methodology to be used in reviewing the applications, in accordance with 641—Chapter 176. Evaluation criteria will include the applicant's outstanding educational loans and professional credentials.

110.16(7) *Contract oversight and administration.* The department of public health shall establish and enforce the terms of the contract, including implementation of any methods, e.g., legal action, that

may be necessary to recoup loan repayment funds in the event of failure on the part of a program recipient to fulfill the terms and conditions of the contract. The department shall take into consideration mitigating circumstances which may prohibit a recipient from fulfilling the recipient's contractual obligation or for whom fulfilling the obligation would cause undue hardship. The department of public health shall also provide for cancellation of contracts for reasonable cause to be determined by the department, unless federal requirements otherwise require.

110.16(8) Appeals. Applicants with a denied request for loan repayment funding may appeal the decision of loan repayment awards. The appeal shall be made in writing to the director, Iowa department of public health, within 10 days of the notification date of the loan repayment awards decision. The appeal shall be mailed by certified mail, return receipt requested, or delivered by personal service. The decision of the director of public health becomes the department's final action and shall be sent by certified mail, return receipt requested, or delivered by personal service within 14 days of the receipt of the appeal.

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These rules are intended to implement Iowa Code sections 135.107 and 135B.33.

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CHAPTER 139
IOWA LAW ENFORCEMENT EMERGENCY CARE PROVIDER
Rescinded **ARC 4077C**, IAB 10/10/18, effective 11/14/18

CHAPTER 154
MEDICAL CANNABIDIOL PROGRAM

641—154.1(124E) Definitions. For the purposes of these rules, the following definitions shall apply:

“*Acceptance criteria*” means the specified limits placed on characteristics of an item or method that are used to determine data quality.

“*Accreditation*” means the procedure by which an authoritative body gives formal recognition that an organization is competent to carry out specific tasks and verifies that the appropriate quality management system is in place.

“*Accredited nonpublic school*” means any nonpublic school accredited by the Iowa state board of education, excluding home schools.

“*Action level*” means the threshold value that provides the criterion for determining whether a sample passes or fails a test performed pursuant to these rules.

“*Aliquot*” means a portion of a sample that is used in an analysis.

“*Analyte*” means a chemical, compound, element, bacteria, yeast, fungus, or toxin to be identified or measured.

“*Analytical batch*” means a group of samples that are prepared together for the same analysis and analyzed sequentially using the same instrument calibration curve and common analytical quality control checks.

“*Analytical method*” means a technique used qualitatively or quantitatively to determine the composition of a sample or a microbial contamination of a sample.

“*Audit*” means a financial review by an independent certified public accountant that includes select scope engagement or other methods of review that analyze operational or compliance issues.

“*Background investigation*” means a thorough review of an entity, an owner, investors, and employees conducted by the department of public safety, including but not limited to state and national criminal history records, credit records, and internal revenue service records.

“*Batch*” means a set of cannabis plants that are grown, harvested, and processed together, such that they are exposed to substantially similar conditions throughout cultivation and processing.

“*Batch number*” means a unique numeric or alphanumeric identifier assigned to a batch of cannabis plants by a manufacturer when the batch is first planted. The batch number shall contain the manufacturer’s number and a sequence to allow for inventory and traceability.

“*Biosecurity*” means a set of preventative measures designed to reduce the risk of transmission of:

1. Infectious diseases in crops;
2. Quarantined pests;
3. Invasive alien species;
4. Living modified organisms.

“*Bordering state*” means the same as defined in Iowa Code section 331.910.

“*Cannabinoid*” means a chemical compound that is unique to and derived from cannabis.

“*Cannabis*” means seeds, plants, cuttings, or plant waste material from *Cannabis sativa* L. or *Cannabis indica* used in the manufacture of medical cannabidiol.

“*CAS number*” means a unique numerical identifier assigned to every chemical substance described in the open literature by Chemical Abstracts Service.

“*CBD*” means cannabidiol, Chemical Abstracts Service number 13956-29-1.

“*CBDA*” means cannabidiolic acid, Chemical Abstracts Service number 1244-58-2.

“*CBG*” means cannabigerol, Chemical Abstracts Service number 25654-31-3.

“*CBN*” means cannabinol, Chemical Abstracts Service number 521-35-7.

“*Certificate of analysis*” means the report prepared for the requester about the analytical testing performed and the results obtained by a laboratory.

“*Certification*” means a procedure by which a third party gives written assurance (certificate of conformity) that a product, process or service conforms to specified requirements.

“*Certified*” means that a laboratory demonstrates to the satisfaction of the department its ability to consistently produce valid data within the acceptance limits as specified in the department’s

requirements for certification and meets the minimum requirements of this chapter and all applicable regulatory requirements.

“*Certified reference material*” means a reference material prepared by a certifying body.

“*Crop input*” means any substance applied to or used in the cultivation and growth of a cannabis plant. “Crop input” includes, but is not limited to, pesticides, fungicides, fertilizers, and other soil or medium amendments.

“*Data-quality assessment*” means a scientific and statistical process that establishes whether the collected data are of the right type, quality, and quantity to support the intended use of the data.

“*Date of expiration*” means one year from the date of issuance of the medical cannabidiol registration card by the department of transportation.

“*Date of issuance*” means the date of issuance of the medical cannabidiol registration card by the department of transportation.

“*Debilitating medical condition*” means any of the following:

1. Cancer, if the underlying condition or treatment produces one or more of the following:
 - Severe or chronic pain.
 - Nausea or severe vomiting.
 - Cachexia or severe wasting.
2. Multiple sclerosis with severe and persistent muscle spasms.
3. Seizures, including those characteristic of epilepsy.
4. AIDS or HIV as defined in Iowa Code section 141A.1.
5. Crohn’s disease.
6. Amyotrophic lateral sclerosis.
7. Any terminal illness, with a probable life expectancy of under one year, if the illness or its treatment produces one or more of the following:

- Severe or chronic pain.
 - Nausea or severe vomiting.
 - Cachexia or severe wasting.
8. Parkinson’s disease.
 9. Untreatable pain.

“*Department*” means the Iowa department of public health.

“*Department of transportation*” means the Iowa department of transportation.

“*Director*” means the director of the Iowa department of public health.

“*Dispensary*” means an individual or entity licensed by the department to dispense medical cannabidiol to patients and primary caregivers pursuant to Iowa Code chapter 124E and these rules. “Dispensary” includes the employees and agents of the dispensary.

“*Dispensary facility*” means any secured building, space, grounds, and physical structure of a dispensary licensed by the department to dispense medical cannabidiol and where the dispensing of medical cannabidiol is authorized.

“*Dispense*” or “*dispensing*” means to supply medical cannabidiol to patients pursuant to Iowa Code chapter 124E and these rules.

“*Disqualifying felony offense*” means a violation under federal or state law of a felony under federal or state law, which has as an element the possession, use, or distribution of a controlled substance, as defined in 21 U.S.C. §802(6).

“*Edible medical cannabidiol products*” means food items containing medical cannabidiol. “Edible medical cannabidiol products” does not include pills, tinctures, oils, or other forms of medical cannabidiol that may be consumed orally or through the nasal cavity that do not contain food or food additives; provided that food or food additives used as carriers, excipients, or processing aids shall not be considered food or food additives.

“*Field duplicate sample*” means a sample that is taken in the identical manner and from the same batch, process lot, or lot being sampled as the primary sample. A field duplicate sample is analyzed separately from the primary sample and is used for quality control only.

“*Form and quantity*” means the types and amounts of medical cannabidiol allowed to be dispensed to a patient or primary caregiver as approved by the department subject to recommendation by the medical cannabidiol board and approval by the board of medicine.

“*Frequency*” means the number of items occurring in a given category. Frequency may be determined by analytical method or laboratory-specific requirements for the purpose of accuracy, precision of the analysis, or statistical calculation.

“*Health care practitioner*” means an individual licensed under Iowa Code chapter 148 to practice medicine and surgery or osteopathic medicine and surgery who is a patient’s primary care provider. “Health care practitioner” shall not include a physician assistant licensed under Iowa Code chapter 148C or an advanced registered nurse practitioner licensed pursuant to Iowa Code chapter 152 or 152E.

“*Increment*” or “*sample increment*” means a smaller sample that, together with other increments, makes up the primary sample.

“*Inspection*” means an on-site evaluation by the department, the department of public safety, or a department-approved independent consultant of facilities, records, personnel, equipment, methodology, and quality assurance practices for compliance with these rules.

“*International Electrotechnical Commission*” or “*IEC*” means an independent, nongovernmental membership organization that prepares and publishes international standards for all electrical, electronic, and related technologies.

“*International Organization for Standardization*” or “*ISO*” means an independent, nongovernmental membership organization and the largest developer of voluntary international standards.

“*Laboratory*” means the state hygienic laboratory at the University of Iowa or other independent medical cannabidiol testing facility accredited to Standard ISO/IEC 17025 by an ISO-approved accrediting body, with a controlled substance registration certificate from the Drug Enforcement Administration of the U.S. Department of Justice and a certificate of registration from the Iowa board of pharmacy, and approved by the department to examine, analyze, or test samples of medical cannabidiol or any substance used in the manufacture of medical cannabidiol.

“*Limit of detection*” or “*LOD*” means the lowest quantity of a substance or analyte that can be distinguished from the absence of that substance within a stated confidence limit.

“*Limit of quantitation*” or “*LOQ*” means the minimum concentration of an analyte in a specific matrix that can be reliably quantified while also meeting predefined goals for bias and imprecision.

“*Lot*” means a specific quantity of medical cannabidiol that is uniform and intended to meet specifications for identity, strength, purity, and composition, and that is manufactured, packaged, and labeled during a specified time period according to a single manufacturing, packaging, and labeling record.

“*Lot number*” means a unique numeric or alphanumeric identifier assigned to a lot by a manufacturer when medical cannabidiol is produced. The lot number shall contain the manufacturer’s number and a sequence to allow for inventory, traceability, and identification of the plant batches used in the production of a lot of medical cannabidiol.

“*Manufacture*” or “*manufacturing*” means the process of converting harvested cannabis plant material into medical cannabidiol.

“*Manufacturer*” means an individual or entity licensed by the department to produce medical cannabidiol and distribute it to dispensaries pursuant to Iowa Code chapter 124E and these rules. “Manufacturer” includes the employees and agents of the manufacturer.

“*Manufacturing facility*” means any secured building, space, grounds, and physical structure of a manufacturer for the cultivation, harvesting, packaging, processing, storage, and distribution of cannabis or medical cannabidiol and where access is restricted to designated employees of a manufacturer and escorted visitors.

“*Market withdrawal*” means the voluntary removal of medical cannabidiol from dispensaries and patients by a manufacturer for minor issues that do not pose a serious health threat.

“*Mass spectrometry*” means an analytical technique that ionizes chemical species and sorts the ions based on their mass-to-charge ratio.

“*Matrix*” means the component or substrate that contains the analyte of interest.

“*Matrix spike duplicate*” means a duplicate sample prepared by adding a known quantity of a target analyte to a field sample matrix or other matrix that is as closely representative of the matrix under analysis as possible.

“*Matrix spike sample*” means a sample prepared by adding a known quantity of the target analyte to a field sample matrix or to a matrix that is as closely representative of the matrix under analysis as possible.

“*Medical assistance program*” means IA Health Link, Medicaid Fee-for-Service, or HAWK-I, as administered by the Iowa Medicaid enterprise of the Iowa department of human services.

“*Medical cannabidiol*” means any pharmaceutical grade cannabinoid found in the plant *Cannabis sativa* L. or *Cannabis indica* or any other preparation thereof that has a tetrahydrocannabinol level of no more than 3 percent and that is delivered in a form recommended by the medical cannabidiol board, approved by the board of medicine, and designated in this chapter.

“*Medical cannabidiol waste*” means medical cannabidiol that is returned, damaged, defective, expired, or contaminated.

“*Medical cannabis goods*” means medical cannabidiol process lots, medical cannabidiol products, and cannabis plant material, including dried tissue.

“*Method blank*” means an analyte-free matrix to which all reagents are added in the same volumes or proportions as are used in sample preparation.

“*Moisture content*” means the percentage of water in a dry sample by weight.

“*National criminal history background check*” means fingerprint processing through the department of public safety and the Federal Bureau of Investigation (FBI) and review of records on file with national organizations, courts, and law enforcement agencies to the extent allowed by law.

“*Non-target organism*” means an organism that the test method or analytical procedure is not testing for. Non-target organisms are used in evaluating the specificity of a test method.

“*Patient*” means a person who is a permanent resident of the state of Iowa who suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E and these rules.

“*Percent recovery*” means the percentage of a measured concentration relative to the added (spiked) concentration in a reference material, matrix spike sample, or matrix spike duplicate.

“*Permanent resident*” means a natural person who physically resides in Iowa as the person’s principal and primary residence and who establishes evidence of such residency by providing the department with one of the following:

1. A valid Iowa driver’s license,
2. A valid Iowa nonoperator’s identification card,
3. A valid Iowa voter registration card,
4. A current Iowa vehicle registration certificate,
5. A utility bill,
6. A statement from a financial institution,
7. A residential lease agreement,
8. A check or pay stub from an employer,
9. A child’s school or child care enrollment documents,
10. Valid documentation establishing a filing for homestead or military tax exemption on property located in Iowa, or
11. Other valid documentation as deemed acceptable by the department to establish residency.

“*Pharmaceutical grade*” means medical cannabidiol that meets standards for content, contamination, and consistency set by the department as determined by testing conducted at a laboratory pursuant to Iowa Code chapter 124E and these rules.

“*Plant material*” means any cannabis plant, cutting, trimming, or clone that has roots or that is cultivated with the intention of growing roots.

“*Plant material waste*” means plant material that is not used in the production of medical cannabidiol in a form allowable under these rules.

“*Primary caregiver*” means a person who is a resident of this state or a bordering state, including but not limited to a parent or legal guardian, at least 18 years of age, who has been designated by a patient’s health care practitioner as a necessary caretaker taking responsibility for managing the well-being of the patient with respect to the use of medical cannabidiol pursuant to the provisions of Iowa Code chapter 124E and these rules.

“*Primary care provider*” means any health care practitioner involved in the diagnosis and treatment of a patient’s debilitating medical condition.

“*Primary sample*” means a portion of a batch, process lot, or lot that is used for testing for identity, strength, purity, and composition.

“*Process lot*” means any amount of cannabinoid concentrate or extract that is uniform, produced from one or more batches, and used for testing for identity, strength, purity, and composition prior to being packaged.

“*Product expiration date*” means the date after which a medical cannabidiol product may not be sold by a manufacturer or a dispensary.

“*Production*” or “*produce*” means:

1. Cultivating or harvesting plant material;
2. Processing or manufacturing; or
3. Packaging of medical cannabidiol.

“*Proficiency test*” means an evaluation of a laboratory’s performance against preestablished criteria by means of interlaboratory comparisons of test measurements.

“*Proficiency test sample*” means a sample prepared by a party independent of the testing laboratory, with a concentration and identity of an analyte that is known to the independent party but is unknown to the testing laboratory and testing laboratory personnel.

“*Public or private school*” means any property operated by a school district, charter school, or accredited nonpublic school for purposes related to elementary, middle, or secondary schools or secondary vocation centers.

“*Qualitative analysis*” means identification of an analyte in a substance or mixture.

“*Quality assurance*” means a set of operating principles to produce data of known accuracy and precision. “Quality assurance” encompasses employee training, equipment preventative maintenance procedures, calibration procedures, and quality control testing, among other things.

“*Quality control*” means a set of measures implemented within an analytical procedure to ensure that the measurement system is operating in a state of statistical control in which errors have been reduced to acceptable levels.

“*Quality control samples*” means samples produced and used for the purpose of assuring quality control. Quality control samples include but are not limited to blank samples, spike samples, duplicate samples, and reference material samples.

“*Quantitative analysis*” means measurement of the quantities of chemical components present in a substance or mixture. Quantitative analysis typically uses a certified reference material, if available, to create a calibration curve.

“*Reagent*” means a compound or mixture added to a system to cause a chemical reaction or to test if a reaction occurs. A reagent may be used to tell whether or not a specific chemical substance is present by causing a reaction to occur with the chemical substance.

“*Recall*” means the return of medical cannabidiol from patients and dispensaries to a manufacturer because of the potential for serious health consequences from the use of the medical cannabidiol.

“*Reference material*” means a material containing a known concentration of an analyte of interest that is in solution or in a homogeneous matrix. Reference material is used to document the bias of the analytical process.

“*Reference method*” means a method by which the performance of an alternate method is measured or evaluated.

“*Relative percent difference*” or “*RPD*” means a comparative statistic used to calculate precision or random error. RPD is calculated using the following equation: $RPD = \text{absolute value (primary sample}$

measurement - duplicate sample measurement) / ([primary sample measurement + duplicate sample measurement] / 2) × 100.

“*Relative standard deviation*” or “*RSD*” means the standard deviation expressed as a percentage of the mean recovery. “*RSD*” is the coefficient of variation multiplied by 100. If any results are less than the limit of quantitation, then the absolute value of the limit of quantitation is used in the following equation: $RSD = (s / x) \times 100$, where s = standard deviation and x = mean recovery.

“*Requester*” means a person who submits a request to a licensed testing laboratory for state-mandated testing of medical cannabis goods. The requester may be a licensed manufacturer or the department.

“*Residual solvents and processing chemicals*” means volatile organic chemicals that are used or produced in the manufacture or production of medical cannabidiol.

“*Restricted access area*” means a building, room, or other contiguous area on the premises where plant material is grown, cultivated, harvested, stored, packaged, or processed for sale under control of the manufacturer, and where no person under the age of 18 is permitted.

“*Sample*” means a representative part of or a single item from a larger whole or group.

“*Sanitize*” means to sterilize, disinfect, or make hygienic.

“*Semiquantitative analysis*” means less than quantitative precision and does not involve a full calibration. Analyte identification is based on a single-point reference or high-probability library match. The determination of amount uses the ratio of the unknown chemical analyte to that of a known analyte added to the sample before analysis. Uncertainty for semiquantitative results is higher than for quantitative results.

“*Significant figures*” means the number of digits used to express a measurement.

“*Stability*” or “*stable*” means that after storage of an unopened package of medical cannabidiol, the contents shall not vary in concentrations of THC and CBD by more or less than 15 percent by weight in milligrams per milliliter (mg/ml) for liquids and milligrams per gram (mg/g) for solids from the concentration indicated on the package label. Thus, after storage, a solid product labeled as containing a concentration of CBD of 10 milligrams per gram shall have a detected concentration of CBD that is no more than 11.50 milligrams per gram and no less than 8.50 milligrams per gram.

“*Standard operating procedure*” means a written document that provides detailed instructions for the performance of all aspects of an analysis, operation, or action.

“*State*” means a state of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

“*Synthetic cannabinoid*” means a designed compound with structural features that allow binding to the known cannabinoid receptors present in human cells and that produce biological effects similar to those of natural cannabinoids.

“*Tamper-evident*” means that one or more one-time-use seals are affixed to the opening of a package, allowing a person to recognize whether or not the package has been opened.

“*Target organism*” means an organism that is being tested for in an analytical procedure or test method.

“*Testing laboratory record*” means information relating to the testing laboratory and the analyses it performs that is prepared, owned, used, or retained by the laboratory and includes electronic files and video footage.

“*THC*” or “*delta-9 THC*” means tetrahydrocannabinol, Chemical Abstracts Service number 1972-08-3.

“*THCA*” means tetrahydrocannabinolic acid, Chemical Abstracts Service number 23978-85-0.

“*Untreatable pain*” means any pain whose cause cannot be removed and, according to generally accepted medical practice, the full range of pain management modalities appropriate for the patient has been used without adequate result or with intolerable side effects.

“*Validation*” means the confirmation by examination and objective evidence that the particular requirements for a specific intended use are fulfilled.

“*Written certification*” means a document signed by a health care practitioner, with whom the patient has established a patient-provider relationship, which states that the patient has a debilitating medical condition and identifies that condition and provides any other relevant information.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17; ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 3836C, IAB 6/6/18, effective 7/11/18]

REGISTRATION CARDS

641—154.2(124E) Health care practitioner certification—duties.

154.2(1) Prior to a patient’s submission of an application for a medical cannabidiol registration card pursuant to this rule, a health care practitioner shall do all of the following:

a. Determine, in the health care practitioner’s medical judgment, whether the patient whom the health care practitioner has examined and treated suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol as defined by this chapter, and if so determined, provide the patient with a written certification of that diagnosis by completing the health care practitioner section of the application form provided for this purpose on the department’s website (www.idph.iowa.gov).

b. Provide explanatory information to the patient as provided on the department’s website (www.idph.iowa.gov) about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

154.2(2) Subsequently, the health care practitioner shall do the following:

a. Determine, on an annual basis, if the patient continues to suffer from a debilitating medical condition and, if so, issue the patient a new certification of that diagnosis.

b. Otherwise comply with all requirements in this chapter and requests from the department for more information.

154.2(3) A health care practitioner may provide, but has no duty to provide, a written certification pursuant to this rule.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.3(124E) Medical cannabidiol registration card—application and issuance to patient.

154.3(1) Subject to subrule 154.3(7), the department may approve the issuance of a medical cannabidiol registration card by the department of transportation to a patient who:

a. Is at least 18 years of age.

b. Is a permanent resident of Iowa.

c. Submits a written certification to the department, provided to the patient pursuant to rule 641—154.2(124E) and signed by the patient’s health care practitioner certifying that the patient is suffering from a debilitating medical condition.

d. Submits an application to the department, on a form created by the department in consultation with the department of transportation and available at the department’s website (www.idph.iowa.gov), that contains all of the following:

(1) The patient’s full legal name, Iowa residence address, mailing address (if different from the patient’s residence address), telephone number, date of birth, and sex designation. The patient shall not provide as a mailing address an address for which a forwarding order is in place.

(2) A copy of the patient’s valid photo identification. Acceptable photo identification includes:

1. A valid Iowa driver’s license,

2. A valid Iowa nonoperator’s identification card, or

3. An alternative form of valid photo identification. A patient who possesses or is eligible for an Iowa driver’s license or an Iowa nonoperator’s identification card shall present such document as valid photo identification. A patient who is ineligible to obtain an Iowa driver’s license or an Iowa nonoperator’s identification card may apply for an exemption and request submission of an alternative form of valid photo identification. A patient who applies for an exemption is subject to verification of the patient’s identity through a process established by the department and the department of transportation to ensure the genuineness, regularity, and legality of the alternative form of valid photo identification.

(3) Full name, address, and telephone number of the patient’s health care practitioner.

(4) Full legal name, residence address, date of birth, and telephone number of each primary caregiver of the patient, if any.

(5) An attestation as to the truthfulness and accuracy of the information provided by the patient on the application.

e. Has not been convicted of a disqualifying felony offense.

f. Submits the required fee, as described in subrule 154.12(1).

154.3(2) Upon the completion, verification, and approval of the patient's application and the receipt of the required fee, the department shall notify the department of transportation that the patient may be issued a medical cannabidiol registration card.

154.3(3) A medical cannabidiol registration card issued to a patient by the department of transportation shall contain all of the following:

a. The patient's full legal name, Iowa residence address, date of birth, and sex designation, as shown on the patient's Iowa driver's license, nonoperator's identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1) "d"(2)"3." If the patient's name, Iowa residence address, date of birth, or sex designation has changed since the issuance of the patient's Iowa driver's license, nonoperator's identification card, or alternative form of valid photo identification, the patient shall first update the patient's Iowa driver's license or nonoperator's identification card to reflect the current information, according to the procedures set forth in 761—subrule 605.11(2), 761—subrule 605.25(4), or rule 761—630.3(321), or shall update the alternative form of valid photo identification in accordance with the process of the issuing agency.

b. The date of issuance and the date of expiration, which shall be one year from the date of issuance.

c. A distinguishing registration number that is not the patient's social security number.

d. The patient's signature. The signature shall be without qualification and shall contain only the patient's usual signature without any other titles, characters, or symbols. The patient's signature certifies, under penalty of perjury and pursuant to the laws of the state of Iowa, that the statements made and information provided in the patient's application for a medical cannabidiol registration card are true and correct. The patient's signature shall be captured electronically.

e. A color photograph of the patient.

f. A statement that the medical cannabidiol registration card is not valid for identification purposes.

154.3(4) Every patient 18 years of age or older must obtain a valid medical cannabidiol registration card to use medical cannabidiol in Iowa.

154.3(5) An authorization to use medical cannabidiol or marijuana for medicinal purposes issued by another state, territory, or jurisdiction does not satisfy the requirements of Iowa Code chapter 124E or these rules for the issuance of a medical cannabidiol registration card.

154.3(6) A valid medical cannabidiol registration card, or its equivalent, issued under the laws of another state that allow an out-of-state patient to possess or use medical cannabidiol in the jurisdiction of issuance shall have the same force and effect as a valid medical cannabidiol registration card issued pursuant to Iowa Code chapter 124E, except that an out-of-state patient in Iowa shall not obtain medical cannabidiol from a medical cannabidiol dispensary in Iowa.

154.3(7) The department shall not approve the issuance of a medical cannabidiol registration card for a patient who is enrolled in a federally approved clinical trial for the treatment of a debilitating medical condition with medical cannabidiol.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.4(124E) Medical cannabidiol registration card—application and issuance to primary caregiver.

154.4(1) For a patient in a primary caregiver's care, the department may approve the issuance of a medical cannabidiol registration card by the department of transportation to a primary caregiver who:

a. Is at least 18 years of age.

b. Submits a written certification to the department, provided to the patient pursuant to rule 641—154.2(124E) and signed by the patient's health care practitioner certifying that the patient is suffering from a debilitating medical condition.

c. Submits an application as a primary caregiver for each patient for whom the person is the primary caregiver. The primary caregiver application must be on a form created by the department in consultation with the department of transportation and available at the department's website (www.idph.iowa.gov) that contains all of the following:

(1) The primary caregiver's full legal name, residence address, mailing address (if different from the primary caregiver's residence address), telephone number, date of birth, and sex designation. The primary caregiver shall not provide as a mailing address an address for which a forwarding order is in place.

(2) The patient's full legal name, date of birth, and parent or legal guardian's name if the patient is under the age of 18.

(3) A copy of the primary caregiver's valid photo identification. Acceptable photo identification includes:

1. A valid Iowa driver's license,

2. A valid Iowa nonoperator's identification card,

3. If the primary caregiver is not a resident of the state of Iowa, a valid state-issued driver's license or nonoperator's identification card issued by a state other than Iowa, or

4. An alternative form of valid photo identification. A primary caregiver who possesses or is eligible for a driver's license or a nonoperator's identification card shall present such document as valid photo identification. A primary caregiver who is ineligible to obtain a driver's license or a nonoperator's identification card may apply for an exemption and request submission of an alternative form of valid photo identification. A primary caregiver who applies for an exemption is subject to verification of the primary caregiver's identity through a process established by the department and the department of transportation to ensure the genuineness, regularity, and legality of the alternative form of valid photo identification.

(4) Full name, address, and telephone number of the patient's health care practitioner.

(5) An attestation as to the truthfulness and accuracy of the information provided by the primary caregiver on the application.

d. Has not been convicted of a disqualifying felony offense.

e. Submits the required fee, as described in subrule 154.12(2).

154.4(2) Upon the completion, verification, and approval of the primary caregiver's application, the department shall notify the department of transportation that the primary caregiver may be issued a medical cannabidiol registration card.

154.4(3) A medical cannabidiol registration card issued to a primary caregiver by the department of transportation shall contain all of the following:

a. The primary caregiver's full legal name, current residence address, date of birth, and sex designation, as shown on the primary caregiver's state-issued driver's license, nonoperator's identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.4(1)“c”(3)“4.” If the primary caregiver's name, current residence address, date of birth, or sex designation has changed since issuance of the primary caregiver's Iowa-issued driver's license, nonoperator's identification card, or other form of valid photo identification, the primary caregiver shall first update the primary caregiver's Iowa-issued driver's license or nonoperator's identification card according to the procedures set forth in 761—subrule 605.11(2), 761—subrule 605.25(4), or rule 761—630.3(321) or update the alternative form of valid photo identification in accordance with the process of the issuing agency.

b. The date of issuance and the date of expiration, which shall be one year from the date of issuance.

c. A distinguishing registration number that is not the primary caregiver's social security number.

d. The medical cannabidiol registration number for each patient in the primary caregiver's care. This number shall not be the primary caregiver's or patient's social security number. If the patient in the

primary caregiver's care is under the age of 18, the full name of the patient's parent or legal guardian shall be printed on the primary caregiver's registration card in lieu of the patient's medical cannabidiol registration number.

e. The primary caregiver's signature. The signature shall be without qualification and shall contain only the primary caregiver's usual signature without any other titles, characters, or symbols. The primary caregiver's signature certifies, under penalty of perjury and pursuant to the laws of the state of Iowa, that the statements made and information provided in the primary caregiver's application for a medical cannabidiol registration card are true and correct. The primary caregiver's signature shall be captured electronically.

f. A color photograph of the primary caregiver.

g. A statement that the medical cannabidiol registration card is not valid for identification purposes.

h. A statement distinguishing the medical cannabidiol registration cardholder as a primary caregiver.

154.4(4) A patient who is 18 years of age or older must have an approved application and a distinguishing medical cannabidiol registration number that is not the patient's social security number prior to the issuance of a medical cannabidiol registration card to the patient's primary caregiver.

154.4(5) An authorization to use, or to act as a primary caregiver for a patient authorized to use, cannabidiol or marijuana for medicinal purposes issued by another state, territory, or jurisdiction does not satisfy the requirements of Iowa Code chapter 124E or these rules for the issuance of a medical cannabidiol registration card.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.5(124E) Tamperproofing. The department of transportation shall issue a medical cannabidiol registration card by a method or process which prevents as nearly as possible the alteration, reproduction, or superimposition of a photograph on the cannabidiol registration card without ready detection.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.6(124E) Denial and cancellation. The department may deny an application for a medical cannabidiol registration card, or may cancel or direct the department of transportation to cancel a medical cannabidiol registration card, for any of the following reasons:

1. Information contained in the application is illegible, incomplete, falsified, misleading, deceptive, or untrue.

2. The department or the department of transportation is unable to verify the identity of the applicant from the photo identification or other documentation presented pursuant to paragraph 154.3(1)“d”(2)“3” or 154.4(1)“c”(3)“4.”

3. The applicant violates or fails to satisfy any of the provisions of Iowa Code chapter 124E or these rules.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.7(124E) Appeal. If the department denies an application for or cancels a medical cannabidiol registration card, the department shall inform the applicant or cardholder of the denial or cancellation and state the reasons for the denial or cancellation in writing. An applicant or cardholder may appeal the denial or cancellation of a medical cannabidiol registration card by submitting a request for appeal to the department by certified mail, return receipt requested, within 20 days of receipt of the notice of denial or cancellation. The department's address is Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0075. Upon receipt of a request for appeal, the department shall forward the request within five working days to the department of inspections and appeals. A contested case hearing shall be conducted in accordance with 641—Chapter 173.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.8(124E) Duplicate card.

154.8(1) *Lost, stolen, or destroyed card.* To replace a medical cannabidiol registration card that is lost, stolen, or destroyed, a cardholder shall present to the department of transportation the cardholder's valid state-issued driver's license, nonoperator's identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1) "d"(2)"3" or 154.4(1) "c"(3)"4."

154.8(2) *Change in card information and voluntary replacement.*

a. To replace a medical cannabidiol registration card that is damaged, the cardholder shall surrender to the department of transportation the card to be replaced and present the cardholder's valid state-issued driver's license, nonoperator's identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1) "d"(2)"3" or 154.4(1) "c"(3)"4."

b. A patient or primary caregiver to whom a medical cannabidiol registration card is issued shall notify the department of a change in current residence address, name, or sex designation listed on the card, within ten calendar days of the change. To replace a medical cannabidiol registration card to change the current residence address, name, or sex designation listed on the card, the cardholder shall surrender to the department of transportation the card to be replaced and present a valid state-issued driver's license, nonoperator's identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1) "d"(2)"3" or 154.4(1) "c"(3)"4" that has been updated according to the procedures established by the state or agency of issuance to reflect the requested residence address, name, or sex designation.

c. To replace a medical cannabidiol registration card held by a primary caregiver to change, add, or remove a patient's medical cannabidiol registration number or the name of a patient's parent or legal guardian listed on the primary caregiver's card, the primary caregiver shall submit a new application to the department pursuant to rule 641—154.4(124E). A medical cannabidiol registration card issued pursuant to this paragraph shall not be considered a duplicate card.

154.8(3) *Expiration date.* A duplicate medical cannabidiol registration card shall have the same expiration date as the medical cannabidiol registration card being replaced, changed, or amended.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.9(124E) *Renewal.* A medical cannabidiol registration card shall be valid for one year from the date of issuance unless canceled pursuant to rule 641—154.6(124E).

154.9(1) A cardholder seeking renewal of a medical cannabidiol registration card shall submit a renewal application and fee to the department at least 60 days prior to the date of expiration.

a. A patient applying for renewal of a medical cannabidiol registration card shall submit a renewal application and fee to the department on a form approved by the department.

b. A primary caregiver applying for a renewal of a medical cannabidiol registration card shall submit a renewal application and fee to the department on a form approved by the department.

154.9(2) A cardholder who fails to renew the medical cannabidiol registration card may not lawfully possess medical cannabidiol pursuant to this chapter.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.10(124E) *Confidentiality.* The department shall maintain a confidential file of the names of each patient to or for whom the department approves the issuance of a medical cannabidiol registration card and the name of each primary caregiver to whom the department issues a medical cannabidiol registration card under Iowa Code section 124E.4.

154.10(1) Personally identifiable information of patients and primary caregivers shall be maintained as confidential and is not accessible to the public. The department and the department of transportation shall release aggregate and statistical information regarding the medical cannabidiol act registration card program in a manner which prevents the identification of any patient or primary caregiver.

154.10(2) Personally identifiable information of patients and primary caregivers may be disclosed under the following limited circumstances:

a. To authorized employees or agents of the department and the department of transportation as necessary to perform the duties of the department and the department of transportation pursuant to Iowa Code chapter 124E.

b. To authorized employees of state or local law enforcement agencies located in Iowa, solely for the purpose of verifying that a person is lawfully in possession of a medical cannabidiol registration card issued pursuant to Iowa Code chapter 124E.

c. To a patient, primary caregiver, or health care practitioner, upon written authorization of the patient or primary caregiver.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.11(124E) Agreement with department of transportation. The department may enter into a chapter 28E agreement with the department of transportation to facilitate the issuance of medical cannabidiol registration cards. The agreement may include provisions which govern the issuance, denial, and cancellation of medical cannabidiol registration cards, the sharing of information between the department and the department of transportation, and reimbursement for costs incurred by the department of transportation for issuing the card.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.12(124E) Fees. All fees are nonrefundable.

154.12(1) Patient medical cannabidiol registration card fee.

a. Each application fee is \$100 unless the patient qualifies for a reduced fee as described in paragraph 154.12(1) "b."

b. Each reduced application fee is \$25 if the patient attests to receiving social security disability benefits, supplemental security income payments, or is enrolled in the medical assistance program as defined in rule 641—154.1(124E).

c. Each renewal fee is the same as the initial card application fee.

154.12(2) Primary caregiver medical cannabidiol registration card fee.

a. Each application fee is \$25.

b. Each renewal fee is \$25.

[ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.13(124E) Use of medical cannabidiol—smoking prohibited. A patient shall not consume medical cannabidiol possessed or used pursuant to Iowa Code chapter 124E by smoking medical cannabidiol.

[ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.14(124E) Form and quantity of medical cannabidiol. The form and quantity of medical cannabidiol authorized in this rule may be modified pursuant to recommendations by the medical cannabidiol board, subsequent approval of the recommendations by the board of medicine and adoption of the recommendations by the department by rule.

154.14(1) Quantity. A 90-day supply is the maximum amount of each product that shall be dispensed by a dispensary at one time.

154.14(2) Form.

a. A manufacturer may only manufacture medical cannabidiol in the following forms:

(1) Oral forms, including but not limited to:

1. Tablet.
2. Capsule.
3. Liquid.
4. Tincture.
5. Sublingual.

(2) Topical forms, including but not limited to:

1. Gel.
 2. Ointment, cream or lotion.
 3. Transdermal patch.
- (3) Nebulizable inhaled forms.
- (4) Rectal/vaginal forms, including but not limited to suppository.

- b. A manufacturer may not produce medical cannabidiol in any form that may be smoked.
- c. A manufacturer may not produce medical cannabidiol in an edible form as defined in rule 641—154.1(124E).

[ARC 3150C, IAB 7/5/17, effective 6/13/17; ARC 3836C, IAB 6/6/18, effective 7/11/18]

641—154.15 Reserved.

MANUFACTURING

641—154.16(124E) Duties of the department.

154.16(1) *Interagency agreements.* The department may enter into any interagency agreements with other state agencies for technical services or other assistance related to the regulation or inspection of manufacturers.

154.16(2) *Notice to law enforcement.* The department shall notify local law enforcement agencies and the department of public safety of the locations of manufacturers. If the department determines there is a threat to public safety, the department shall notify local law enforcement agencies and the department of public safety of any conditions that pose a threat to public safety, including but not limited to:

- a. Loss or theft of medical cannabidiol or plant material;
- b. Diversion or potential diversion of medical cannabidiol or plant material;
- c. Unauthorized access to the secure sales and inventory tracking system or other patient and caregiver information system or file; or
- d. Other violations of law.

154.16(3) *Inspection of manufacturers.* The department or its agents shall conduct regular inspections of manufacturers and manufacturing facilities as described in rule 641—154.28(124E).

154.16(4) *Establishment and maintenance of a secure sales and inventory tracking system.* The department shall establish and maintain a secure, electronic system that is available 24 hours a day, seven days a week to track:

- a. Inventory of plant material, medical cannabidiol, and waste material;
- b. Transport of plant material, waste material, and laboratory samples;
- c. Application and use of crop inputs and other solvents and chemicals;
- d. Sales of medical cannabidiol to dispensaries;
- e. Sales of medical cannabidiol from dispensaries to patients and primary caregivers.

154.16(5) *Licensure and licensure renewal of manufacturers.* The department shall issue a request for proposals to select and license by December 1, 2017, up to two manufacturers to manufacture and to possess, cultivate, harvest, transport, package, process, and supply medical cannabidiol within the state consistent with the provisions of Iowa Code chapter 124E and these rules.

a. To be eligible for licensure, an applicant manufacturer shall provide information on forms and in a manner required by the department of public safety for the completion of a background investigation. In addition, the applicant manufacturer shall submit to the department of public safety necessary funds to satisfy the full reimbursement of costs associated with completing the background investigations. If an applicant manufacturer is not found suitable for licensure as a result of the background investigation, a license shall not be issued by the department.

b. As a condition for licensure, an applicant manufacturer shall agree to begin supplying medical cannabidiol to licensed medical cannabidiol dispensaries in Iowa no later than December 1, 2018.

c. The initial license to manufacture medical cannabidiol shall be valid from December 1, 2017, through November 30, 2018. The license shall be renewed annually unless a manufacturer relinquishes the license, there is a change in state law prohibiting the department from renewing the license, or the license is revoked pursuant to Iowa Code chapter 124E or these rules.

d. A license to manufacture issued by the department pursuant to these rules is not assignable or transferable.

e. The department shall consider the following factors in determining whether to select and license a medical cannabidiol manufacturer:

- (1) The technical expertise of an applicant manufacturer regarding medical cannabidiol;
- (2) The qualifications of an applicant manufacturer's employees;
- (3) The long-term financial stability of an applicant manufacturer;
- (4) The ability to provide appropriate security measures on the premises of an applicant manufacturer;

(5) Whether an applicant manufacturer has demonstrated an ability to meet certain medical cannabidiol production needs for medical use regarding the range of recommended dosages for each debilitating medical condition, the range of chemical compositions of any plant of the genus cannabis that will likely be medically beneficial for each of the debilitating medical conditions, and the form or forms of medical cannabidiol that may be appropriate for the approved debilitating medical conditions;

- (6) An applicant manufacturer's projection of and ongoing assessment of wholesale product costs.

f. Pursuant to Iowa Code section 124E.6(1) "b," information submitted during the application process shall be confidential until the licensure process is completed unless otherwise protected from disclosure under state or federal law.

g. A licensed manufacturer shall submit an application to renew its license with the department at least six months before the license expires. The application shall be submitted on a form created by the department.

h. The department shall notify a manufacturer of the decision to approve or deny the manufacturer's license by August 1 of the year in which the renewal application is submitted.

154.16(6) Collection of fees from manufacturers. Except as provided in this rule, all fees are nonrefundable, shall be retained by the department, and shall be considered repayment receipts as defined in Iowa Code section 8.2.

a. Fees to the department.

(1) Each application for licensure as a manufacturer shall include a nonrefundable application fee of \$7,500.

(2) Licensed manufacturers shall pay an annual fee to the department to cover costs associated with regulating and inspecting manufacturers and for other expenses necessary for the administration of the medical cannabidiol program. The department shall assess the fee with the notice of approval of license renewal each year by August 1, payable by the manufacturer to the department no later than December 1.

b. Fees to the department of public safety.

(1) An applicant manufacturer shall be responsible to reimburse the department of public safety the full cost of conducting background investigations related to an application for licensure and operation as a licensed manufacturer. The department of public safety shall retain the right to bill a manufacturer for additional background investigations, as needed.

(2) Each manufacturer submitting an application for licensure shall, at the time of application, submit to the department of public safety a deposit of \$10,000 for each business owner subject to a background investigation and a national criminal history background check. Background investigation costs shall be deducted from the funds deposited. If the background investigation fees exceed the funds deposited, the applicant shall submit additional funds as required by the department of public safety. If the background investigation fees are less than the funds deposited, the department of public safety may refund or retain the fees as mutually agreed with the manufacturer.

(3) A licensed manufacturer shall pay a deposit of \$200 per employee to the department of public safety for a background investigation and a national criminal history background check on any person being considered for hire as an employee of the manufacturer. Background investigation costs shall be deducted from the funds deposited. If the background investigation fees exceed the funds deposited, the manufacturer shall submit additional funds as required by the department of public safety. If the background investigation fees are less than the funds deposited, the department of public safety may refund or retain the fees as mutually agreed with the manufacturer. The department shall retain the right to preclude a potential employee from hire based upon the results of the background investigation and national criminal history background check.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.17(124E) Manufacturer operations.

154.17(1) *Operating documents.* The operating documents of a manufacturer shall include all of the following:

a. Procedures for the oversight of the manufacturer, including descriptions of operational and management practices regarding:

(1) The forms and quantities of medical cannabidiol products that are produced at the manufacturing facility;

(2) The methods of planting, harvesting, drying, and storing cannabis;

(3) The estimated types and amounts of all crop inputs used in the production of medical cannabidiol;

(4) The estimated types and amounts of medical cannabidiol waste and plant material waste to be generated;

(5) The disposal methods for all waste materials;

(6) Employee training methods for the specific phases of production;

(7) Biosecurity measures used in the production and manufacturing of medical cannabidiol;

(8) Strategies for identifying and reconciling discrepancies in inventory of plant material or medical cannabidiol;

(9) Sampling strategy and quality testing for labeling purposes;

(10) Medical cannabidiol packaging and labeling procedures;

(11) Procedures for recall and market withdrawal of medical cannabidiol;

(12) Plans for responding to a security breach at a manufacturing facility or while medical cannabidiol is in transit to a dispensary;

(13) A business continuity plan;

(14) Records relating to all transport activities; and

(15) Other information requested by the department.

b. Procedures to ensure accurate record keeping.

c. Procedures for the implementation of appropriate security measures to deter and prevent the theft of medical cannabidiol and unauthorized entrance into areas containing medical cannabidiol.

154.17(2) *Prohibited activities.* A manufacturer shall not:

a. Own or operate a medical cannabidiol manufacturing facility unless the manufacturer is licensed by the department pursuant to Iowa Code chapter 124E and these rules;

b. Produce or manufacture medical cannabidiol in any location except in those areas approved by the department;

c. Sell, deliver, transport, or distribute medical cannabidiol from any location except its manufacturing facility or a dispensary facility;

d. Produce or manufacture medical cannabidiol in Iowa for sales or distribution outside of Iowa;

e. Sell or distribute medical cannabidiol to any person or business other than a dispensary;

f. Refuse to sell, deliver, transport, or distribute medical cannabidiol in any form or quantity produced by the manufacturer to a dispensary, unless deemed appropriate in the manufacturer's reasonable business judgment and approved by the department in writing;

g. Transport or deliver medical cannabidiol to any location except as allowed in subrule 154.22(1);

h. Sell medical cannabidiol that is not packaged and labeled in accordance with rule 641—154.21(124E);

i. Sell medical cannabidiol in any form or quantity other than a form or quantity approved by the department, subject to recommendation by the medical cannabidiol board and approval by the board of medicine;

j. Permit any person to consume medical cannabidiol on the property of the manufacturer;

k. Employ a person who is under 18 years of age or who has been convicted of a disqualifying felony offense;

l. Manufacture edible medical cannabidiol products.

154.17(3) *Criminal background investigations.*

a. A manufacturer shall not have been convicted of a disqualifying felony offense and shall be subject to a background investigation conducted by the department of public safety, including but not limited to a national criminal history record check.

b. An employee of a manufacturer shall not have been convicted of a disqualifying felony offense and shall be subject to a background investigation conducted by the department of public safety, including but not limited to a national criminal history background check.

154.17(4) Relationship to health care practitioners. A manufacturer shall not share office space with, refer patients to, or have any financial relationship with a health care practitioner.
[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 3836C, IAB 6/6/18, effective 7/11/18]

641—154.18(124E) Security requirements. The department may request assistance from the department of public safety in ensuring manufacturers meet the security requirements in this rule.

154.18(1) Visitor logs. Visitors to the manufacturing facility shall sign visitor manifests with name, date, and times of entry and exit, and shall wear badges that are visible at all times and that identify them as visitors.

154.18(2) Restricted access. A manufacturer shall use a controlled access system and written manifests to limit entrance to all restricted access areas of its manufacturing facility and shall retain a record of all persons who entered the restricted access areas.

a. The controlled access system shall do all of the following:

- (1) Limit access to authorized individuals;
- (2) Maintain a log of individuals with approved access, including dates of approvals and revocations;
- (3) Track times of personnel entry to and exit from the facility;
- (4) Store data for retrieval for a minimum of one year; and
- (5) Limit access to authorized individuals in the event of a power failure.

b. Separate written manifests of visitors to restricted access areas shall be kept and stored for a minimum of one year if the controlled access system does not include electronic records of visitors to the restricted access areas.

c. A manufacturer shall promptly, but no later than five business days after receipt of request, submit stored controlled access system data to the department.

d. Restricted access areas shall be identified with signs that state: “Do Not Enter – Restricted Access Area – Access Limited to Authorized Personnel Only.”

154.18(3) Perimeter intrusion detection system.

a. *Computer-controlled video surveillance system.* A manufacturer shall operate and maintain in good working order a computer-controlled, closed-circuit television surveillance system on its premises that operates 24 hours per day, seven days a week, and visually records:

- (1) All phases of medical cannabidiol production;
- (2) All areas that might contain plant material and medical cannabidiol, including all safes and vaults;
- (3) All points of entry and exit;
- (4) The entrance to the video surveillance control room; and
- (5) Parking areas, which shall have appropriate lighting for the normal conditions of the area under surveillance.

b. *Camera specifications.* Cameras shall:

- (1) Capture clear and certain identification of any person entering or exiting a manufacturing facility or its parking areas to the extent identification is technologically feasible with generally accepted commercial security cameras;
- (2) Have the ability to produce a clear, color still photograph live or from a recording;
- (3) Have on all recordings an embedded date-and-time stamp that is synchronized to the recording and does not obscure the picture; and
- (4) Continue to operate during a power outage.

c. *Video recording specifications.*

(1) A video recording shall export still images in an industry standard image format, such as .jpg, .bmp, or .gif.

(2) Exported video shall be archived in a format that ensures authentication and guarantees that the recorded image has not been altered.

(3) Exported video shall also be saved in an industry standard file format that can be played on a standard computer operating system.

(4) All recordings shall be erased or destroyed at the end of the retention period and prior to disposal of any storage medium.

d. Additional requirements. A manufacturer shall maintain all security system equipment and recordings in a secure location to prevent theft, loss, destruction, corruption, and alterations.

e. Retention. A manufacturer shall ensure that recordings from all video cameras are:

(1) Available for viewing by the department upon request;

(2) Retained for at least 60 days;

(3) Maintained free of alteration or corruption; and

(4) Retained longer, as needed, if a manufacturer is given actual notice of a pending criminal, civil, or administrative investigation, or other legal proceeding for which the recording may contain relevant information.

f. Required signage. A manufacturer shall post a sign in capital letters in a conspicuous location at every entrance to the manufacturing facility that reads, "THESE PREMISES ARE UNDER CONSTANT VIDEO SURVEILLANCE."

154.18(4) Security alarm system requirements.

a. A manufacturer shall install and maintain a professionally monitored security alarm system that provides intrusion and fire detection of all:

(1) Facility entrances and exits;

(2) Rooms with exterior windows;

(3) Rooms with exterior walls;

(4) Roof hatches;

(5) Skylights; and

(6) Storage rooms.

b. For the purposes of this subrule, a security alarm system means a device or series of devices that summons law enforcement personnel during, or as a result of, an alarm condition. Devices may include:

(1) Hardwired systems and systems interconnected with a radio frequency method such as cellular or private radio signals that emit or transmit a remote or local audio, visual, or electronic signal;

(2) Motion detectors;

(3) Pressure switches;

(4) A duress alarm;

(5) A panic alarm;

(6) A holdup alarm;

(7) An automatic voice dialer; and

(8) A failure notification system that provides an audio, text, or visual notification of any failure in the surveillance system.

c. A manufacturer's security alarm system and all devices shall continue to operate during a power outage.

d. A manufacturer's security alarm system shall be inspected and all devices tested annually by a qualified alarm vendor. A manufacturer shall provide documentation of the annual inspection and device testing to the department upon request.

154.18(5) Personnel identification system. A manufacturer shall use a personnel identification system that controls and monitors individual employee access to restricted access areas within the manufacturing facility and that meets the requirements of this subrule and subrule 154.18(1).

a. Requirement for employee identification card. An employee identification card shall contain:

(1) The name of the employee;

(2) The date of issuance and expiration;

- (3) An alphanumeric identification number that is unique to the employee; and
 - (4) A photographic image of the employee.
 - b.* A manufacturer's employee shall keep the identification card visible at all times when the employee is in a manufacturing facility, a dispensary, or a vehicle transporting medical cannabidiol.
 - c.* Upon termination or resignation of an employee, a manufacturer shall immediately:
 - (1) Revoke the employee's access to the manufacturing facility; and
 - (2) Obtain and destroy the employee's identification card, if possible.
- [ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.19(124E) Location. All of a manufacturer's manufacturing, cultivating, harvesting, packaging, processing, and storage of medical cannabidiol shall take place in one secured manufacturing facility location at a physical address provided to the department during the licensure and application processes.

154.19(1) Proximity to dispensary. A manufacturer shall not operate a manufacturing facility at the same physical location as a medical cannabidiol dispensary.

154.19(2) Proximity to school. A manufacturer shall not operate a manufacturing facility in any location, whether for manufacturing, possessing, cultivating, harvesting, transporting, packaging, processing, storing, or supplying, within 1,000 feet of a public or private school existing before the date of the manufacturer's licensure by the department.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.20(124E) Advertising and marketing.

154.20(1) Permitted marketing and advertising activities.

- a.* A manufacturer may:
 - (1) Display the manufacturer's business name and logo on medical cannabidiol labels, signs, website, and informational material provided to patients. The name or logo shall not include:
 - 1. Images of cannabis or cannabis-use paraphernalia;
 - 2. Colloquial references to cannabis;
 - 3. Names of cannabis plant strains or varieties;
 - 4. Unsubstantiated medical claims; or
 - 5. Medical symbols that bear a reasonable resemblance to established medical associations. Examples of established medical organizations include the American Medical Association or American Academy of Pediatrics. The use of medical symbols is subject to approval by the department;
 - (2) Display signs on the manufacturing facility; and
 - (3) Maintain a business website that contains the following information:
 - 1. The manufacturer's name and contact information;
 - 2. The medical cannabidiol forms and quantities manufactured in Iowa; and
 - 3. Other information as approved by the department.
- b.* The business website shall not include any false, misleading, or unsubstantiated statements regarding health or physical benefits to the patient.

- c.* The department reserves the right to review a manufacturer's marketing and advertising materials and to require a manufacturer to make changes to the content. The department has 30 calendar days following submission to approve or deny marketing and advertising materials of a manufacturer.

154.20(2) Other marketing and advertising activities. A manufacturer shall request and receive the department's written approval before beginning marketing or advertising activities that are not specified in subrule 154.20(1). The department has 30 calendar days to approve, deny, or request additional information regarding marketing and advertising activity requests from a manufacturer. In the event the department fails to respond to a manufacturer within 30 days with an approval, denial, or request for additional information, the manufacturer's marketing and advertising activity requests shall be deemed approved.

154.20(3) *Inconspicuous display.* A manufacturer shall arrange displays of medical cannabidiol, interior signs, and other exhibits to reasonably prevent public viewing from outside the manufacturing facility.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.21(124E) Packaging and labeling.

154.21(1) *Medical cannabidiol packaging.* A manufacturer shall package all medical cannabidiol intended for distribution according to the following standards:

a. The manufacturer shall properly package medical cannabidiol in compliance with the United States Poison Prevention Packing Act regarding child-resistant packaging and exemptions for packaging for elderly patients.

b. The manufacturer shall label packaged medical cannabidiol as described in subrule 154.21(3).

c. The manufacturer shall use medical containers that are:

(1) Of sufficient size to accommodate a separate dispensary label containing the information described in rule 641—154.46(124E);

(2) Designed to maximize the shelf life of the contained medical cannabidiol;

(3) Tamper-evident; and

(4) Child-resistant.

d. Medical cannabidiol packaging shall not bear a reasonable resemblance to commonly available nonmedical commercial products.

e. The manufacturer shall package medical cannabidiol in a manner that minimizes the package's appeal to children.

f. The manufacturer shall not depict images other than the manufacturer's business name or logo on the packaging.

154.21(2) *Trade names.* A manufacturer's medical cannabidiol trade names shall comply with the following:

a. Names shall be limited to those that clearly reflect the form's medical cannabidiol nature;

b. Any name that is identical to, or similar to, the name of an existing nonmedical cannabidiol product is prohibited;

c. Any name that is identical to, or similar to, the name of an unlawful product or substance is prohibited; and

d. Any name that contains language that suggests using medical cannabidiol for recreational purposes or for a condition other than a qualifying debilitating medical condition is prohibited.

154.21(3) *Package labeling.*

a. A manufacturer shall ensure that all medical cannabidiol packaging is labeled with the following information:

(1) The name and address of the manufacturer where the medical cannabidiol was manufactured;

(2) The medical cannabidiol's primary active ingredients, including concentrations of tetrahydrocannabinol, tetrahydrocannabinolic acid, cannabidiol, and cannabidiolic acid;

(3) Directions for use of the product, including recommended and maximum amount by age and weight, if applicable;

(4) All ingredients of the product shown with common or usual names, including any colors, artificial flavors, and preservatives, listed in descending order by predominance of weight;

(5) Instructions for storage, including light and temperature requirements, if any;

(6) Product expiration date;

(7) The date of manufacture and lot number;

(8) A notice with the statement, including capitalization: "This product has not been analyzed or approved by the United States Food and Drug Administration. There is limited information on the side effects of using this product, and there may be associated health risks and medication interactions. This product is not recommended for use by pregnant or breastfeeding women. KEEP THIS PRODUCT OUT OF REACH OF CHILDREN.";

(9) The universal warning symbol provided by the department; and

(10) A notice with the statement: “This medical cannabidiol is for therapeutic use only. Use of this product by a person other than the patient listed on the label is unlawful and may result in the cancellation of the patient’s medical cannabidiol registration card. Return unused medical cannabidiol to a dispensary for disposal.”

b. Labeling text shall not include any false or misleading statements.

c. A package may contain multiple labels if the information required by this rule is not obstructed.

d. Labeling text font size shall be no smaller than 6 point.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 3836C, IAB 6/6/18, effective 7/11/18]

641—154.22(124E) Transportation of medical cannabidiol and plant material.

154.22(1) *Transport of medical cannabidiol.* A manufacturer is authorized to transport medical cannabidiol to and from:

a. Dispensaries;

b. A laboratory for testing;

c. A waste facility for disposal;

d. Other sites only with departmental approval.

154.22(2) *Transport of plant material.* A manufacturer is authorized to transport cannabis plant material from its manufacturing facility to:

a. A waste disposal site;

b. Other sites only with departmental approval.

154.22(3) *Chain-of-custody tracking system.*

a. A manufacturer shall use the secure sales and inventory tracking system, if available, or a department-approved manifest system to track shipping of medical cannabidiol. The system shall include a chain of custody that records:

(1) The name and address of the destination;

(2) The weight and description of each individual package that is part of the shipment, and the total number of individual packages;

(3) The date and time the medical cannabidiol shipment is placed into the transport vehicle;

(4) The date and time the shipment is accepted at the delivery destination;

(5) The person’s identity, and the circumstances, duration, and disposition of any other person who had custody or control of the shipment; and

(6) Any handling or storage instructions.

b. Before transporting medical cannabidiol, a manufacturer shall:

(1) Record in the secure sales and inventory tracking system or on the manifest information about the material to be transported; and

(2) Notify the dispensary, laboratory, or waste facility, as applicable, of the expected arrival time and transmit a copy of the manifest to the dispensary, laboratory, or waste facility, if applicable.

c. Each transport shall be approved electronically or in writing by:

(1) An authorized manufacturer employee when the transport vehicle is departing the manufacturing facility; and

(2) An authorized employee of the receiving dispensary, laboratory, or waste facility.

d. An authorized employee at the dispensary, laboratory, or waste facility receiving medical cannabidiol shall:

(1) Verify and document the type and quantity of the transported medical cannabidiol against the information in the secure sales and inventory tracking system or written manifest;

(2) Approve the transport electronically or return a signed copy of the manifest to the manufacturing facility; and

(3) Record the medical cannabidiol that is received as inventory in the secure sales and inventory tracking system, if available. If a manifest system is being used, the dispensary, laboratory, or waste facility shall also maintain a signed copy of manifest, and shall maintain records of the inventory received consistent with these rules.

e. A manufacturer shall maintain all manifests for at least five years and make them available upon request of the department.

154.22(4) Vehicle requirements for transport.

a. A manufacturer shall ensure that all medical cannabidiol transported on public roadways is:

- (1) Packaged in tamper-evident, bulk containers;
- (2) Transported so it is not visible or recognizable from outside the vehicle; and
- (3) Transported in a vehicle that does not bear any markings to indicate that the vehicle contains medical cannabidiol or bears the name or logo of the manufacturer.

b. When the motor vehicle contains medical cannabidiol, manufacturer employees who are transporting the medical cannabidiol on public roadways shall:

- (1) Travel directly to a dispensary or other department-approved locations; and
- (2) Document refueling and all other stops in transit, including:
 1. The reason for the stop;
 2. The duration of the stop; and
 3. The location of the stop.

c. If the vehicle must be stopped due to an emergency situation, the employee shall notify 911 and complete an incident report on a form approved by the department.

d. Under no circumstance shall any person other than a designated manufacturer employee have actual physical control of the motor vehicle that is transporting the medical cannabidiol.

e. A manufacturer shall staff all motor vehicles with a minimum of two employees when transporting medical cannabidiol between a manufacturing facility and a dispensary. At least one employee shall remain with the motor vehicle at all times that the motor vehicle contains medical cannabidiol. A single employee may transport medical cannabidiol to the laboratory.

f. Each employee in a transport motor vehicle shall have telephone or other communication access with the manufacturer's personnel and have the ability to contact law enforcement via telephone or other method at all times that the motor vehicle contains medical cannabidiol.

g. An employee shall carry the employee's identification card at all times when transporting or delivering medical cannabidiol and, upon request, produce the identification card to the department or to a law enforcement officer acting in the course of official duties.

h. A manufacturer shall not leave a vehicle that is transporting medical cannabidiol unattended overnight.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.23(124E) Disposal of medical cannabidiol and plant material.

154.23(1) Return of medical cannabidiol from dispensaries and laboratory. A manufacturer shall collect at no charge unused, excess, or expired medical cannabidiol from dispensaries, including medical cannabidiol that was returned to a dispensary from a patient or primary caregiver, and from the laboratory that has tested samples submitted by the manufacturer. A manufacturer shall:

a. Collect waste medical cannabidiol from each dispensary on a schedule mutually agreed upon by the manufacturer and dispensary;

b. Collect waste medical cannabidiol from a laboratory on a schedule mutually agreed upon by the manufacturer and laboratory;

c. Dispose of the returned medical cannabidiol as provided in subrule 154.23(2); and

d. Maintain a written record of disposal that includes:

(1) The tracking number assigned at the time of the dispensing, if available, or the name of the patient, if the tracking number is unavailable, when the medical cannabidiol was returned to the dispensary from a patient or primary caregiver;

(2) The date the medical cannabidiol was returned;

(3) The quantity of medical cannabidiol returned; and

(4) The type and lot number of medical cannabidiol returned.

154.23(2) *Medical cannabidiol and plant material waste.* A manufacturer shall store, secure, and manage medical cannabidiol waste and plant material waste in accordance with all applicable federal, state, and local regulations.

a. The manufacturer shall dispose of medical cannabidiol waste at a waste facility according to federal and state law and in a manner which renders it unusable.

b. The manufacturer shall dispose of plant material waste at an approved solid waste disposal facility, according to federal and state law.

c. Before transport of plant material waste, the manufacturer shall render the plant material waste unusable and unrecognizable by grinding and incorporating the waste with a greater quantity of nonconsumable, solid wastes including:

- (1) Paper waste;
- (2) Cardboard waste;
- (3) Food waste;
- (4) Yard waste;
- (5) Vegetative wastes generated from industrial or manufacturing processes that prepare food for human consumption;
- (6) Soil; or
- (7) Other waste approved by the department.

154.23(3) *Liquid and chemical waste disposal.* A manufacturer shall dispose of all liquid and chemical product waste generated in the process of cultivating, manufacturing, and distributing medical cannabidiol in accordance with all applicable federal, state, and local regulations.

154.23(4) *Waste-tracking requirements.* A manufacturer shall use forms approved by the department to maintain accurate and comprehensive records regarding waste material. The records shall account for, reconcile, and evidence all waste activity related to the disposal of medical cannabidiol waste and plant material waste.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.24(124E) Record-keeping requirements.

154.24(1) *Sales and distribution.* A manufacturer shall maintain complete and accurate electronic sales transaction records in the department's secure sales and inventory tracking system, including:

- a.* The date of each sale or distribution;
- b.* The item number, product name and description, and quantity of medical cannabidiol sold or otherwise distributed; and
- c.* The sale price.

154.24(2) *Financial transactions.* A manufacturer shall maintain records that reflect all financial transactions and the financial condition of the business. The following records shall be maintained for at least five years and made available for review, upon request of the department:

- a.* Purchase invoices, bills of lading, sales records, copies of bills of sale, and any supporting documents, to include the items or services purchased, from whom the items were purchased, and the date of purchase;
- b.* Bank statements and canceled checks for all business accounts;
- c.* Accounting and tax records;
- d.* Records of all financial transactions, including contracts and agreements for services performed or services received;

154.24(3) *Other records.*

a. A manufacturer shall maintain the following for at least five years, unless otherwise noted, and provide to the department upon request:

- (1) All personnel records;
- (2) Records of any theft, loss, or other unaccountability of any medical cannabidiol or plant material;
- (3) Transport manifests and incident reports; and
- (4) Records of all samples sent to a testing laboratory and the quality assurance test results.

b. A manufacturer shall maintain for at least one year and provide to the department upon request its controlled access system data and visitor manifests.

c. A manufacturer shall use the department's secure sales and inventory tracking system to maintain the following:

- (1) Crop input records;
- (2) Production records;
- (3) Transportation records; and
- (4) Inventory records, including disposal of waste.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.25(124E) Production requirements.

154.25(1) Cultivation and processing.

a. Only a licensed manufacturer is authorized to produce and manufacture medical cannabidiol.

b. All phases of production shall take place in designated, restricted access areas that are monitored by a surveillance camera system in accordance with rule 641—154.18(124E).

c. The production process shall be designed to limit contamination. Examples of contamination include mold, fungus, bacterial diseases, rot, pests, nonorganic pesticides, and mildew.

d. Each production area shall allow for access, observation, and inventory of each plant group.

e. Biosecurity measures shall be in effect as described in the operating documents pursuant to subrule 154.17(1).

154.25(2) Record-keeping and tracking requirements.

a. The manufacturer shall use the department's secure sales and inventory tracking system to maintain an electronic record of all crop inputs for at least five years. The record shall include the following:

- (1) The date of input application;
- (2) The name of the employee applying the crop input;
- (3) The crop input that was applied;
- (4) The plants that received the application;
- (5) The amount of crop input that was applied; and
- (6) A copy of or electronic link to the safety data sheet for the crop input applied.

b. At the time of planting, all plants shall be tracked in a batch process with a unique batch number that shall remain with the batch through final processing into medical cannabidiol.

c. A manufacturer shall record any removal of plants from the batch, including the reason for removal, on a record maintained at the manufacturing facility for at least five years.

d. Each batch or part of a batch of cannabis plants that contributes to a lot of medical cannabidiol shall be recorded in the department's secure sales and inventory tracking system or other manifest system.

154.25(3) Production of medical cannabidiol.

a. A manufacturer shall comply with all state and local building and fire code requirements.

b. A manufacturer shall obtain approval from the department for use of any hydrocarbon-based extraction process. Examples of a hydrocarbon-based extraction process include the use of butane, ethanol, hexane, and isopropyl alcohol.

c. Medical cannabidiol shall be prepared, handled, and stored in compliance with the sanitation requirements in this rule.

d. A manufacturer shall produce shelf-stable, nonperishable forms of medical cannabidiol.

e. A manufacturer shall ensure that the cannabinoid content of the medical cannabidiol it produces is homogenous.

f. Each lot of medical cannabidiol shall be assigned a unique lot number and recorded in the department's secure sales and inventory tracking system or other manifest system.

154.25(4) General sanitation requirements. A manufacturer shall take all reasonable measures and precautions to ensure that:

a. Any employee who has a communicable disease does not perform any tasks that might contaminate plant material or medical cannabidiol;

- b.* Hand-washing facilities are:
 - (1) Convenient and furnished with running water at a suitable temperature;
 - (2) Located in all production areas; and
 - (3) Equipped with effective hand-cleaning and -sanitizing preparations and sanitary towel service or electronic drying devices;
- c.* All employees working in direct contact with plant material and medical cannabidiol use hygienic practices while on duty, including:
 - (1) Maintaining personal cleanliness; and
 - (2) Washing hands thoroughly in a hand-washing area before starting work and at any other time when the hands may have become soiled or contaminated;
- d.* Litter and waste are routinely removed and the operating systems for waste disposal are routinely inspected;
- e.* Floors, walls, and ceilings are constructed with a surface that can be easily cleaned and maintained in good repair to inhibit microbial growth;
- f.* Lighting is adequate in all areas where plant material and medical cannabidiol are processed, stored, or sold;
- g.* Screening or other protection against the entry of pests is provided, including that rubbish is disposed of to minimize the development of odor and the potential for the waste becoming an attractant, harborage, or breeding place for pests;
- h.* Any buildings, fixtures, and other facilities are maintained in a sanitary condition;
- i.* Toxic cleaning compounds, sanitizing agents, and other potentially harmful chemicals are identified and stored in a separate location away from plant material and medical cannabidiol and in accordance with applicable local, state, or federal law;
- j.* All contact surfaces, utensils, and equipment used in the production of plant material and medical cannabidiol are maintained in a clean and sanitary condition;
- k.* The manufacturing facility water supply is sufficient for necessary operations;
- l.* Plumbing size and design meets operational needs and all applicable state and local laws;
- m.* Employees have accessible toilet facilities that are sanitary and in good repair; and
- n.* Plant material and medical cannabidiol that could support the rapid growth of undesirable microorganisms are isolated to prevent the growth of those microorganisms.

154.25(5) Storage.

- a.* A manufacturer shall store plant material and medical cannabidiol during production, transport, and testing to prevent diversion, theft, or loss, including ensuring that:
 - (1) Plant material and medical cannabidiol are returned to a secure location immediately after completion of the process or at the end of the scheduled business day; and
 - (2) The tanks, vessels, bins, or bulk containers containing plant material or medical cannabidiol are locked inside a secure area if a process is not completed at the end of a business day.
- b.* A manufacturer shall store all plant material and medical cannabidiol during production, transport, and testing, and all saleable medical cannabidiol:
 - (1) In areas that are maintained in a clean, orderly, and well-ventilated condition; and
 - (2) In storage areas that are free from infestation by insects, rodents, birds, and other pests of any kind.
- c.* To prevent degradation, a manufacturer shall store all plant material and medical cannabidiol in production, transport, and testing, and all saleable medical cannabidiol under conditions that will protect the product and its container against physical, chemical, and microbial contamination and deterioration.
- d.* A manufacturer shall maintain a separate secure storage area for medical cannabidiol that is returned from a dispensary, including medical cannabidiol that is outdated, damaged, deteriorated, mislabeled, or contaminated, or whose containers or packaging has been opened or breached, until the returned medical cannabidiol is destroyed. For purposes of this rule, a separate secure storage area includes a container, closet, or room that can be locked or secured.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.26(124E) Quality assurance and control.

154.26(1) *Quality control program.* A manufacturer shall develop and implement a written quality assurance program that assesses the chemical and microbiological composition of medical cannabidiol. Assessment includes a profile of the active ingredients, including shelf life, and the presence of inactive ingredients and contaminants. A manufacturer shall use these testing results to determine appropriate storage conditions and product expiration dates.

154.26(2) *Sampling protocols.* A manufacturer shall develop and follow written procedures for sampling medical cannabidiol that require the manufacturer to:

- a. Conduct sample collection in a manner that provides analytically sound and representative samples;
- b. Document every sampling event and provide this documentation to the department upon request;
- c. Describe all sampling and testing plans in written procedures that include the sampling method and the number of units per lot to be tested;
- d. Ensure that random samples from each lot are:
 - (1) Taken in an amount necessary to conduct the applicable test;
 - (2) Labeled with the lot number; and
 - (3) Submitted for testing;
- e. Retain the results from the random samples for at least five years; and
- f. Notify the department at least two business days prior to sample collection and allow the department or its designees to be present to observe the sampling procedures when the samples are to be sent to a laboratory for testing.

154.26(3) *Sampling and testing.* A manufacturer shall:

- a. Work with the department and laboratory personnel to develop acceptance criteria for all potential contaminants based on the levels of metals, microbes, or other contaminants that the manufacturer uses in cultivating and producing medical cannabidiol;
- b. Conduct sampling and testing of all medical cannabidiol lots using acceptance criteria that are protective of patient health. The sampling and testing results shall be approved by the department and laboratory personnel and shall ensure that lots of medical cannabidiol meet allowable health risk limits for contaminants. Testing of lots shall occur as follows:
 - (1) At a minimum, testing of lots for cannabinoid potency and all microbiological impurities except microbiological toxins shall occur after packaging but before transport or sale to a dispensary;
 - (2) At a minimum, testing of lots for residual solvents and processing chemicals, pesticides, and metals shall occur at the process lot stage. A packaged product that contains medical cannabidiol solely from process lots that passed laboratory testing for residual solvents and processing chemicals, pesticides, and metals does not need to be retested for these analytes provided that solvents and processing chemicals are not used during the processing into the packaged product;
 - (3) Testing of lots for residual solvents and processing chemicals shall also occur after packaging but before transport or sale to a dispensary if solvents or processing chemicals are used in the production process after the testing of the process lot has occurred;
- c. Refrain from packaging or selling medical cannabidiol from a process lot that fails to meet established standards, specifications, and any other relevant quality control criteria. Medical cannabidiol from a process lot that fails quality assurance testing may be remixed and retested;
- d. Reject and destroy medical cannabidiol from a lot that fails to meet established standards, specifications, and any other relevant quality control criteria when remixing and retesting are not warranted;
- e. Develop and follow a written procedure for responding to results failing to meet established standards, specifications, and any other relevant quality control criteria, including:
 - (1) Criteria for when remixing and retesting are warranted;
 - (2) Instructions for destroying contaminated or substandard medical cannabidiol as provided in subrule 154.23(2) when remixing and retesting are not warranted; and
 - (3) Instructions for determining the source of contamination;

f. Retain documentation of test results, assessment, and destruction of medical cannabidiol for at least five years.

154.26(4) Stability testing.

a. The quality assurance program shall include procedures for performing stability testing of each product type produced to determine product expiration dates. The procedures shall describe:

(1) Sample size and test intervals based on statistical criteria and departmental guidance pursuant to subrule 154.69(1) for each attribute examined to ensure valid stability estimates;

(2) Storage conditions for samples retained for testing; and

(3) Reliable and specific test methods.

b. Stability studies shall include:

(1) Medical cannabidiol testing at appropriate intervals; and

(2) Medical cannabidiol testing in the same container-closure system in which the medical cannabidiol is marketed and dispensed.

c. If product-expiration-date studies have not been completed before December 1, 2018, a manufacturer shall assign a tentative product expiration date, not to exceed one year, based on any available stability information. A manufacturer shall concurrently conduct stability studies to determine the actual product expiration date.

d. After a manufacturer verifies the tentative product expiration date, or determines the appropriate product expiration date, a manufacturer shall include that product expiration date on each lot of medical cannabidiol.

e. Stability testing shall be repeated if the manufacturing process or the product's chemical composition is changed.

154.26(5) Reserve samples.

a. A manufacturer shall retain a uniquely labeled reserve sample that represents each lot of medical cannabidiol and store the reserve sample under conditions consistent with product labeling. The reserve sample shall be stored in the same immediate container-closure system in which the medical cannabidiol is marketed or in one that has similar characteristics. The reserve sample shall consist of at least twice the quantity necessary to perform all the required tests.

b. A manufacturer shall retain the reserve for at least two years from the date of manufacture.

c. After two years from the date of manufacture, reserve samples shall be destroyed as provided in subrule 154.23(2).

154.26(6) Retesting. If the department deems that public health may be at risk, the department may require the manufacturer to retest any sample of plant material or medical cannabidiol.

154.26(7) Disposal of substandard product. A manufacturer shall dispose of all medical cannabidiol as provided in subrule 154.23(2) when samples fail to meet established standards, specifications, and other relevant quality control criteria and when an adequate remedy for remixing and retesting as provided in paragraph 154.26(3) "c" is unavailable.

154.26(8) Recall and market withdrawal procedures. Each manufacturer shall establish a procedure for recalling or withdrawing from the market, as applicable, medical cannabidiol that has a reasonable probability of causing an unexpected or harmful response in a patient population, despite appropriate use, that outweighs the potential benefit of the medical cannabidiol. This procedure shall include:

a. Factors that make a recall or market withdrawal necessary;

b. Manufacturer's personnel who are responsible for overseeing the recall or market withdrawal; and

c. How to notify affected parties of a recall or market withdrawal.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.27(124E) Supply and inventory.

154.27(1) Reliable and ongoing supply. A manufacturer shall provide a reliable and ongoing supply of medical cannabidiol to medical cannabidiol dispensaries.

154.27(2) *Inventory controls and procedures.* A manufacturer shall establish inventory controls and procedures for conducting inventory reviews to prevent and detect any diversion, theft, or loss in a timely manner.

154.27(3) *Real-time inventory required.* A manufacturer shall use the department-approved secure sales and inventory tracking system to track medical cannabidiol production from seed or plant cutting through distribution of medical cannabidiol to a dispensary. The manufacturer shall use the system to maintain a real-time record of the manufacturer's inventory of plant material and medical cannabidiol to include:

- a. The quantity and form of medical cannabidiol maintained by the manufacturer at the manufacturing facility on a daily basis;
- b. The amount of plants being grown at the manufacturing facility on a daily basis;
- c. The names of the employees or employee conducting the inventory; and
- d. Other information deemed necessary and requested by the department.

154.27(4) *Waste inventory.* A manufacturer shall maintain a record of its inventory of all medical cannabidiol waste and plant material waste for disposal.

154.27(5) *Reconciliation.* No less often than every two calendar weeks, a manufacturer shall reconcile its physical inventory with the inventory recorded in the department's secure sales and inventory tracking system.

- a. Reconciliation shall include:
 - (1) Plant material at the manufacturing facility and in transit; and
 - (2) Medical cannabidiol at the manufacturing facility, at distribution and storage facilities, and in transit.

b. Discrepancies between the physical inventory of the manufacturer and the inventory recorded in the department's secure sales and inventory system shall be handled as follows:

- (1) A manufacturer shall report suspected diversion of plant material or medical cannabidiol to the department and law enforcement within 72 hours of discovery.
- (2) A manufacturer shall have up to 72 hours to reconcile discrepancies in the manufacturer's physical inventory with the inventory recorded in the secure sales and inventory tracking system. If the manufacturer cannot reconcile the manufacturer's physical inventory with the secure sales and inventory tracking system's inventory within 72 hours but diversion of plant material or medical cannabidiol is not suspected, the manufacturer shall immediately contact the department to report the discrepancy and to initiate a compliance action plan pursuant to paragraph 154.28(4) "b."

154.27(6) *Scales.* All scales used to weigh usable plant material for purposes of these rules shall be certified in accordance with ISO/IEC Standard 17025, which is incorporated herein by reference.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.28(124E) *Inspection by department or independent consultant.* A manufacturer is subject to reasonable inspection by the department, a department-approved consultant, or other agency pursuant to Iowa Code chapter 124E and these rules and as authorized by laws and regulations.

154.28(1) *Types of inspections.* Inspections may include:

- a. Aspects of the business operations;
- b. The manufacturing facility;
- c. Vehicles used for transport or delivery of medical cannabidiol or plant material;
- d. Financial information and inventory documentation;
- e. Physical and electronic security alarm systems; and
- f. Other inspections as determined by the department.

154.28(2) *Local safety inspections.* A manufacturer may be subject to inspection of its manufacturing facility and grounds by the local fire department, building inspector, or code enforcement officer to confirm that no health or safety concerns are present. The inspection could result in additional specific standards to meet local licensing authority restrictions related to medical cannabidiol manufacturing or other local businesses. An annual fire safety inspection may result in the required installation of fire suppression devices, or other means necessary for adequate fire safety.

154.28(3) Health and sanitary inspection. The department has discretion to determine when an inspection by an independent consultant is necessary. The following is a nonexhaustive list of examples that may justify an independent inspection:

a. The department has reasonable grounds to believe that the manufacturer is in violation of one or more of the requirements set forth in these rules or other applicable public health or sanitary laws, rules or regulations; or

b. The department has reasonable grounds to believe that the manufacturer was the cause or source of contamination of medical cannabidiol.

154.28(4) Compliance required. A manufacturer shall respond to deficiencies found during inspections or inventory reconciliation as follows:

a. Deficiencies not related to inventory reconciliation.

(1) Upon written notification by the department of deficiencies that do not involve reconciliation of inventory, a manufacturer shall have up to 30 days to submit an action plan to the department with proposed remedies and timelines for completion of the remedies.

(2) The department shall have up to two weeks to accept or require revision of the action plan.

b. Deficiencies related to inventory reconciliation.

(1) Upon notifying the department that the manufacturer cannot reconcile the manufacturer's physical inventory with the inventory recorded in the department's secure sales and inventory tracking system, the manufacturer shall have up to two business days to submit an action plan to the department with proposed remedies and timelines for completion of the remedies.

(2) The department shall have up to two business days to accept or require revision of the action plan.

c. Failure to complete actions in the action plan within the timelines mutually agreed upon by the manufacturer and the department shall result in assessment of penalties or in suspension or revocation of a manufacturer license as authorized by these rules.

d. At the department's request and in a timely manner, a manufacturer shall pay for and undergo an independent health and sanitary inspection in accordance with this rule.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.29(124E) Assessment of penalties. The department shall assess to a manufacturer a civil penalty of up to \$1,000 per violation of Iowa Code chapter 124E or these rules in addition to other applicable penalties.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.30(124E) Suspension or revocation of a manufacturer license.

154.30(1) The department may suspend or revoke a manufacturer license upon any of the following grounds:

a. Submission of false, inaccurate, misleading, or fraudulent information to the department in the application or inspection processes.

b. Failure to submit required reports and documents.

c. Violation of Iowa Code chapter 124E or these rules, or violation of state or local law related to operation of the licensee.

d. Conduct or practices detrimental to the safety, health, or welfare of a patient, primary caregiver, or the public.

e. Criminal, civil, or administration action taken against a license or registration in this or another state or country related to manufacturing or dispensing medical cannabidiol.

f. False, misleading, or deceptive representations to the department, another state or federal agency, or a law enforcement agency.

g. Discontinuance of operation for more than 30 days, unless the department approves an extension of such period for good cause shown.

h. Failure to maintain effective controls against diversion, theft, or loss of medical cannabidiol.

i. Failure to correct a deficiency within the time frame required by the department.

j. Failure of a manufacturer's business owner to have a satisfactory result in a background investigation or national criminal history background check conducted by the department of public safety and as determined by the department.

154.30(2) The department shall notify the licensee of the proposed action pursuant to Iowa Code sections 17A.12 and 17A.18. Notice of issuance of a suspension or revocation shall be served by restricted certified mail, return receipt requested, or by personal service.

154.30(3) A request for appeal concerning the suspension or revocation of a license shall be submitted by the aggrieved party in writing to the department by certified mail, return receipt requested, within 20 days of the receipt of the department's notice. The address is: Iowa Department of Public Health, Office of Medical Cannabidiol, Lucas State Office Building, Des Moines, Iowa 50319-0075. If such a request is made within the 20-day time period, the notice shall be deemed to be suspended. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the suspension or revocation has been or will be removed. After the hearing or upon default of the applicant or alleged violator, the administrative law judge shall affirm, modify or set aside the suspension or revocation. If no request for appeal is received within the 20-day time period, the department's notice of suspension or revocation shall become the department's final agency action.

154.30(4) Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the department of inspections and appeals. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

154.30(5) The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10.

154.30(6) When the administrative law judge makes a proposed decision and order, it shall be served by restricted certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken.

154.30(7) Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

154.30(8) Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

- a.* All pleadings, motions, and rules.
- b.* All evidence received or considered and all other submissions by recording or transcript.
- c.* A statement of all matters officially noticed.
- d.* All questions and offers of proof, objections, and rulings thereon.
- e.* All proposed findings and exceptions.
- f.* The proposed decision and order of the administrative law judge.

154.30(9) The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by restricted certified mail, return receipt requested, or by personal service.

154.30(10) It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

154.30(11) Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service. The address is: Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

154.30(12) The party who appeals a final agency action to the district court shall pay the cost of the preparation of a transcript of the contested case hearing for the district court.

154.30(13) Emergency adjudicative proceedings.

a. Necessary emergency action. To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the Constitution and other provisions of law, the department may issue a written order in compliance with Iowa Code section 17A.18A to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order.

b. Before issuing an emergency adjudicative order, the department shall consider factors including, but not limited to, the following:

(1) Whether there has been a sufficient factual investigation to ensure that the department is proceeding on the basis of reliable information;

(2) Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;

(3) Whether the licensee required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;

(4) Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and

(5) Whether the specific action contemplated by the department is necessary to avoid the immediate danger.

c. Issuance of order.

(1) An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the department's decision to take immediate action. The order is a public record.

(2) The written emergency adjudicative order shall be immediately delivered to the licensee that is required to comply with the order. The order shall be delivered by one or more of the following methods:

1. Personal delivery.

2. Certified mail, return receipt requested, to the last address on file with the department.

3. Fax. Fax may be used as the sole method of delivery if the licensee required to comply with the order has filed a written request that agency orders be sent by fax and has provided a fax number for that purpose.

(3) To the degree practicable, the department shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

(4) Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the licensee that is required to comply with the order.

(5) After the issuance of an emergency adjudicative order, the department shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

(6) Issuance of a written emergency adjudicative order shall include notification of the date on which department proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further department proceedings to a later date will be granted only in compelling circumstances upon application in writing unless the licensee that is required to comply with the order is the party requesting the continuance.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.31(124E) Closure of operations.

154.31(1) Notice. A manufacturer shall notify the department at least six months before the closure of the manufacturing facility.

154.31(2) Procedures. If a manufacturer ceases operation, the manufacturer shall work with the department to verify the remaining inventory of the manufacturer and ensure that any plant material, plant material waste, and medical cannabidiol are destroyed at a waste facility as provided in subrule 154.23(2).

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.32 to 154.39 Reserved.

DISPENSING

641—154.40(124E) Duties of the department.

154.40(1) *Interagency agreements.* The department may enter into any interagency agreements with other state agencies for technical services or other assistance related to the regulation or inspection of dispensaries.

154.40(2) *Notice to law enforcement.* The department shall notify local law enforcement agencies and the department of public safety of the locations of dispensaries. If the department has sufficient cause to believe that there is a threat to public safety, the department shall notify local law enforcement agencies and the department of public safety of any conditions that pose a threat to public safety including but not limited to:

- a. Loss or theft of medical cannabidiol;
- b. Diversion or potential diversion of medical cannabidiol;
- c. Unauthorized access to the secure sales and inventory tracking system or other patient and caregiver information system or file; or
- d. Other violations of law.

154.40(3) *Inspection of dispensaries.* The department or its agents shall conduct regular inspections of dispensaries and their facilities as described in rule 641—154.52(124E).

154.40(4) *Establishment and maintenance of a secure sales and inventory tracking system.* The department shall establish and maintain a secure, electronic system that is available 24 hours a day, seven days a week to track:

- a. Inventory of medical cannabidiol and waste material;
- b. Sales of medical cannabidiol from dispensaries to patients and primary caregivers.

154.40(5) *Licensure and licensure renewal of dispensaries.* The department shall issue a request for proposals to select and license by April 1, 2018, up to five dispensaries to dispense medical cannabidiol within the state consistent with the provisions of Iowa Code chapter 124E and these rules.

a. To be eligible for licensure, an applicant dispensary shall provide information on forms and in a manner required by the department of public safety for the completion of a background investigation. In addition, the applicant dispensary shall submit to the department of public safety necessary funds to satisfy the full reimbursement of costs associated with completing the background investigations. If the applicant dispensary is not found suitable for licensure as a result of the background investigation, a license shall not be issued by the department.

b. As a condition for licensure, an applicant dispensary shall agree to begin dispensing medical cannabidiol to patients and primary caregivers in Iowa no later than December 1, 2018.

c. The initial license to dispense medical cannabidiol shall be valid from April 1, 2018, through November 30, 2018. The license shall be renewed annually unless a dispensary relinquishes the license, there is a change in state law prohibiting the department from renewing the license, or the license is revoked pursuant to Iowa Code chapter 124E or these rules.

d. A license to dispense medical cannabidiol issued by the department pursuant to these rules is not assignable or transferable.

e. The department shall consider the following factors in determining whether to select and license a medical cannabidiol dispensary:

- (1) Geographical location of the proposed dispensary facility;
- (2) The technical expertise of an applicant dispensary's staff regarding medical cannabidiol;
- (3) The qualifications of an applicant dispensary's employees;
- (4) The long-term financial stability of an applicant dispensary;
- (5) The ability of an applicant dispensary to provide appropriate security measures on the premises of the dispensary;
- (6) An applicant dispensary's projection of and ongoing assessment of retail product costs, including any dispensing fees.

f. Pursuant to Iowa Code section 124E.8(1) “*b*,” information submitted during the application process shall be confidential until an applicant dispensary is licensed by the department unless otherwise protected from disclosure under state or federal law.

g. A licensed dispensary shall submit an application to renew its license with the department at least six months before the license expires. The application shall be submitted on a form created by the department.

h. The department shall notify a dispensary of the decision to approve or deny the dispensary’s license by August 1 of the year in which the renewal application is submitted.

154.40(6) *Collection of fees from dispensaries.* Except as provided in this rule, all fees are nonrefundable, shall be retained by the department, and shall be considered repayment receipts as defined in Iowa Code section 8.2.

a. Fees to the department.

(1) One application is required for each dispensary location.

(2) Each application for licensure as a dispensary shall include a nonrefundable application fee of \$5,000.

(3) Licensed dispensaries shall pay an annual fee to the department to cover costs associated with regulating and inspecting dispensaries and for other expenses necessary for the administration of the medical cannabidiol program. The department shall assess the fee with the notice of approval of license renewal each year on August 1, payable by the dispensary to the department no later than December 1.

b. Fees to the department of public safety.

(1) An applicant dispensary shall be responsible to reimburse the department of public safety the full cost of conducting background investigations related to an application for licensure and operation as a licensed dispensary. The department of public safety shall retain the right to bill a dispensary for additional background investigations, as needed.

(2) Each dispensary submitting an application for licensure shall, at time of application, submit to the department of public safety a deposit of \$10,000 for each business owner subject to a background investigation and a national criminal history background check. Background investigation costs shall be deducted from the funds deposited. If the background investigation fees exceed the funds deposited, the applicant shall submit additional funds as required by the department of public safety. If the background investigation fees are less than the funds deposited, the department of public safety may refund or retain the fees as mutually agreed with the dispensary.

(3) A licensed dispensary shall pay a deposit of \$200 per employee to the department of public safety for a background investigation and a national criminal history background check on any person being considered for hire as an employee of the dispensary. Background investigation costs shall be deducted from the funds deposited. If the background investigation fees exceed the funds deposited, the dispensary shall submit additional funds as required by the department of public safety. If the background investigation fees are less than the funds deposited, the department of public safety may refund or retain the fees as mutually agreed with the dispensary. The department shall retain the right to preclude a potential employee from hire based upon the results of the background investigation and national criminal history background check.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.41(124E) Dispensary operations.

154.41(1) *Operating documents.* The operating documents of a dispensary shall include all of the following:

a. Procedures for the oversight of the dispensary, including descriptions of operational and management practices regarding:

(1) The forms and quantities of medical cannabidiol products that will be stored and dispensed at the dispensary;

(2) The estimated forms and quantities of medical cannabidiol waste to be generated or collected;

(3) The disposal methods for all waste materials;

(4) Employee training methods for the dispensary employees;

- (5) Strategies for identifying and reconciling discrepancies in inventory of medical cannabidiol;
- (6) Medical cannabidiol labeling procedures;
- (7) Procedures for recall or market withdrawal of medical cannabidiol;
- (8) Plans for responding to a security breach at the dispensary facility;
- (9) A business continuity plan; and
- (10) Other information requested by the department.

b. Procedures to ensure accurate record keeping.

c. Procedures for the implementation of appropriate security measures to deter and prevent the theft of medical cannabidiol and unauthorized entrance into areas of the dispensary facility containing medical cannabidiol.

154.41(2) Prohibited activities.

a. A person or entity shall not own or operate a dispensary unless the person or entity is licensed by the department pursuant to Iowa Code chapter 124E and these rules.

b. A dispensary shall not:

- (1) Dispense medical cannabidiol in any location except in those areas approved by the department;
- (2) Sell, receive, transport, or distribute medical cannabidiol from any location except its dispensary;
- (3) Sell, receive, or distribute medical cannabidiol from any entity other than a manufacturer licensed by the department;
- (4) Sell or distribute medical cannabidiol to any person other than an approved patient or primary caregiver;
- (5) Transport or deliver medical cannabidiol to any location, unless approved by the department;
- (6) Sell medical cannabidiol that is not packaged and labeled in accordance with rules 641—154.21(124E) and 641—154.46(124E);
- (7) Repackage medical cannabidiol or remove the manufacturer's label;
- (8) Sell medical cannabidiol in any form or quantity other than a form or quantity approved by the department and adopted by rule;
- (9) Permit any person to consume medical cannabidiol on the property of the dispensary;
- (10) Employ a person who is under 18 years of age or who has been convicted of a disqualifying felony offense.

154.41(3) Criminal background checks.

a. An owner of a dispensary shall not have been convicted of a disqualifying felony offense and shall be subject to a background investigation conducted by the department of public safety, including but not limited to a national criminal history background check.

b. An employee of a dispensary shall not have been convicted of a disqualifying felony offense and shall be subject to a background investigation conducted by the department of public safety, including but not limited to a national criminal history background check.

154.41(4) Relationship to health care practitioners. A dispensary shall not share office space with, refer patients to, or have any financial relationship with a health care practitioner.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.42(124E) Security requirements. The department may request assistance from the department of public safety in ensuring dispensaries meet the security requirements in this rule.

154.42(1) Restricted access. A dispensary shall have a controlled access system to limit entrance to all restricted access areas of the dispensary facility. Visitors to restricted access areas shall sign manifests with name, date, and times of entry and exit, if the controlled access system cannot electronically record visitors. Visitors shall wear badges that are visible at all times and identify them as visitors.

a. The controlled access system shall do all of the following:

- (1) Limit access to authorized individuals;
- (2) Maintain a log of individuals with approved access, including dates of approvals and revocations;
- (3) Track times of personnel entry to and exit from restricted access areas;

- (4) Store data for retrieval for a minimum of one year; and
- (5) Limit access to authorized individuals in the event of a power failure.

b. A dispensary shall promptly, but no later than five business days after receipt of request, submit stored controlled access system data to the department.

c. Separate written manifests of visitors to restricted access areas shall be kept and stored for a minimum of one year if the controlled access system does not include electronic records of visitors to the restricted access areas.

d. Restricted access areas shall be identified with signs that state: "Do Not Enter – Restricted Access Area – Access Limited to Authorized Personnel Only."

154.42(2) Perimeter intrusion detection system.

a. *Computer-controlled video surveillance system.* A dispensary shall operate and maintain in good working order a computer-controlled, closed-circuit television surveillance system on its premises that operates 24 hours per day, seven days a week, and visually records:

- (1) All areas that might contain medical cannabidiol, including all safes, vaults, and storage areas;
- (2) All points of entry and exit;
- (3) The entrance to the video surveillance control room; and
- (4) Parking areas, which shall have appropriate lighting for the normal conditions of the area under surveillance.

b. *Camera specifications.* Cameras shall:

(1) Capture clear and certain identification of any person entering or exiting a dispensary or its parking areas to the extent identification is technologically feasible with generally accepted commercial security cameras;

(2) Have the ability to produce a clear, color still photograph live or from a recording;

(3) Have on all recordings an embedded date-and-time stamp that is synchronized to the recording and does not obscure the picture; and

(4) Continue to operate during a power outage.

c. *Video recording specifications.*

(1) A video recording shall export still images in an industry standard image format, such as .jpg, .bmp, or .gif.

(2) Exported video shall be archived in a format that ensures authentication and guarantees that the recorded image has not been altered.

(3) Exported video shall also be saved in an industry standard file format that can be played on a standard computer operating system.

(4) All recordings shall be erased or destroyed at the end of the retention period and prior to disposal of any storage medium.

d. *Additional requirements.* A dispensary shall maintain all security system equipment and recordings in a secure location to prevent theft, loss, destruction, corruption, and alterations.

e. *Retention.* A dispensary shall ensure that recordings from all video cameras are:

(1) Available for viewing by the department upon request;

(2) Retained for at least 60 days;

(3) Maintained free of alteration or corruption; and

(4) Retained longer, as needed, if a dispensary is given actual notice of a pending criminal, civil, or administrative investigation, or other legal proceeding for which the recording may contain relevant information.

f. *Required signage.* A dispensary shall post a sign in capital letters in a conspicuous location at every entrance to the dispensary that reads, "THESE PREMISES ARE UNDER CONSTANT VIDEO SURVEILLANCE."

154.42(3) Security alarm system requirements.

a. A dispensary shall install and maintain a professionally monitored security alarm system that provides intrusion and fire detection of all:

(1) Dispensary entrances and exits;

(2) Rooms with exterior windows;

- (3) Rooms with exterior walls;
- (4) Roof hatches;
- (5) Skylights; and
- (6) Storage rooms.

b. For the purposes of this subrule, a security alarm system means a device or series of devices that summons law enforcement personnel during, or as a result of, an alarm condition. Devices may include:

(1) Hardwired systems and systems interconnected with a radio frequency method such as cellular or private radio signals that emit or transmit a remote or local audio, visual, or electronic signal;

- (2) Motion detectors;
- (3) Pressure switches;
- (4) A duress alarm;
- (5) A panic alarm;
- (6) A holdup alarm;
- (7) An automatic voice dialer; and

(8) A failure notification system that provides an audio, text, or visual notification of any failure in the surveillance system.

c. A dispensary's security alarm system and all devices shall continue to operate during a power outage.

d. A dispensary's security alarm system shall be inspected and all devices tested annually by a qualified alarm vendor. A dispensary shall provide documentation of the annual inspection and device testing to the department upon request.

154.42(4) *Personnel identification system.* A dispensary shall use a personnel identification system that controls and monitors individual employee access to restricted access areas within the dispensary and that meets the requirements of this subrule and subrule 154.42(1).

a. Requirement for employee identification card. An employee identification card shall contain:

- (1) The name of the employee;
- (2) The date of issuance and expiration;
- (3) An alphanumeric identification number that is unique to the employee; and
- (4) A photographic image of the employee.

b. A dispensary's employees shall keep the identification card visible at all times when the employee is in a dispensary or a vehicle transporting medical cannabidiol.

c. Upon termination or resignation of an employee, a dispensary shall immediately:

- (1) Revoke the employee's access to restricted access areas of the dispensary; and
- (2) Obtain and destroy the employee's identification card, if possible.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.43(124E) *Location.* All dispensing of medical cannabidiol shall take place in an enclosed facility at one physical address provided to the department during the licensure process.

154.43(1) *Proximity to manufacturers.* A dispensary shall not operate at the same physical location as a manufacturer.

154.43(2) *Proximity to schools.* A dispensary shall not operate in any location within 1,000 feet of a public or private school existing before the date of the dispensary's licensure by the department.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.44(124E) *Advertising and marketing.*

154.44(1) *Permitted marketing and advertising activities.*

a. A dispensary may:

(1) Display the dispensary's business name and logo on medical cannabidiol labels, signs, website, and informational material provided to patients. The name or logo shall not include:

1. Images of cannabis or cannabis-use paraphernalia;
2. Colloquial references to cannabis;
3. Names of cannabis plant strains or varieties;
4. Unsubstantiated medical claims; or

5. Medical symbols that bear a reasonable resemblance to established medical associations. Examples of established medical organizations include the American Medical Association or American Academy of Pediatrics. The use of medical symbols is subject to approval by the department.

- (2) Display signs on the dispensary; and
- (3) Maintain a business website that contains the following information:
 - 1. The dispensary's name and contact information;
 - 2. The medical cannabidiol forms and quantities provided;
 - 3. Medical cannabidiol pricing;
 - 4. Hours of operation; and
 - 5. Other information as approved by the department.

b. The business website shall not include any false, misleading, or unsubstantiated statements.

c. The department reserves the right to review a dispensary's marketing and advertising materials and to require a dispensary to make changes to the content. The department has 30 calendar days following submission to approve or deny marketing and advertising materials of a dispensary.

154.44(2) *Other marketing and advertising activities.* A dispensary shall request and receive the department's written approval before beginning marketing or advertising activities that are not specified in subrule 154.44(1). The department has 30 calendar days to approve, deny, or request additional information regarding marketing and advertising activity requests from a dispensary. In the event the department fails to respond to a dispensary within 30 days with an approval, denial, or request for additional information, the dispensary's marketing and advertising activity requests shall be deemed approved.

154.44(3) *Inconspicuous display.* A dispensary shall arrange displays of medical cannabidiol, interior signs, and other exhibits to reasonably prevent public viewing from outside the dispensary.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.45(124E) Storage.

154.45(1) *Storage of saleable medical cannabidiol.*

a. A dispensary shall store medical cannabidiol to prevent diversion, theft, or loss, including ensuring that:

- (1) Medical cannabidiol is kept in a secure and monitored location within the dispensary; and
- (2) Cabinets or storage containers inside the secure and monitored area are locked at the end of a business day.

b. A dispensary shall store all medical cannabidiol:

- (1) In areas that are maintained in a clean, orderly, and well-ventilated condition;
- (2) In areas that are free from infestation by insects, rodents, birds, and other pests of any kind;
- (3) According to the manufacturer's requirements regarding temperature, light exposure, or other environmental conditions;
- (4) Under conditions that will protect the product and its container against physical, chemical, and microbial contamination and deterioration.

154.45(2) *Storage of returned medical cannabidiol.* A dispensary shall maintain a separate secure storage area for medical cannabidiol that is to be returned to a manufacturer for disposal, including medical cannabidiol that is outdated, damaged, deteriorated, mislabeled, or contaminated, or whose containers or packaging has been opened or breached, until the medical cannabidiol is collected by a manufacturer. For purposes of this subrule, a separate secure storage area includes a container, closet, or room that can be locked or secured.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.46(124E) Dispensing.

154.46(1) *Access to all forms of product.* A dispensary shall provide access to all medical cannabidiol forms produced by each licensed manufacturer.

154.46(2) *Dispensing to a patient.*

a. Prior to dispensing any medical cannabidiol to a patient, a dispensary shall do all of the following:

- (1) Verify the patient's identity;
- (2) Verify that the patient is registered and listed in the secure sales and inventory tracking system and has a valid medical registration card;
- (3) Assign a tracking number to any medical cannabidiol that is to be dispensed to the patient;
- (4) Issue a label that contains the following information:
 1. The medical cannabidiol tracking number;
 2. The date and time the medication is being dispensed;
 3. The name and address of the dispensary;
 4. The patient's registry identification number, name, and date of birth;
 5. The patient's address; and
 6. Any specific instructions for use based upon manufacturer or departmental guidelines. Labeling text shall not include any false, misleading, or unsubstantiated statements regarding health or physical benefits to the patient.

b. The dispensary shall record the patient name, the amount dispensed, the price, the medical cannabidiol tracking number, the time and date, and other information required by the department in the secure sales and inventory tracking system within one business day.

154.46(3) *Dispensing to a primary caregiver.*

a. Prior to dispensing any medical cannabidiol to a primary caregiver, a dispensary shall do all of the following:

- (1) Verify the primary caregiver's identity;
- (2) Verify that the patient and the primary caregiver are registered and listed in the secure sales and inventory tracking system and have valid medical registration cards;
- (3) Assign a medical cannabidiol tracking number to any medical cannabidiol that is to be dispensed to the primary caregiver;
- (4) Issue a label that contains the following information:
 1. The medical cannabidiol tracking number;
 2. The date and time the medication is being dispensed;
 3. The name and address of the dispensary;
 4. The patient's registry identification number, name, and date of birth;
 5. The primary caregiver's registry identification number, name, and date of birth;
 6. The patient's address; and
 7. Any specific instructions for use based upon manufacturer or departmental guidelines. Labeling text shall not include any false, misleading, or unsubstantiated statements regarding health or physical benefits to the patient.

b. The dispensary shall record the names of the patient and primary caregiver, the amount dispensed, the price, the medical cannabidiol tracking number, the time and date, and other information required by the department in the secure sales and inventory tracking system within one business day.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.47(124E) Transportation of medical cannabidiol. A dispensary is not authorized to transport medical cannabidiol, unless approved by the department. Any approved transport shall be logged in the secure sales and inventory tracking system.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.48(124E) Disposal of medical cannabidiol.

154.48(1) *Identification of excess, expired, or damaged medical cannabidiol.*

a. Dispensaries shall identify unused, excess, expired, or damaged medical cannabidiol for return to manufacturers.

b. Unused, excess, expired, or damaged medical cannabidiol shall be stored as described in subrule 154.45(2).

154.48(2) *Return of medical cannabidiol from a patient or primary caregiver to a dispensary.*

a. A dispensary shall accept at no charge unused, expired, or unwanted medical cannabidiol from any patient or primary caregiver.

b. The dispensary shall enter the following information into the secure sales and inventory tracking system for all medical cannabidiol returned from a patient or primary caregiver:

(1) The tracking number assigned at the time of the dispensing, if available, or the name of the patient, if the tracking number is unavailable, when the medical cannabidiol was returned to the dispensary from a patient or primary caregiver;

(2) The date the medical cannabidiol was returned;

(3) The quantity of medical cannabidiol returned; and

(4) The type and lot number of medical cannabidiol returned.

c. A dispensary shall store medical cannabidiol returned from patients and primary caregivers as described in subrule 154.45(2).

154.48(3) *Return of medical cannabidiol to a manufacturer.*

a. A manufacturer shall collect and dispose of medical cannabidiol from dispensaries as provided in rule 641—154.23(124E).

b. A dispensary shall record information on all medical cannabidiol collected by the manufacturer in the secure sales and inventory tracking system. Information shall include:

(1) The date the medical cannabidiol was collected by the manufacturer;

(2) The quantity of medical cannabidiol collected; and

(3) The type and lot number of medical cannabidiol collected.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.49(124E) Record-keeping requirements.

154.49(1) *Sales.* A dispensary shall maintain complete and accurate electronic sales transaction records in the department's secure sales and inventory tracking system, including:

a. The name of the patient and, if purchase is made by the primary caregiver, the name of the primary caregiver;

b. The date of each sale;

c. The item number, product name and description, and quantity of medical cannabidiol sold;

d. The sale price;

e. Other information required by the department.

154.49(2) *Financial transactions.* A dispensary shall maintain records that reflect all financial transactions and the financial condition of the business. The following records shall be maintained for at least five years and made available for review, upon request of the department:

a. Purchase invoices, bills of lading, sales records, copies of bills of sale, and any supporting documents, to include the items or services purchased, from whom the items were purchased, and the date of purchase;

b. Bank statements and canceled checks for all business accounts;

c. Accounting and tax records;

d. Records of all financial transactions, including contracts and agreements for services performed or services received.

154.49(3) *Other records.*

a. A dispensary shall maintain the following for at least five years, unless otherwise noted, and provide to the department upon request:

(1) All personnel records; and

(2) Records of any theft, loss, or other unaccountability of any medical cannabidiol.

b. A dispensary shall maintain for at least one year and provide to the department upon request its controlled access system data and visitor manifests.

c. A dispensary shall use the department's secure sales and inventory tracking system to maintain the following:

(1) Inventory records;

(2) Return of medical cannabidiol from a patient or primary caregiver; and

(3) Return of unused, excess, expired, or damaged medical cannabidiol to a manufacturer.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.50(124E) Quality assurance and control. A dispensary shall cooperate with manufacturers and the department on quality assurance and control procedures, including participating in stability-testing studies, developing sampling strategies, and returning medical cannabidiol that has been recalled or withdrawn from the market.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.51(124E) Inventory.

154.51(1) Inventory controls and procedures. A dispensary shall establish inventory controls and procedures for conducting inventory reviews to prevent and detect any diversion, theft, or loss in a timely manner.

154.51(2) Real-time inventory required. A dispensary shall use the department-approved secure sales and inventory tracking system to maintain a real-time record of the dispensary's inventory of medical cannabidiol to include:

- a. The quantity and form of saleable medical cannabidiol maintained at the dispensary on a daily basis;
- b. The amount of damaged, expired, or returned medical cannabidiol being held at the dispensary for return to a manufacturer; and
- c. Other information deemed necessary and requested by the department.

154.51(3) Reconciliation. At least once a calendar week, a dispensary shall reconcile all medical cannabidiol at the dispensary with the inventory recorded in the department's secure sales and inventory tracking system. Discrepancies shall be handled as follows:

- a. A dispensary shall report suspected diversion of medical cannabidiol to the department and law enforcement within 24 hours of discovery.
- b. A dispensary shall have up to 24 hours to reconcile the dispensary's physical inventory with the inventory recorded in the secure sales and inventory tracking system. If the dispensary cannot reconcile the dispensary's physical inventory with the secure sales and inventory tracking system's inventory within 24 hours but diversion of product is not suspected, the dispensary shall immediately contact the department to report the discrepancy and to initiate a compliance action plan pursuant to paragraph 154.52(4) "b."

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.52(124E) Inspection by department or independent consultant. A dispensary is subject to reasonable inspection by the department, a department-approved consultant, or other agency as authorized by Iowa Code chapter 124E and these rules or state or local laws and regulations.

154.52(1) Types of inspections. Inspections may include:

- a. Aspects of the business operations;
- b. The physical location of a dispensary, including any storage facilities;
- c. Financial information and inventory documentation;
- d. Physical and electronic security alarm systems; and
- e. Other aspects or areas as determined by the department.

154.52(2) Local safety inspections. A dispensary may be subject to inspection of its dispensary by the local fire department, building inspector, or code enforcement officer to confirm that no health or safety concerns are present. The inspection could result in additional specific standards to meet local licensing authority restrictions related to medical cannabidiol dispensing or other local businesses. An annual fire safety inspection may result in the required installation of fire suppression devices, or other means necessary for adequate fire safety.

154.52(3) Health and sanitary inspection. The department has discretion to determine when an inspection by an independent consultant is necessary. The following is a nonexhaustive list of examples that may justify an independent inspection:

- a. The department has reasonable grounds to believe that the dispensary is in violation of one or more of the requirements set forth in these rules or other applicable public health or sanitary laws, rules or regulations;

b. The department has reasonable grounds to believe that the dispensary was the cause or source of contamination of medical cannabidiol; or

c. The department has reasonable grounds to believe that the dispensary was the cause of loss of product quality or change in chemical composition due to improper storage and handling of medical cannabidiol.

154.52(4) Compliance required. A dispensary shall respond to deficiencies found during inspections or inventory reconciliation as follows:

a. Deficiencies not related to inventory reconciliation.

(1) Upon written notification by the department of deficiencies that do not involve reconciliation of inventory, a dispensary shall have up to 30 days to submit an action plan to the department with proposed remedies and timelines for completion of the remedies.

(2) The department shall have up to two weeks to accept or require revision of the action plan.

b. Deficiencies related to inventory reconciliation.

(1) Upon notifying the department that the dispensary cannot reconcile the dispensary's physical inventory with the inventory recorded in the department's secure sales and inventory tracking system, the dispensary shall have up to two business days to submit an action plan to the department with proposed remedies and timelines for completion of the remedies.

(2) The department shall have up to two business days to accept or require revision of the action plan.

c. Failure to complete actions in the action plan within the timelines mutually agreed upon by the dispensary and the department shall result in assessment of penalties or in suspension or revocation of a dispensary license as authorized by these rules.

d. At the department's request and in a timely manner, a dispensary shall pay for and undergo an independent health and sanitary inspection in accordance with this rule.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.53(124E) Assessment of penalties. The department shall assess to a dispensary a civil penalty of up to \$1,000 per violation of Iowa Code chapter 124E or these rules in addition to other applicable penalties.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.54(124E) Suspension or revocation of a dispensary license.

154.54(1) The department may suspend or revoke a dispensary license upon any of the following grounds:

a. Submission of false, inaccurate, misleading, or fraudulent information to the department in the application or inspection processes.

b. Failure to submit required reports and documents.

c. Violation of Iowa Code chapter 124E or these rules, or violation of state or local law related to operation of the licensee.

d. Conduct or practices detrimental to the safety, health, or welfare of a patient, primary caregiver, or the public.

e. Criminal, civil, or administration action taken against a license or registration in this or another state or country related to manufacturing or dispensing medical cannabidiol.

f. False, misleading, or deceptive representations to the department, another state or federal agency, or a law enforcement agency.

g. Discontinuance of operation for more than 30 days, unless the department approves an extension of such period for good cause shown.

h. Failure to maintain effective controls against diversion, theft, or loss of medical cannabidiol.

i. Failure to correct a deficiency within the time frame required by the department.

j. Failure of a dispensary's business owner to have a satisfactory result in a background investigation or national criminal history background check conducted by the department of public safety and as determined by the department.

154.54(2) The department shall notify the licensee of the proposed action pursuant to Iowa Code sections 17A.12 and 17A.18. Notice of issuance of a suspension or revocation shall be served by restricted certified mail, return receipt requested, or by personal service.

154.54(3) A request for appeal concerning the suspension or revocation of a license shall be submitted by the aggrieved party in writing to the department by certified mail, return receipt requested, within 20 days of the receipt of the department's notice. The address is: Iowa Department of Public Health, Office of Medical Cannabidiol, Lucas State Office Building, Des Moines, Iowa 50319-0075. If such a request is made within the 20-day time period, the notice shall be deemed to be suspended. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the suspension or revocation has been or will be removed. After the hearing or upon default of the applicant or alleged violator, the administrative law judge shall affirm, modify or set aside the suspension or revocation. If no request for appeal is received within the 20-day time period, the department's notice of suspension or revocation shall become the department's final agency action.

154.54(4) Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the department of inspections and appeals. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

154.54(5) The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10.

154.54(6) When the administrative law judge makes a proposed decision and order, it shall be served by restricted certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken.

154.54(7) Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

154.54(8) Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

- a. All pleadings, motions, and rules.
- b. All evidence received or considered and all other submissions by recording or transcript.
- c. A statement of all matters officially noticed.
- d. All questions and offers of proof, objections, and rulings thereon.
- e. All proposed findings and exceptions.
- f. The proposed decision and order of the administrative law judge.

154.54(9) The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by restricted certified mail, return receipt requested, or by personal service.

154.54(10) It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

154.54(11) Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service. The address is: Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

154.54(12) The party who appeals a final agency action to the district court shall pay the cost of the preparation of a transcript of the contested case hearing for the district court.

154.54(13) Emergency adjudicative proceedings.

a. Necessary emergency action. To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the Constitution and other provisions of law,

the department may issue a written order in compliance with Iowa Code section 17A.18A to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order.

b. Before issuing an emergency adjudicative order, the department shall consider factors including, but not limited to, the following:

(1) Whether there has been a sufficient factual investigation to ensure that the department is proceeding on the basis of reliable information;

(2) Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;

(3) Whether the licensee required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;

(4) Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and

(5) Whether the specific action contemplated by the department is necessary to avoid the immediate danger.

c. Issuance of order.

(1) An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the department's decision to take immediate action. The order is a public record.

(2) The written emergency adjudicative order shall be immediately delivered to the licensee that is required to comply with the order. The order shall be delivered by one or more of the following methods:

1. Personal delivery.

2. Certified mail, return receipt requested, to the last address on file with the department.

3. Fax. Fax may be used as the sole method of delivery if the licensee required to comply with the order has filed a written request that agency orders be sent by fax and has provided a fax number for that purpose.

(3) To the degree practicable, the department shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

(4) Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the licensee that is required to comply with the order.

(5) After the issuance of an emergency adjudicative order, the department shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

(6) Issuance of a written emergency adjudicative order shall include notification of the date on which department proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further department proceedings to a later date will be granted only in compelling circumstances upon application in writing unless the licensee that is required to comply with the order is the party requesting the continuance.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.55(124E) Closure of operations.

154.55(1) Notice. A dispensary shall notify the department at least six months before the closure of the dispensary.

154.55(2) Procedures. If a dispensary ceases operation, the dispensary shall work with the department to verify the remaining inventory of the dispensary and ensure that any medical cannabidiol is returned to a manufacturer.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.56 to 154.59 Reserved.

MEDICAL CANNABIDIOL BOARD

641—154.60(124E) Purpose and duties of board.

154.60(1) The purpose of the board is to administer the provisions of Iowa Code section 124E.5.

154.60(2) Responsibilities of the board include but are not limited to:

a. Accepting and reviewing petitions to add medical conditions, medical treatments, or debilitating diseases to the list of debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial under Iowa Code chapter 124E.

b. Making recommendations to the board of medicine relating to the removal or addition of debilitating medical conditions to the list of allowable debilitating medical conditions for which the medical use of cannabidiol under Iowa Code chapter 124E would be medically beneficial.

c. Working with the department regarding the requirements for the licensure of manufacturers and dispensaries, including licensure procedures.

d. Advising the department regarding the location of manufacturers and dispensaries throughout the state.

e. Making recommendations to the board of medicine relating to the form and quantity of allowable medical uses of cannabidiol.

f. Considering recommendations to the general assembly for statutory revisions to the definition of medical cannabidiol to increase the tetrahydrocannabinol (THC) level to more than 3 percent.

g. Submitting an annual report to the general assembly detailing the activities of the board no later than January 1.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.61(124E) Organization of board and proceedings.

154.61(1) *Membership.* The board shall be composed of nine members appointed by the governor pursuant to Iowa Code section 124E.5. The appointments, unless provided otherwise by law, shall be for three-year staggered terms which shall expire on June 30. Board members shall be knowledgeable about the use of medical cannabidiol. The medical practitioners appointed to the board shall be licensed in Iowa and be nationally board-certified in their area of specialty.

154.61(2) *Vacancies.* Vacancies shall be filled in the same manner in which the original appointments were made for the balance of the unexpired term.

154.61(3) *Absences.* Three consecutive unexcused absences shall be grounds for the governor to consider dismissal of a board member and to appoint another. Department staff is charged with providing notification of absences to the governor's office.

154.61(4) *Board meetings.*

a. The board shall convene at least twice but no more than four times a year.

b. Board meetings shall be conducted in accordance with the open meetings requirements of Iowa Code chapter 21.

c. The department's office of medical cannabidiol shall schedule the time, date and location of meetings.

d. A majority of the members shall constitute a quorum for conducting business of the board.

e. An affirmative vote of a majority of the board members present at a meeting is required for a motion to pass.

154.61(5) *Facilities and staffing.* The department shall furnish the board with the necessary facilities and employees to perform the duties required by this chapter but shall be reimbursed for all costs incurred by fee revenue generated from licensing activities and registration card applications.

154.61(6) *Subcommittees.* The board may designate one or more subcommittees to perform such duties as may be deemed necessary.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.62(124E) Official communications. All official communications, including submissions, petitions and requests, may be addressed to the Medical Cannabidiol Board, Office of Medical Cannabidiol, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0075. [ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.63(124E) Office hours. The board office is open for public business from 8 a.m. to 4:30 p.m., Monday to Friday of each week, except holidays. [ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.64(124E) Public meetings. Members of the public may be present during board meetings unless the board votes to hold a closed session. Dates and location of board meetings may be obtained through the Iowa department of public health’s website (idph.iowa.gov/mcarcp) or directly from the board office.

154.64(1) Exclusion of participants. The person presiding at a meeting of the board may exclude a person from an open meeting for behavior that obstructs the meeting.

154.64(2) Recording of meetings. Cameras and recording devices may be used at open meetings, provided the cameras or recording devices do not obstruct the meeting. If the user of a camera or recording device obstructs the meeting by the use of such device, the presiding department staff member at the meeting may request the user to discontinue use of the camera or device. [ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.65(124E) Petitions for the addition or removal of medical conditions, medical treatments or debilitating diseases. Petitions for the addition or removal of medical conditions, medical treatments, or debilitating conditions for which the medical use of cannabidiol would be medically beneficial under Iowa Code chapter 124E may be submitted to the board pursuant to this rule.

154.65(1) Petition form. Any person or entity may file a petition to add or remove medical conditions, medical treatments or debilitating diseases with the board. A petition is deemed filed when it is received by the medical cannabidiol office. The board must provide the petitioner with a file-stamped copy of the petition if the petitioner provides the board an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BEFORE THE MEDICAL CANNABIDIOL BOARD	
Petition by (Name of Petitioner) for the (addition or removal) of (medical conditions, medical treatments or debilitating diseases) to the list of debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial.	}
PETITION FOR (ADDITION or REMOVAL)	

The petition must provide the following information:

- a. A statement of the specific medical condition, medical treatment or debilitating disease the petitioner is seeking to add to or remove from the list of debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial.
- b. A brief summary of the petitioner’s arguments in support of the action urged in the petition.
- c. A brief summary of any data or scientific evidence supporting the action urged in the petition.
- d. A list of reference material supporting the petition.
- e. A list of subject matter experts who are willing to testify in support of the petition. The list of subject matter experts must contain names, credentials (if applicable), email addresses, telephone numbers, and mailing addresses.
- f. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the proposed action which is the subject of the petition.

154.65(2) Signature and address. The petition must be dated and signed by the petitioner or the petitioner’s representative. It must also include the name, mailing address, telephone number and email

address of the petitioner and petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.

154.65(3) Denial for format. The board may deny a petition because it does not substantially conform to the required form.

154.65(4) Briefs. The petitioner may attach a brief to the petition in support of the action urged in the petition. The board may request a brief from the petitioner or from any other person or entity concerning the substance of the petition.

154.65(5) Inquiries. Inquiries concerning the status of a petition may be made to the Office of Medical Cannabidiol, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

154.65(6) Additional information. The board may request the petitioner to submit additional information concerning the petition. The board may also solicit comments from any person on the substance of the petition. Comments on the substance of the petition may be submitted to the board by any person.

154.65(7) Presentation to the board. The board may request or allow the petitioner to make an oral presentation of the contents of a petition at a board meeting following submission of the petition.

154.65(8) Board response. Within six months after the filing of the petition, or within any longer period agreed to by the petitioner, the board must, in writing, either deny the petition and notify the petitioner of the board's action and the reasons therefore, or grant the petition and notify the petitioner that the board has recommended addition or removal of the medical condition, medical treatment, or debilitating disease to the board of medicine. A petitioner shall be deemed notified of the denial or recommendation on the date when the board mails the required notification to the petitioner.

154.65(9) Denials. Denial of a petition because it does not substantially conform to the required form does not preclude the filing of a new petition on the same subject that seeks to eliminate the grounds for the agency's rejection of the petition.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.66 to 154.68 Reserved.

LABORATORY TESTING

641—154.69(124E) Requirements of the department.

154.69(1) Laboratory testing requirements and acceptance criteria. The department shall work with manufacturers and laboratories to create and maintain a document describing required sampling methodology, acceptance criteria, stability-testing procedures, and other guidance for manufacturers and laboratories on testing procedures. The document shall:

a. Describe the minimum number of sample units and reserve samples required for testing by the laboratory;

b. Describe an option for manufacturers to reduce the amount of testing conducted by allowing compositing of sample units or other techniques that reduce the number of tests required without compromising the safety of the products once a manufacturer has satisfactorily completed a control study for a specific extraction or production process;

c. Describe the minimum requirements for sample size and testing intervals for stability testing;

d. Be available on the department's website (www.idph.iowa.gov).

154.69(2) Review and approval of manufacturer sampling protocols. The department shall have up to two weeks to review and approve or request revisions to a manufacturer's sampling protocols required pursuant to subrules 154.26(2) and 154.26(3).

154.69(3) Review and approval of manufacturer stability-testing procedures. The department shall have up to two weeks to review and approve or request revisions to a manufacturer's stability-testing procedures required pursuant to subrule 154.26(4).

[ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.70(124E) Requirements of a laboratory.

154.70(1) *Minimum testing requirements.* A laboratory shall establish and implement test methods and corresponding standard operating procedures for the analyses of cannabinoids, residual solvents and processing chemicals, pesticides, microbiological impurities, and metals.

154.70(2) *Additional tests upon request.* A laboratory shall establish and implement test methods and corresponding standard operating procedures for other analyses as requested by the department.

154.70(3) *Level of quantitation.* A laboratory shall be able to demonstrate that its LOQ is below any action level established by the department.

154.70(4) *Inventory tracking.*

a. A laboratory shall use the department's secure sales and inventory tracking system, if available, or a manifest system to record the receipt of medical cannabis goods from a manufacturer for testing.

b. A laboratory shall use the department's secure sales and inventory tracking system, if available, or a manifest system to record the return of medical cannabis goods or waste to a manufacturer.

154.70(5) *Hazardous waste disposal.*

a. A laboratory shall discard hazardous waste, including hazardous waste containing medical cannabis goods, in accordance with federal and state hazardous waste laws.

b. A laboratory shall document the waste disposal procedures followed for each sample.

[ARC 3836C, IAB 6/6/18, effective 7/11/18]

641—154.71(124E) Requirements of a manufacturer.

154.71(1) *Assuming costs.* A manufacturer shall assume the costs for all laboratory testing requested by the department or laboratory for medical cannabis goods produced by the manufacturer.

154.71(2) *Sample waste retrieval.* A manufacturer shall retrieve analyzed samples and waste containing medical cannabis goods from the laboratory at a duration and frequency approved by the department.

154.71(3) *Obtaining approval for sampling protocols.* A manufacturer shall obtain approval from the department for the manufacturer's sampling protocols pursuant to subrule 154.26(2) prior to submitting samples for laboratory testing related to content and contamination.

154.71(4) *Obtaining approval for stability-testing procedures.* A manufacturer shall obtain approval from the department for the manufacturer's stability-testing procedures pursuant to subrule 154.26(4) prior to submitting samples for laboratory testing related to stability testing and product-expiration-date studies.

[ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.72(124E) Content testing.

154.72(1) *Cannabinoids.*

a. For each unique lot of medical cannabidiol, and if asked to do so by a requester for other medical cannabis goods, a laboratory shall, at minimum, test for and report measurements for the following cannabinoid analytes:

- (1) THC;
- (2) THCA;
- (3) CBD;
- (4) CBDA;
- (5) CBG; and
- (6) CBN.

b. A laboratory shall report that the primary sample passed THC potency testing if the detected concentration of THC does not exceed 3 percent by weight in milligrams per milliliter (mg/ml) for liquids and milligrams per gram (mg/g) for solids and if the detected concentration of THC does not vary from the manufacturer's labeled concentration by more than 15 percent by weight in mg/ml for liquids and mg/g for solids. Thus, a solid product labeled as containing a concentration of THC of 10 mg/g shall have a detected concentration of THC that is no more than 11.50 mg/g and no less than 8.50 mg/g.

c. A laboratory shall report that the primary sample failed THC potency testing if the detected concentration of THC exceeds 3 percent by weight in mg/ml for liquids and mg/g for solids or if the

detected concentration of THC varies from the labeled concentration of THC by more than 15 percent by weight in mg/ml for liquids and mg/g for solids.

d. A laboratory shall report that the primary sample passed CBD potency testing if the detected concentration of CBD does not vary from the manufacturer's labeled concentration by more than 15 percent by weight in mg/ml for liquids and mg/g for solids. Thus, a solid product labeled as containing a concentration of CBD of 10 mg/g shall have a detected concentration of CBD that is no more than 11.50 mg/g and no less than 8.50 mg/g.

e. A laboratory shall report that the primary sample failed potency testing if the detected concentration of CBD varies from the labeled concentration of CBD by more than 15 percent by weight in mg/ml for liquids and mg/g for solids.

f. For each cannabinoid analyte test, a laboratory shall issue a certificate of analysis that contains the following:

(1) Concentrations of cannabinoid analytes in mg/ml for liquids and mg/g for solids, or other measures approved by the department.

(2) Whether the primary sample passed or failed the test in accordance with paragraphs 154.72(1)“*b*” and 154.72(1)“*c*.”

g. The laboratory may test for and provide test results for additional cannabinoid analytes if asked to do so by a requester.

154.72(2) Contaminants—residual solvents and processing chemicals.

a. For each unique lot of medical cannabidiol, and if asked to do so by a requester for other medical cannabis goods, a laboratory shall analyze primary samples for residual solvents and processing chemicals.

b. The department shall provide a list of residual solvents and processing chemicals for which primary samples are to be tested with corresponding action levels on the department's website (www.idph.iowa.gov).

c. For each residual solvent or processing chemical for which a primary sample is tested, a laboratory shall report that the primary sample passed the testing if the concentration of residual solvent or processing chemical is at or below the action level approved by the department.

d. For each residual solvent or processing chemical for which a laboratory tests, the laboratory shall report that the primary sample failed the testing if the concentration of residual solvent or processing chemical is above the action level approved by the department.

e. If a laboratory is using mass spectrometry instrumentation to analyze primary samples for residual solvents and processing chemicals and the laboratory determines that a primary sample contains residual solvent or processing chemical analytes that are not included in the department-approved list of required tests, the laboratory shall attempt to achieve tentative identification and semiquantitative results of the residual solvent or processing chemical analytes.

f. The laboratory may test for and provide test results for additional residual solvents or processing chemicals if asked to do so by a requester.

g. For each primary sample tested, a laboratory shall issue a certificate of analysis that contains the following:

(1) The name and concentration of each residual solvent or processing chemical for which the primary sample was tested.

1. The concentrations shall be listed in parts per million (ppm) or other units as determined by the department.

2. The laboratory shall report a result of “detected but not quantified” for any target residual solvent or processing chemical that falls below the LOQ, has a signal-to-noise ratio of greater than 3:1, and meets identification criteria.

(2) Whether the primary sample passed or failed the test in accordance with paragraphs 154.72(2)“*c*” and 154.72(2)“*d*.”

(3) The names and amounts of any additional residual solvents and processing chemicals identified by the laboratory.

h. If the primary sample fails testing for residual solvents and processing chemicals, the lot fails laboratory testing.

i. When a laboratory identifies additional residual solvents and processing chemicals in a primary sample, the laboratory shall:

(1) Notify the department of the additional residual solvents and processing chemicals and the amounts detected.

(2) Refrain from issuing a final certificate of analysis to a manufacturer until given approval to do so by the department.

154.72(3) Contaminants—pesticides.

a. For each unique lot of medical cannabidiol, and if asked to do so by a requester for other medical cannabis goods, the laboratory shall analyze primary samples for pesticides.

b. The department shall provide a list of pesticides for which primary samples are to be tested with corresponding action levels on the department's website (www.idph.iowa.gov).

c. For each pesticide for which a laboratory tests, the laboratory shall report that the primary sample passed the testing if the concentration of pesticide is at or below the action level approved by the department.

d. For each pesticide for which a laboratory tests, the laboratory shall report that the primary sample failed the testing if the concentration of pesticide is above the action level approved by the department.

e. If a laboratory is using mass spectrometry instrumentation to analyze primary samples for pesticides and the laboratory determines that a primary sample contains pesticide analytes that are not included in the department-approved list of required tests, the laboratory shall attempt to achieve tentative identification and semiquantitative results of the pesticide analytes.

f. The laboratory may test for and provide test results for additional pesticides if asked to do so by a requester.

g. For each primary sample tested, a laboratory shall issue a certificate of analysis that contains the following:

(1) The name and concentration of each pesticide for which the primary sample was tested.

1. The concentrations shall be listed in parts per million (ppm) or other units as determined by the department.

2. The laboratory shall report a result of "detected but not quantified" for any pesticide that falls below the LOQ, has a signal-to-noise ratio of greater than 3:1, and meets identification criteria.

(2) Whether the primary sample passed or failed the test in accordance with paragraphs 154.72(3)"c" and 154.72(3)"d."

(3) The names and amounts of any additional pesticides identified by the laboratory.

h. If the primary sample fails testing for pesticides, the lot fails laboratory testing.

i. When a laboratory identifies additional pesticides in a primary sample, the laboratory shall:

(1) Notify the department of the additional pesticides and the amounts detected.

(2) Refrain from issuing a final certificate of analysis to a manufacturer until given approval to do so by the department.

154.72(4) Contaminants—metals.

a. For each unique lot of medical cannabidiol, and if asked to do so by a requester for other medical cannabis goods, the laboratory shall analyze primary samples for metals.

b. The department shall provide a list of metals for which primary samples are to be tested with corresponding action levels on the department's website (www.idph.iowa.gov).

c. For each metal for which a laboratory tests, the laboratory shall report that the primary sample passed the testing if the concentration of metal is at or below the action level approved by the department.

d. For each metal for which a laboratory tests, the laboratory shall report that the primary sample failed the testing if the concentration of metal is above the action level approved by the department.

e. If a laboratory is using mass spectrometry instrumentation to analyze primary samples for metals and the laboratory determines that a primary sample contains metal analytes that are not included

in the department-approved list of required tests, the laboratory shall attempt to achieve tentative identification and semiquantitative results of the metal analytes.

f. The laboratory may test for and provide test results for additional metals if asked to do so by a requester.

g. For each primary sample tested, a laboratory shall issue a certificate of analysis that contains the following:

(1) The name and concentration of each metal for which the primary sample was tested.

1. The concentrations shall be listed in micrograms per gram or other units as determined by the department.

2. The laboratory shall report a result of “detected but not quantified” for any metal that falls below the LOQ, has a signal-to-noise ratio of greater than 3:1, and meets identification criteria.

(2) Whether the primary sample passed or failed the test in accordance with paragraphs 154.72(4) “*c*” and 154.72(4) “*d*.”

(3) The names and amounts of any additional metals identified by the laboratory.

h. If the primary sample fails testing for metals, the lot fails laboratory testing.

i. When a laboratory identifies additional metals in a primary sample, the laboratory shall:

(1) Notify the department of the additional metals and the amounts detected.

(2) Refrain from issuing a final certificate of analysis to a manufacturer until given approval to do so by the department.

154.72(5) Contaminants—microbiological impurities.

a. For each unique lot of medical cannabidiol, and if asked to do so by a requester for other medical cannabis goods, the laboratory shall analyze primary samples for microbiological impurities.

b. The department shall provide a list of microbiological impurities for which primary samples are to be tested on the department’s website (www.idph.iowa.gov).

c. For each microbiological impurity for which a laboratory tests, the laboratory shall report that the primary sample passed the testing if the microbiological impurity is not detected in 1 gram of matrix or as approved by the department. A primary sample may be reported as passed if a screening procedure yields a negative result or if a presumptively positive result is not found to be positive on the confirmatory procedure.

d. For each microbiological impurity for which a laboratory tests, the laboratory shall report that the primary sample failed the testing if the microbiological impurity is detected in 1 gram of matrix or as approved by the department. Confirmatory procedures shall be conducted on all presumptively positive results.

e. If a laboratory is using methods to test primary samples for microbiological impurities and the laboratory determines that a primary sample contains microbiological impurities that are not included in the department-approved list of required tests, the laboratory shall attempt to achieve tentative identification of the biological impurity.

f. The laboratory may test for and provide test results for additional microbiological impurities if asked to do so by a requester.

g. For each primary sample tested, a laboratory shall issue a certificate of analysis that contains the following:

(1) The name of each microbiological impurity for which the primary sample was tested.

(2) Whether the primary sample passed or failed the test in accordance with paragraphs 154.72(5) “*c*” and 154.72(5) “*d*.”

(3) The names of any additional microbiological impurities identified by the laboratory.

h. If the primary sample fails testing for microbiological impurities, the lot fails laboratory testing.

i. When a laboratory identifies additional microbiological impurities in a primary sample, the laboratory shall:

(1) Notify the department of the additional microbiological impurities detected.

(2) Refrain from issuing a final certificate of analysis to a manufacturer until given approval to do so by the department.

154.72(6) Additional tests. The laboratory may perform additional tests if asked to do so by a requester.

[ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.73(124E) Reporting requirements.

154.73(1) Reporting test results. The laboratory shall generate a certificate of analysis for each primary sample that it tests and make the certificate of analysis available to the manufacturer who ordered the tests and the department through the department's secure sales and inventory tracking system, if available, or another laboratory information management system.

154.73(2) Tentatively identified analytes. A laboratory shall report on the certificate of analysis any tentatively identified analytes detected during the analysis of the primary sample. When a laboratory identifies additional analytes in a primary sample, the laboratory shall:

- a. Notify the department of the additional analytes detected.
- b. Refrain from issuing a final certificate of analysis to a manufacturer until given approval to do so by the department.

154.73(3) Additional reporting requirements.

a. In addition to the requirements described in rule 641—154.72(124E), the certificate of analysis shall contain, at a minimum, the following information:

- (1) All requirements of Standard ISO/IEC 17025;
- (2) Date of primary sample collection;
- (3) Date the primary sample was received by the laboratory;
- (4) Date of each analysis;
- (5) The LOQ and action level for each analyte, as applicable;
- (6) Whether the primary sample and lot passed or failed laboratory testing; and
- (7) A signature by the laboratory quality officer and the date the certificate of analysis was validated as being accurate by the laboratory quality officer.

b. Any test result that is not covered under the laboratory's ISO/IEC 17025 scope of accreditation shall be clearly identified on the certificate of analysis.

c. Measurements below a method's limit of detection shall be reported as "<" (less than) or "not detected" and reference the reportable limit. The reporting of zero concentration is not permitted.

d. Measurements \geq LOD but $<$ LOQ shall be reported as "detected but not quantified."

e. The number of significant figures reported shall reflect the precision of the analysis.

[ARC 3836C, IAB 6/6/18, effective 7/11/18]

641—154.74(124E) Record-keeping requirements.

154.74(1) Data package. A laboratory shall create a data package for each analytical batch of primary samples that the laboratory analyzes. The data package shall contain at minimum the following information:

- a. The name and address of the laboratory that performed the analytical procedures;
- b. The names, functions, and signatures (electronic or handwritten) of the laboratory personnel that performed the primary sample preparation, analyzed the primary samples, and reviewed and approved the data;
- c. All primary sample and analytical batch quality control sample results;
- d. Raw data for each primary sample analyzed;
- e. Instrument raw data, if any was produced;
- f. Instrument test method with parameters;
- g. Instrument tune report, if one was created;
- h. All instrument standard calibration data;
- i. Test-method worksheets or forms used for primary sample identification, characterization, and calculations, including chromatograms, sample-preparation worksheets, and final datasheets;

j. The quality control report with worksheets, forms, or copies of laboratory notebook pages containing pertinent information related to the identification and traceability of all reagents, reference materials, and standards used for analysis;

k. The analytical batch sample sequence;

l. The field sample log; and

m. The chain-of-custody form.

154.74(2) Review of data package. After the laboratory has compiled a data package, another individual at the laboratory shall independently review the data package. The reviewer shall:

a. Assess the analytical results for technical correctness and completeness;

b. Verify that the results of each analysis carried out by the laboratory are reported accurately, clearly, unambiguously, and objectively;

c. Verify that the measurements can be traced back; and

d. Approve the measurement results by signing and dating the data package prior to release of the certificate of analysis by the laboratory.

154.74(3) Data package record retention. The entire data package shall be stored by a laboratory for a minimum of five years and shall be made available upon request by the department or the requester of the laboratory testing.

154.74(4) Other records. A laboratory shall maintain all documents, forms, records, and standard operating procedures associated with the testing of medical cannabis goods.

a. A laboratory shall maintain analytical testing laboratory records in such a manner that the analyst, the date the analysis was performed, the approver of the certificate of analysis, the reviewer and approver of the data package, the test method, and the materials that were used can be determined by the department.

b. Records shall be stored in such a way that the data may be readily retrieved when requested by the department.

c. All testing laboratory records shall be kept for a minimum of five years, unless otherwise noted in these rules.

d. The department shall be allowed access to all electronic data, including standards records, calibration records, extraction logs, and laboratory notebooks.

e. A laboratory shall keep and make available to the department the following records related to the testing of medical cannabis goods:

(1) Personnel qualification, training, and competency documentation, including but not limited to résumés, training records, continuing education records, analytical proficiency testing records, and demonstration of competency records for laboratory work. These records shall be kept current.

(2) Method verification and validation records, including method modification records, method detection limit and quantitation limit determination records, ongoing verification records such as proficiency test records and reference material analysis records.

(3) Quality control and quality assurance records, including the laboratory's quality assurance manual and control charts with control limits.

(4) Chain-of-custody records, including chain-of-custody forms, field sample logs, sample-receipt records, sample-description records, sample-rejection records, laboratory information management system records, sample-storage records, sample-retention records, and disposal records.

(5) Purchasing and supply records, equipment-services records, and other equipment records, including purchase requisition records, packing slips, supplier records, and certificates of analysis.

(6) Laboratory equipment installation records, maintenance records, and calibration records. These records shall include the date and name of the person performing the installation of, calibration of, or maintenance on the equipment, with a description of the work performed, maintenance logs, pipette calibration records, balance calibration records, working and reference mass calibration records, and daily verification-of-calibration records.

(7) Customer service records, including customer contracts, customer requests, certificates of analysis, customer transactions, customer feedback, records related to the handling of complaints and nonconformities, and corrective action pertaining to complaints.

(8) Nonconforming work and corrective action records, including corrective action, nonconformance, nonconformities resolved by correction, customer notification of nonconformities, internal investigations, implementation of corrective action, and resumption-of-work records.

(9) Internal-audit and external-audit records, including audit checklists, standard operating procedures, and audit observation and findings reports. These records shall include the date and name of the person performing the audit.

(10) Management review records, including technical data review reports and final management-review reports. These records shall include the review date and the name of the reviewer.

(11) Laboratory data reports, data review, and data approval records, including instrument and equipment identification records, records with unique sample identifiers, analysts' laboratory notebooks and logbooks, traceability records, test-method worksheets and forms, instrumentation-calibration data, and test-method raw data. These records shall include the analysis date and the name of the analyst.

(12) Proficiency testing records, including the proficiency test schedule, proficiency tests, data-review records, data-reporting records, nonconforming work and corrective actions, and quality control and quality assurance records related to proficiency testing.

(13) Electronic data, backed-up data, records regarding the protection of data, including unprocessed instrument output data files and processed quantitation output files, electronic data protocols and records, and authorized personnel records.

(14) Security data, including laboratory-security records and laboratory-access records, surveillance-equipment records, and security-equipment records. These records shall be stored for at least one year.

(15) Traceability, raw data, standards records, calibration records, extraction logs, reference materials records, analysts' laboratory notebooks and logbooks, supplier records, and certificates of analysis, and all other data-related records.

(16) Laboratory contamination and cleaning records, including autoclave records, acid-wash logs and records, and general laboratory-safety and chemical-hygiene protocols.

[ARC 3836C, IAB 6/6/18, effective 7/11/18]

641—154.75(124E) Quality control. The laboratory shall have quality control protocols that include the following elements:

154.75(1) *Quality control samples required.*

a. The laboratory shall run quality control samples with every analytical batch of samples for chemical and microbiological analysis.

b. For microbiological analysis, the laboratory shall develop procedures for quality control requirements for each analytical batch of samples.

c. The laboratory shall analyze the quality control samples in exactly the same manner as the test samples to validate the laboratory testing results.

154.75(2) *Types of quality control samples.* At a minimum, a laboratory shall have the following quality control samples as part of every analytical batch tested for chemical analytes:

a. Negative control (method blank). A laboratory shall prepare and run at least one method blank sample with an analytical batch of 10 to 20 samples along with and under the same conditions, including all sample preparation steps, as the other samples in the analytical batch, to demonstrate that the analytical process did not introduce contamination.

b. Positive control (laboratory control sample). A laboratory shall prepare and run at least one laboratory control sample with an analytical batch of 10 to 20 samples along with and under the same conditions, including all sample preparation steps, as the other samples in the analytical batch.

c. Matrix spike sample. A laboratory shall prepare and run one or more matrix spike samples for each analytical batch.

(1) A laboratory shall calculate the percent recovery for quantitative chemical analysis by dividing the sample result by the expected result and multiplying that by 100. All quality control measures shall be assessed and evaluated on an ongoing basis, and quality control acceptance criteria shall be

used. When necessary, the department may establish acceptance criteria on the department's website (www.idph.iowa.gov).

(2) If quality control acceptance criteria are not acceptable, a laboratory shall investigate the cause, correct the problem, and rerun the analytical batch of samples. If the problem persists, the laboratory shall reprepare the samples and run the analysis again, if possible.

d. Field duplicate sample. A laboratory shall prepare and run a duplicate sample with every 10 to 20 samples for each analytical method. The acceptance criterion between the primary sample and the duplicate sample is less than 20 percent relative percentage difference.

154.75(3) *Certified reference material for chemical analysis.* The laboratory shall use a reference material for each analytical batch in accordance with the following standards:

a. The reference material should be certified and obtained from an outside source, if possible. If a reference material is not available from an outside source, the laboratory shall make its own in-house reference material.

b. Reference material made in-house should be made from a different source of standards than the source from which the calibration standards are made.

c. The test result for the reference material shall fall within the quality control acceptance criteria. If it does not, the laboratory shall document and correct the problem and run the analytical batch again.

154.75(4) *Calibration standards.* The laboratory shall prepare calibration standards by serially diluting a standard solution to produce working standards used for calibration of an instrument and quantitation of analyses in samples.

154.75(5) *Quality control-sample report.* A laboratory shall generate a quality control-sample report that includes quality control parameters and measurements, analysis date, and type of matrix.

154.75(6) *Limit-of-detection and limit-of-quantitation calculations.* For chemical method analysis, a laboratory shall calculate the limit of detection and limit of quantitation using generally accepted methodology.

[ARC 3836C, IAB 6/6/18, effective 7/11/18]

641—154.76(124E) Security requirements. The department may request assistance from the department of public safety in ensuring a laboratory meets the security requirements in this rule.

154.76(1) *Security policy requirement.* A laboratory shall maintain a security policy to prevent the loss, theft, or diversion of medical cannabis goods and samples. The security policy shall apply to all staff and visitors at a laboratory facility.

154.76(2) *Visitor logs.* Visitors to a laboratory facility shall sign visitor manifests with name, date, and times of entry and exit, and shall wear badges that are visible at all times and that identify them as visitors.

154.76(3) *Restricted access.* A laboratory shall use a controlled access system and written manifests to limit entrance to all restricted access areas of its laboratory facility and shall retain a record of all persons who entered the restricted access areas.

a. The controlled access system shall do all of the following:

(1) Limit access to authorized individuals;

(2) Maintain a log of individuals with approved access, including dates of approvals and revocations;

(3) Track times of personnel entry;

(4) Track times of personnel movement between restricted access areas;

(5) Store data for retrieval for a minimum of one year; and

(6) Remain operable in the event of a power failure.

b. Separate written manifests of visitors to restricted areas shall be kept and stored for a minimum of one year if the controlled access system does not include electronic records of visitors to the restricted areas.

c. A laboratory shall promptly, but no later than five business days after receipt of request, submit stored controlled access system data to the department.

154.76(4) *Personnel identification system.* A laboratory shall use a personnel identification system that controls and monitors individual employee access to restricted access areas within the laboratory facility and that meets the requirements of this subrule and subrule 154.76(2).

a. Requirement for employee identification card. An employee identification card shall contain:

- (1) The name of the employee;
- (2) The date of issuance;
- (3) An alphanumeric identification number that is unique to the employee; and
- (4) A photographic image of the employee.

b. A laboratory employee shall keep the identification card visible at all times when the employee is in the laboratory.

c. Upon termination or resignation of an employee, a laboratory shall immediately:

- (1) Revoke the employee's access to the laboratory; and
- (2) Obtain and destroy the employee's identification card, if possible.

154.76(5) *Video monitoring and surveillance.*

a. Video surveillance system. A laboratory shall operate and maintain in good working order a video surveillance system for its premises that operates 24 hours per day, seven days a week, and visually records all areas where medical cannabis goods are stored or tested.

b. Camera specifications. Cameras shall:

- (1) Capture clear and certain identification of any person entering or exiting a restricted access area containing medical cannabis goods;
- (2) Have the ability to produce a clear, color still photograph live or from a recording;
- (3) Have on all recordings an embedded date-and-time stamp that is synchronized to the recording and does not obscure the picture; and
- (4) Continue to operate during a power outage.

c. Video recording specifications.

(1) A video recording shall export still images in an industry standard image format, such as .jpg, .bmp, or .gif.

(2) Exported video shall be archived in a format that ensures authentication and guarantees that the recorded image has not been altered.

(3) Exported video shall also be saved in an industry standard file format that can be played on a standard computer operating system.

(4) All recordings shall be erased or destroyed at the end of the retention period and prior to disposal of any storage medium.

d. Additional requirements. A laboratory shall maintain all security system equipment and recordings in a secure location to prevent theft, loss, destruction, corruption, and alterations.

e. Retention. A laboratory shall ensure that 24-hour recordings from all video cameras are:

- (1) Available for viewing by the department upon request;
- (2) Retained for a minimum of 60 days;
- (3) Maintained free of alteration or corruption; and

(4) Retained longer, as needed, if a manufacturer is given actual notice of a pending criminal, civil, or administrative investigation, or other legal proceeding for which the recording may contain relevant information.

154.76(6) *Chain-of-custody policy and procedures.* A laboratory shall maintain a current chain-of-custody policy and procedures. The policy should ensure that:

a. Chain of custody is maintained for samples which may have probable forensic evidentiary value; and

b. Annual training is available for individuals who will be involved with testing medical cannabis goods.

154.76(7) *Information technology systems security.* A laboratory shall maintain information technology systems protection by employing comprehensive security controls that include security

firewall protection, antivirus protection, network and desktop password protection, and security patch management procedures.

[ARC 3836C, IAB 6/6/18, effective 7/11/18]

These rules are intended to implement Iowa Code chapter 124E.

[Filed ARC 1640C (Notice ARC 1571C, IAB 8/6/14), IAB 10/1/14, effective 1/30/15]

[Filed Emergency ARC 3150C, IAB 7/5/17, effective 6/13/17]

[Filed ARC 3606C (Notice ARC 3420C, IAB 10/25/17), IAB 1/31/18, effective 3/7/18]

[Filed ARC 3836C (Notice ARC 3707C, IAB 3/28/18), IAB 6/6/18, effective 7/11/18]

[Filed ARC 4078C (Notice ARC 3899C, IAB 7/18/18), IAB 10/10/18, effective 11/14/18]

CHAPTER 15
CORRECTIONAL PHARMACY PRACTICE

657—15.1(155A) Purpose and scope. It is the intent of these rules to authorize the department of corrections to distribute prescription drugs to patients in correctional facilities from one or more correctional pharmacies. Each correctional pharmacy shall be responsible for the provision of pharmacy services for a specific number of correctional facilities. The correctional pharmacies may be located on the grounds of a correctional facility or may be located off site from all facilities. The correctional pharmacies shall be licensed by the board with limited-use pharmacy licenses designated as correctional pharmacy licenses. Pharmacists shall be responsible for any delegated act performed by supportive personnel under the pharmacists' supervision. The requirements of these rules for correctional pharmacy practice are in addition to the requirements of 657—Chapter 8 and other rules of the board relating to the services provided by the pharmacies.

[ARC 8670B, IAB 4/7/10, effective 5/12/10]

657—15.2(126,155A) Definitions. For purposes of this chapter, the following definitions shall apply:

“*Board*” means the Iowa board of pharmacy.

“*Department*” means the Iowa department of corrections.

“*Emergency/first dose drug supply*” means a limited inventory of drugs stored outside the correctional pharmacy and accessible to designated health care staff for the purpose of initiating emergency or first dose prescription drug orders issued during periods when the pharmacist is unavailable.

“*Medication administration record*” means the record of the administration of drugs to patients.

“*Med-pak*” means a customized patient medication package prepared for a specific patient which comprises a series of immediate containers containing prescribed solid oral dosage forms, each container being labeled with the time or the appropriate period for the patient to take its contents.

“*Prescription drug order*” means an order that is for a drug or device for a patient in custody status in a correctional facility, that is originated by a practitioner authorized to prescribe, and that meets the information requirements for a prescription drug order but is recorded, distributed, and administered as though it were a medication order.

“*Qualified individual*” means a pharmacist, a person who has successfully completed a medication administration course, or a person specifically authorized under pertinent sections of the Iowa Code to administer prescription drugs.

“*Single unit package*” means a package that contains one discrete pharmaceutical dosage form.

“*Unit dose dispensing system*” means a drug distribution system utilizing single unit, unit dose, or unit of issue packaging in a manner that helps reduce or remove traditional drug stocks from resident care areas and enables the selection and distribution of drugs to be pharmacy-based and controlled.

“*Unit dose package*” means a package that contains that particular dose of a drug ordered for the patient for one administration time. A unit dose package is not always a single unit package.

“*Unit of issue package*” means a package that provides multiple units or doses attached to each other but separated in a card or specifically designed container.

[ARC 8670B, IAB 4/7/10, effective 5/12/10]

657—15.3(155A) Responsibilities. In any correctional pharmacy, the following responsibilities, which are in addition to the responsibilities required by all applicable federal and state laws, rules and regulations and the responsibilities as described in rule 657—8.3(155A), shall be assigned as follows:

1. The pharmacist in charge or designee shall ensure that a quarterly inspection of all pharmaceuticals located at the correctional facility, including any emergency/first dose drug supply located outside the confines of the pharmacy, is completed and documented.

2. The pharmacist in charge or a pharmacist shall provide drug information to other health professionals, to other caregivers, and to patients as required or requested.

[ARC 8670B, IAB 4/7/10, effective 5/12/10; ARC 1961C, IAB 4/15/15, effective 5/20/15]

657—15.4(155A) Reference library. Each correctional pharmacy shall maintain a reference library, which is either printed or computer-accessed and which adequately meets the needs of the services provided and patients served. Examples of references include:

1. A reference including all pertinent Iowa laws, rules, and regulations that impact the pharmacy's practice.
2. A patient information reference that includes or provides patient information in compliance with rule 657—6.14(155A).
3. A reference on drug interactions.
4. A drug information reference.
5. A drug equivalency reference.
6. A reference on natural or herbal medicines.
7. The readily accessible telephone number of a poison control center that serves the area.
8. Additional references relating to specific patient populations served.

[ARC 8670B, IAB 4/7/10, effective 5/12/10; ARC 2196C, IAB 10/14/15, effective 11/18/15; ARC 4073C, IAB 10/10/18, effective 11/14/18]

657—15.5(124,155A) Security. The pharmacy shall be located in an area or areas that provide for effective control against theft of, diversion of, and unauthorized access to prescription drugs and pharmacy records. The following conditions shall be met to ensure appropriate control over drugs and chemicals in the pharmacy:

15.5(1) Locked areas. All areas occupied by the correctional pharmacy or where drugs or devices are maintained or stored shall be lockable by a key, combination, or electronic device so as to prevent access by unauthorized personnel and shall be locked when unoccupied or unattended.

15.5(2) Access when pharmacist absent. Pursuant to rule 657—8.3(155A), the pharmacy shall have policies and procedures for the security of the correctional pharmacy. Policies and procedures shall identify who will have access to the pharmacy, what areas may be accessed, and the procedures to be followed for obtaining drugs and chemicals when the pharmacist is absent from the pharmacy.

15.5(3) Pharmacist responsibility. Each pharmacist, while on duty, shall be responsible for the security of the correctional pharmacy. This responsibility includes provisions for effective control against theft of, diversion of, or unauthorized access to prescription drugs or devices, controlled substances, records for such drugs and devices, and patient records as provided in 657—Chapter 21 and rule 657—8.16(124,155A). A pharmacist shall be on site during all times that the pharmacy is open.

15.5(4) Drugs in the correctional facility. All drugs distributed from the pharmacy to areas of the correctional facility for subsequent administration to patients shall be kept in locked storage when not in use. Policies and procedures shall identify the qualified individuals who are authorized to access these drugs and the process to be followed for their removal.

[ARC 8670B, IAB 4/7/10, effective 5/12/10; ARC 1961C, IAB 4/15/15, effective 5/20/15; ARC 4073C, IAB 10/10/18, effective 11/14/18]

657—15.6 Reserved.

657—15.7(124,126,155A) Training and utilization of pharmacy technicians or pharmacy support persons. Pharmacy technician and pharmacy support person training shall be documented and maintained by the pharmacy for at least two years from the last date of employment. Policies and procedures and documentation of pharmacy technician and pharmacy support person training shall be available for inspection by the board or an agent of the board.

[ARC 8670B, IAB 4/7/10, effective 5/12/10; ARC 1961C, IAB 4/15/15, effective 5/20/15; ARC 4073C, IAB 10/10/18, effective 11/14/18]

657—15.8(124,126,155A) Drug distribution and dispensing controls. Prescription drugs shall be distributed or dispensed only from the original or a properly verified prescription drug order. There shall be no transcribing of prescription drug orders by nursing staff or clerical staff except for their own records.

15.8(1) Required information. Prescription drug orders written in patient health records shall include the following information:

- a. Patient name, identification number, and correctional facility location;
- b. Drug name, strength, dosage form, and quantity or duration;
- c. Directions for use of the drug;
- d. Date the prescription drug order is authorized;
- e. Prescriber's name, signature or electronic signature, and office address;
- f. Prescriber's DEA number for controlled substances.

15.8(2) Original maintained. The original prescription drug order and the medication administration record shall be maintained for a minimum of two years in the patient's health record.

15.8(3) Effect upon transfer of patient. Current prescription drug orders remain in effect when a patient is transferred to another correctional facility.

15.8(4) Unit dose dispensing. Drugs dispensed in a unit dose dispensing system for subsequent administration by nurses or other qualified individuals shall be packaged and labeled by pharmacy staff in compliance with the provisions of rule 657—22.1(155A). Policies and procedures shall be implemented that include, but are not limited to, the following:

- a. Return and reuse of drugs;
- b. Expiration dating;
- c. Record keeping.

15.8(5) Med-pak dispensing. Drugs may be dispensed in med-pak dispensing systems for subsequent administration by nurses or other qualified individuals. Policies and procedures shall be implemented that are in accordance with rule 657—22.5(155A) and include, but are not limited to, the following:

- a. Return and reuse of containers;
- b. Expiration dating;
- c. Record keeping.

15.8(6) Drug administration. Only a licensed health care professional authorized to administer drugs or a qualified individual shall administer to a patient prepackaged drugs from the supply distributed by the pharmacy. Documentation of administration shall be recorded in the medication administration record. The single unit, unit dose, or med-pak packaging shall remain intact to the point of administration.

15.8(7) Dispensing for patient self-administration. Drugs dispensed for self-administration by a patient shall be packaged and labeled in accordance with rule 657—6.10(126,155A).

15.8(8) Labeling of drugs under special circumstances.

a. *Insulin, ophthalmics, otic preparations, inhalers, nasal sprays, topicals, and other similarly packaged drugs.* A label shall be affixed to the immediate container showing at least the patient's name and ID number. A label that complies with 657—subrule 6.10(1) shall be affixed to the outer container.

b. *Leave and release drugs.* Labeling of prescription drugs for patients leaving the correctional facility for temporary absences in excess of 24 hours, such as court appearances, and for patients being released from custody shall comply with 657—subrule 6.10(1) before the drug is removed from the facility. The dispensing pharmacy shall be responsible for packaging and labeling leave and release drugs in compliance with this paragraph.

15.8(9) Drug product selection. Correctional pharmacies shall be exempt from the patient notification requirements of Iowa Code section 155A.32 when exercising drug product selection.

15.8(10) Emergency/first dose drug supply. An emergency/first dose drug supply of prescription drugs may be supplied to a correctional facility for use by authorized personnel pursuant to rule 657—22.7(124,155A). Only pharmacists, pharmacist-interns, and pharmacy technicians may restock, replace, or return drugs to the emergency/first dose drug supply. A drug shall be removed from the emergency/first dose drug supply only pursuant to a valid prescription drug order. The pharmacy shall be notified of the removal and administration of a drug from the emergency/first dose drug supply. The pharmacist shall perform drug use review prior to the administration of a second dose. All drugs removed from the emergency/first dose drug supply that are not administered, including any wastage,

shall be returned to the pharmacy. A written or electronic record shall be made of all removals from the emergency/first dose drug supply. The record shall include the following information:

- a. Patient's name and identification number;
- b. Prescriber;
- c. Name, strength, dosage form, and quantity of the drug removed;
- d. Signature, unique identification, or initials of the authorized person removing the drug;
- e. Date and time the drug was removed;
- f. Returns of unused drugs to the pharmacy.

[ARC 8670B, IAB 4/7/10, effective 5/12/10; ARC 4073C, IAB 10/10/18, effective 11/14/18]

657—15.9 Reserved.

657—15.10(124,126,155A) Policies and procedures. Pharmacy policies and procedures, established, implemented, and complied with pursuant to rule 657—8.3(155A), shall address, but not be limited to, the following:

1. Controlled substances;
2. Formulary or drug list;
3. Stop orders;
4. Drug sample use and distribution;
5. Drug recalls;
6. Outdated drugs;
7. Patient records;
8. Inspection of drug inventories;
9. Adverse reaction reports;
10. Leave and release drugs;
11. Emergency/first dose drug supply;
12. Drugs brought into the facility;
13. Medication administration and records;
14. Drug compounding;
15. Sterile products;
16. Access to the pharmacy in the absence of the pharmacist;
17. Transfers of drugs between facilities and correctional pharmacies;
18. Transfers of prescription drug orders between correctional pharmacies;
19. Delivery of drugs;
20. Notification when a drug or device is not available;
21. Drug destruction within the pharmacy;
22. Return of unused drugs.

[ARC 8670B, IAB 4/7/10, effective 5/12/10; ARC 1961C, IAB 4/15/15, effective 5/20/15]

These rules are intended to implement Iowa Code sections 124.301, 124.303, 124.306, 124.308, 126.10, 126.11, 155A.6A, 155A.13, 155A.27, 155A.28, 155A.31, 155A.32, and 155A.34 through 155A.36 and 2009 Iowa Code Supplement section 155A.6B.

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CHAPTER 1
ADMISSION RULES COMMON TO THE THREE STATE UNIVERSITIES
[Prior to 4/20/88, Regents, Board of[720]]

PREAMBLE

The state board of regents has adopted the following requirements governing admission of students to the three state universities.

Each university is expected to describe in its catalog the requirements and other information necessary to make the admission process operate within the framework of these requirements.

Amendments and changes in these requirements normally are proposed by the universities to the regent committee on educational relations, which examines the proposals and makes specific recommendations through the council of provosts to the state board of regents, which is empowered by law to establish the admission requirements.

The regent universities recognize that the traditional measures of academic performance do not adequately describe some students' potential for success. Therefore, the regent universities strongly encourage all interested students to apply for admission. Applicants who feel their academic record is not an accurate reflection of their potential for success are encouraged to provide supplemental information explaining their circumstances, in addition to the application, academic transcripts, and test scores.

[ARC 2051C, IAB 7/8/15, effective 8/12/15]

681—1.1(262) Admission of undergraduate students directly from high school. Students desiring admission to the University of Iowa, Iowa State University, or the University of Northern Iowa must meet the requirements in this rule and also any special requirements for the curriculum, school, or college of their choice.

1.1(1) Application. Applicants must submit a formal application for admission, together with the appropriate application fee as approved by the state board of regents pursuant to Iowa Code subsection 262.9(3) and detailed in rule 681—1.7(262), and have their secondary school provide a transcript of their academic record, including credits and grades, rank in class (when available), and certification of graduation. Applicants must also submit SAT Reasoning Test or ACT scores. Applicants whose primary language is not English must also meet the English language proficiency requirement specified by each university. Applicants may be required to submit additional information or data to support their applications.

1.1(2) Admission criteria.

a. Effective for students who seek admission in fall 2009 and thereafter through spring 2020.

(1) A primary regent admission index (RAI) will be calculated for each freshman applicant using the formula below when the high school has provided a class rank. For purposes of calculating the primary RAI, the ACT composite score has a top value of 36 (SAT scores will be converted to ACT composite equivalents), high school rank is expressed as a percentile with 99 percent as the top value, high school GPA is expressed on a four-point scale, and number of high school courses completed in the core subject areas is expressed in terms of years or fractions of years of study.

$$\text{RAI} = \frac{(2 \times \text{ACT composite score})}{36} + \frac{(1 \times \text{high school rank expressed as a percentile})}{99} + \frac{(20 \times \text{high school grade point average})}{40} + \frac{(5 \times \text{number of high school courses completed in the core subject areas})}{5}$$

(2) An alternative RAI will be calculated for each freshman applicant using the equation identified in paragraph 1.1(2)“*b*” when the high school has not provided a class rank.

b. Effective for students who seek admission in summer 2020 and thereafter. An RAI will be calculated for each freshman applicant using the equation below. For purposes of calculating the RAI, the ACT composite score has a top value of 36 (SAT scores will be converted to ACT composite equivalents),

high school GPA is expressed on a four-point scale, and number of high school courses completed in the core subject areas is expressed in terms of years or fractions of years of study.

$$\text{RAI} = \frac{3 \times \text{ACT composite score}}{\text{composite score}} + \frac{30 \times \text{high school grade point average}}{\text{grade point average}} + \frac{5 \times \text{number of high school courses completed in the core subject areas}}{\text{number of high school courses completed in the core subject areas}}$$

c. Freshman applicants from Iowa high schools who have an RAI of at least 245 and who meet the minimum requirements of the regent universities will qualify for automatic admission to any of the three regent universities. Freshman applicants who have an RAI below 245 may also be admitted to a specific regent university; however, each regent university will review these applications on an individual basis, and admission decisions will be specific to each institution.

1.1(3) Graduates of approved high schools in other states may be held to higher academic standards, but must meet at least the same requirements as graduates of Iowa high schools. The options for conditional admission or summer tryout enrollment may not necessarily be offered to these students.

1.1(4) Applicants who are graduates of nonapproved high schools will be considered for admission in a manner similar to applicants from approved high schools, but additional emphasis will be given to scores obtained on standardized examinations.

1.1(5) Applicants who are not high school graduates, but whose classes have graduated, may be considered for admission. These applicants will be required to submit all academic data to the extent that it exists and achieve scores on standardized examinations which will demonstrate that they are adequately prepared for academic study.

1.1(6) Early admission.

a. Students with superior academic records may be admitted, on an individual basis, for part-time university study while enrolled in high school or during the summers prior to high school graduation.

b. In rare situations, exceptional students may be admitted as full-time students to a regent university before completing high school. Early admission to a regent university is provided to serve persons whose academic achievement and personal and intellectual maturity clearly suggest readiness for collegiate level study. Each university will specify requirements and conditions for early admission.

This rule is intended to implement Iowa Code section 262.9(3).

[ARC 2051C, IAB 7/8/15, effective 8/12/15; ARC 4079C, IAB 10/10/18, effective 11/14/18]

681—1.2(262) Admission of undergraduate students by transfer from other colleges. Students desiring admission to the University of Iowa, Iowa State University, or the University of Northern Iowa must meet the requirements in this rule and also any special requirements for the curriculum, school, or college of their choice.

Applicants must submit a formal application for admission, together with the appropriate application fee as approved by the state board of regents pursuant to Iowa Code subsection 262.9(18) and detailed in rule 681—1.7(262), and request that each college they have attended send an official transcript of record to the admissions office. High school academic records and standardized test results may also be required. The Test of English as a Foreign Language (TOEFL) is required of foreign students whose first language is not English.

1.2(1) Transfer applicants with a minimum of 24 semester hours of graded credit from regionally accredited colleges or universities, who have achieved for all college work previously attempted the grade point required by each university for specific programs, will be admitted. Higher academic standards may be required of students who are not residents of Iowa.

Applicants who have not maintained the grade point required by each university for specific programs or who are under academic suspension from the last college attended may, after a review of their academic and test records, and at the discretion of the admissions officers:

- a.* Be admitted unconditionally,
- b.* Be admitted conditionally,
- c.* Be required to enroll for a tryout period during a preceding summer session, or
- d.* Be denied admission.

1.2(2) Admission of students with fewer than 24 semester hours of college credit will be based on high school academic and standardized test records in addition to review of the college record.

1.2(3) Transfer applicants under disciplinary suspension will not be considered for admission until information concerning the reason for the suspension has been received from the college assigning the suspension. Applicants granted admission under these circumstances will be admitted on probation.

1.2(4) Transfer applicants from colleges and universities not regionally accredited will be considered for admission on an individual basis taking into account all available academic information.

This rule is intended to implement Iowa Code section 262.9(3).

681—1.3(262) Transfer credit practices. The regent universities endorse the Joint Statement on Transfer and Award of Academic Credit approved in 1978 by the American Council on Education (ACE), the American Association of Collegiate Registrars and Admissions Officers (AACRAO), and the Council on Postsecondary Accreditation (COPA). The current issue of Transfer Credit Practices of Selected Educational Institutions, published by the American Association of Collegiate Registrars and Admissions Officers (AACRAO), and publications of the Council on Postsecondary Accreditation (COPA) are examples of references used by the universities in determining transfer credit. The acceptance and use of transfer credit is subject to limitations in accordance with the educational policies operative at each university.

1.3(1) *Students from regionally accredited colleges and universities.* Credit earned at regionally accredited colleges and universities is acceptable for transfer except that credit in courses determined by the receiving university to be of a remedial, vocational, or technical nature, or credit in courses or programs in which the institution granting the credit is not directly involved, may not be accepted, or may be accepted to a limited extent.

Of the coursework earned at a two-year college, students may apply up to one-half but no more than 65 hours of the credits required for a bachelor's degree toward that degree at a regent university. This policy becomes effective September 29, 1993.

1.3(2) *Students from colleges and universities which have candidate status.* Credit earned at colleges and universities which have become candidates for accreditation by a regional association is acceptable for transfer in a manner similar to that from regionally accredited colleges and universities if the credit is applicable to the bachelor's degree at the receiving university.

Credit earned at the junior and senior classification from an accredited two-year college which has received approval by a regional accrediting association for change to a four-year college may be accepted by a regent university.

1.3(3) *Students from colleges and universities not regionally accredited.* When students are admitted from colleges and universities not regionally accredited, they may validate portions or all of their transfer credit by satisfactory academic study in residence, or by examination. Each university will specify the amount of the transfer credit and the terms of the validation process at the time of admission.

In determining the acceptability of transfer credit from private colleges in Iowa which do not have regional accreditation, the regent committee on educational relations, upon request from the institutions, evaluates the nature and standards of the academic program, faculty, student records, library, and laboratories.

In determining the acceptability of transfer credit from colleges in states other than Iowa which are not regionally accredited, acceptance practices indicated in the current issue of Transfer Credit Practices of Selected Educational Institutions will be used as a guide. For institutions not listed in the publication, guidance is requested from the designated reporting institution of the appropriate state.

1.3(4) *Students from foreign colleges and universities.* Transfer credit from foreign educational institutions may be granted after a determination of the type of institution involved and after an evaluation of the content, level, and comparability of the study to courses and programs at the receiving university. Credit may be granted in specific courses, but is frequently assigned to general areas of study. Extensive use is made of professional journals and references which describe the education systems and programs of individual countries.

This rule is intended to implement Iowa Code section 262.9(3).

681—1.4(262) Classification of residents and nonresidents for admission, tuition, and fee purposes.**1.4(1) General.**

a. A person enrolling at one of the three state universities shall be classified as a resident or nonresident for admission, tuition, and fee purposes by the registrar or someone designated by the registrar. The decision shall be based upon information furnished by the student and other relevant information.

b. In determining resident or nonresident classification, the issue is essentially one of why the person is in the state of Iowa. If the person is in the state primarily for educational purposes, that person will be considered a nonresident. For example, it may be possible that an individual could qualify as a resident of Iowa for such purposes as voting, or holding an Iowa driver's license, and not meet the residency requirements as established by the board of regents for admission, tuition, and fee purposes.

c. The registrar, or designated person, is authorized to require written documents, affidavits, verifications, or other evidence deemed necessary to determine why a student is in Iowa. The burden of establishing that a student is in Iowa for other than educational purposes is upon the student.

A student may be required to file any or all of the following:

- (1) A statement from the student describing employment and expected sources of support;
- (2) A statement from the student's employer;
- (3) A statement from the student's parents verifying nonsupport and the fact that the student was not listed as a dependent on tax returns for the past year and will not be so listed in future years;
- (4) A statement from the student's spouse related to sources of family support, length of residence in Iowa, and reasons for being in the state of Iowa;
- (5) Supporting statements from persons who might be familiar with the family situation;
- (6) Iowa state income tax return.

d. Applications for resident classification for a given semester or session are due no later than the fifteenth class day of that semester or session. Applications received after the fifteenth class day of that semester or session will be considered for the next semester or session. Appeals of any nonresident classification decision resulting from applications for resident classifications are due no later than midterm of that semester or session. Change of classification from nonresident to resident will not be made retroactive beyond the term in which application for resident classification is made.

e. A student who gives incorrect or misleading information to evade payment of nonresident fees shall be subject to serious disciplinary action and must also pay the nonresident fees for each term previously attended.

f. Review committee. These regulations shall be administered by the registrar or someone designated by the registrar. The decision of the registrar or designated person may be appealed to a university review committee. The decision of the review committee may be appealed to the state board of regents.

1.4(2) Guidelines.

a. The following general guidelines are used in determining the resident classification of a student for admission, tuition, and fee purposes:

(1) A financially dependent student whose parents move from Iowa after the student is enrolled remains a resident provided the student maintains continuous enrollment. A financially dependent student whose parents move from Iowa during the senior year of high school will be considered a resident provided the student has not established domicile in another state.

(2) In deciding why a person is in the state of Iowa, the person's domicile will be considered. A person who comes to Iowa from another state and enrolls in any institution of postsecondary education for a full program or substantially a full program shall be presumed to have come to Iowa primarily for educational reasons rather than to establish a domicile in Iowa.

(3) A student who was a former resident of Iowa may continue to be considered a resident provided absence from the state was for a period of less than 12 months and provided domicile is reestablished. If the absence from the state is for a period exceeding 12 months, a student may be considered a resident if evidence can be presented showing that the student has long-term ties to Iowa and reestablishes an Iowa domicile.

A person or the dependent of a person whose domicile is permanently established in Iowa, who has been classified as a resident for admission, tuition, and fee purposes, may continue to be classified as a resident so long as domicile is maintained, even though circumstances may require extended absence of the person from the state. It is required that a person who claims Iowa domicile while living in another state or country will provide proof of the continual Iowa domicile as evidence that the person:

1. Has not acquired a domicile in another state,
2. Has maintained a continuous voting record in Iowa, and
3. Has filed regular Iowa resident income tax returns during absence from the state.

(4) A student who moves to Iowa may be eligible for resident classification at the next registration following 12 consecutive months in the state provided the student is not enrolled as more than a half-time student (6 credits for an undergraduate or professional student, 5 credits for a graduate student) in any academic year term, is not enrolled for more than 4 credits in a summer term for any classification, and provides sufficient evidence of the establishment of an Iowa domicile.

(5) A student who has been a continuous student and whose parents move to Iowa may become a resident at the beginning of the next term provided the student is dependent upon the parents for a majority of financial assistance.

(6) A person who has been certified as a refugee or granted asylum by the appropriate agency of the United States who enrolls as a student at a university governed by the Iowa state board of regents may be accorded immediate resident status for admission, tuition, and fee purposes when the person:

1. Comes directly to the state of Iowa from a refugee facility or port of debarkation, or
2. Comes to the state of Iowa within a reasonable time and has not established domicile in another state.

Any refugee or individual granted asylum not meeting these standards will be presumed to be a nonresident for admission, tuition, and fee purposes and thus subject to the usual method of proof of establishment of Iowa residency.

(7) An alien who has immigrant status establishes Iowa residency in the same manner as a United States citizen.

(8) At the regent institutions, American Indians who have origins in any of the original people of North America and who maintain a cultural identification through tribal affiliation or community recognition with one or more of the tribes or nations connected historically with the present state of Iowa, including the Iowa, Kickapoo, Menominee, Miami, Missouri, Ojibwa (Chippewa), Omaha, Otoe, Ottawa (Odawa), Potawatomi, Sac and Fox (Sauk, Meskwaki), Sioux, and Winnebago (Ho Chunk), will be assessed Iowa resident tuition and fees.

b. Additional guidelines are used in determining the resident classification of a veteran, qualified military person, and other qualified individuals for purposes of undergraduate, graduate, professional, or certificate tuition and mandatory fees:

(1) A person who is stationed on active duty at the Rock Island arsenal as a result of military orders, or the child or spouse/domestic partner of such person, is entitled to resident status for purposes of undergraduate, graduate, professional, or certificate tuition and mandatory fees. The child or spouse/domestic partner may be required to submit appropriate documentation to the university.

(2) The rules for classification of veterans and qualified individuals shall be in full compliance with all federal laws, including Section 702 of the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act). The qualified individual may be required to submit appropriate documentation to the university.

(3) A person who is moved into the state as the result of military or civil orders from the government for other than educational purposes, or the child or spouse/domestic partner of such a person, is entitled to resident status. The child or spouse/domestic partner may be required to submit appropriate documentation to the university. Legislation, effective July 1, 1977, requires that military personnel who claim residency in Iowa (home of record) will be required to file Iowa resident income tax returns.

1.4(3) Facts.

a. The following circumstances, although not necessarily conclusive, have probative value in support of a claim for resident classification:

(1) Reside in Iowa for 12 consecutive months, and be primarily engaged in activities other than those of a full-time student, immediately prior to the beginning of the term for which resident classification is sought.

(2) Reliance upon Iowa resources for financial support.

(3) Domicile in Iowa of persons legally responsible for the student.

(4) Former domicile in the state and maintenance of significant connections therein while absent.

(5) Acceptance of an offer of permanent employment in Iowa.

(6) Military orders, if for other than educational purposes.

(7) Other facts indicating the student's domicile will be considered by the universities in classifying the student.

b. The following circumstances, standing alone, do not constitute sufficient evidence of domicile to effect classification of a student as a resident under these regulations:

(1) Voting or registration for voting.

(2) Employment in any position normally filled by a student.

(3) The lease of living quarters.

(4) Admission to a licensed practicing profession in Iowa.

(5) Automobile registration.

(6) Public records, for example, birth and marriage records, Iowa driver's license.

(7) Continuous presence in Iowa during periods when not enrolled in school.

(8) Ownership of property in Iowa, or the payment of Iowa taxes.

This rule is intended to implement Iowa Code section 262.9(3).

[ARC 7911B, IAB 7/1/09, effective 7/1/09; ARC 1991C, IAB 5/13/15, effective 6/17/15; ARC 2332C, IAB 12/23/15, effective 12/23/15]

681—1.5(262) Registration and transcripts—general. A person may not be permitted to register for a course or courses at a state board of regents institution until any delinquent accounts owed by the person to an institution or any affiliated organization for which an institution acts as fiscal agent have been paid.

A state board of regents institution may withhold official transcripts of the academic record of a person until any delinquent accounts owed by the person to an institution or any affiliated organization for which an institution acts as fiscal agent have been paid.

This rule is intended to implement Iowa Code section 262.9.

681—1.6(262) College-bound program.

1.6(1) Definitions.

“*Accredited private institution*” means an institution of higher education as defined in Iowa Code section 261.9, subsection 5.

“*Commission*” means the college aid commission.

“*Financial need*” means the difference between the student's financial resources, including resources available from the student's parents and the student, as determined by a completed parents' financial statement and including any non-campus-administered federal or state grants and scholarships, and the student's estimated expenses while attending the institution. A student shall accept all available federal and state grants and scholarships before being considered eligible for grants under the Iowa minority academic grants for economic success program. Financial need shall be reconsidered on at least an annual basis.

“*Full-time student*” means an individual who is enrolled at an accredited private institution or board of regents university for at least 12 semester hours or the trimester or quarter equivalent.

“*Minority person*” means an individual who is black, Hispanic, Asian, or a Pacific Islander, American Indian, or an Alaskan Native American.

“*Part-time student*” means an individual who is enrolled at an accredited private institution or board of regents university in a course of study including at least three semester hours or the trimester or quarter equivalent of three semester hours.

“*Program*” means the Iowa minority academic grants for economic success program established in this division.

1.6(2) Policy on college-bound program.

a. The regent institutions will cooperate with other state and local agencies, including the department of education, the college aid commission, and educational institutions in implementing the college-bound program.

b. The universities will develop programs for elementary, middle and secondary school students and their families in the following areas:

- (1) Encouragement to consider attending a postsecondary institution;
- (2) Enrichment and academic preparation;
- (3) Information about how to apply for admission.

c. College-bound program vouchers will be awarded to students on the basis of the participation of the student and the student’s family in the college-bound program. One voucher will be awarded for participation in each college-bound program sponsored by a university.

(1) Each university will maintain records concerning those students who participate in the college-bound program, according to its established policies and procedures. The records will include information on those students who have received college-bound program vouchers which are described in Iowa Code section 262.92(2). The University of Iowa will maintain a central record on all students who have received college-bound program vouchers on behalf of all regent institutions and will make appropriate information available to the college aid commission.

(2) College-bound program vouchers may be used by students enrolled at a regent institution or at a private college or university in Iowa.

(3) A student holding vouchers and enrolling at a regent institution will receive priority in the award of funds under the Iowa minority academic grants for economic success (IMAGES) program. Awards under the IMAGES program are made on the basis of financial need. A student may be eligible for an additional award from the institution in which the student is enrolled.

(4) A student holding vouchers and enrolling at a private college or university in Iowa will receive priority in the award of funds under the Iowa minority academic grants for economic success program as provided by the rules of the college aid commission.

(5) The presidents, or their designees, will administer and coordinate the college-bound program at the universities. As part of the coordination, they will establish liaison with the appropriate state and local agencies, serve as the university contact and promote collaborative efforts among the regent universities and other appropriate agencies and institutions. Annual reports to the board of regents shall be prepared by each regent university. The reports shall contain relevant information as to the accomplishments of the program in the past year and a plan of action with goals and objectives for the forthcoming year. Reports shall be submitted to the board of regents on October 1 of each year.

This rule is intended to implement Iowa Code section 262.92.

681—1.7(262) Application fees. Application fees required for admission to the University of Iowa, Iowa State University and the University of Northern Iowa are as follows:

University of Iowa

Undergraduate domestic student and nondegree student	\$40
Undergraduate international student	\$85
Graduate/professional domestic student	\$60
Graduate/professional international student	\$100
PharmD student	\$50
Reentry fee	\$20
Iowa dental advanced standing program (international DDS student)	\$250

Iowa State University

Undergraduate domestic student and nondegree student	\$40
Undergraduate international student	\$50
Graduate/professional domestic student	\$60
Graduate/professional international student	\$100
Veterinary Medicine	\$75

University of Northern Iowa

Undergraduate domestic student and nondegree student	\$40
Undergraduate international student	\$50
Graduate/professional domestic student	\$60
Graduate/professional international student	\$75
Reentry fee	\$20

This rule is intended to implement Iowa Code section 262.9(3).

[**ARC 9034B**, IAB 8/25/10, effective 9/29/10; **ARC 9033B**, IAB 8/25/10, effective 9/29/10; **ARC 0037C**, IAB 3/7/12, effective 4/11/12; **ARC 0630C**, IAB 3/6/13, effective 4/10/13; **ARC 1895C**, IAB 3/4/15, effective 4/8/15; **ARC 2982C**, IAB 3/15/17, effective 4/19/17; **ARC 3986C**, IAB 8/29/18, effective 10/3/18]

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[Filed 3/28/90, Notice 11/1/89—published 4/18/90, effective 5/23/90]

[Filed 6/19/91, Notice 5/15/91—published 7/10/91, effective 8/14/91]

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[Filed 3/20/98, Notice 2/11/98—published 4/8/98, effective 6/1/98]

[Filed 6/2/04, Notice 3/31/04—published 6/23/04, effective 7/28/04]

- [Filed emergency 9/24/04—published 10/13/04, effective 9/24/04]
- [Filed 8/11/06, Notice 5/24/06—published 8/30/06, effective 10/4/06]
- [Filed 5/3/07, Notice 2/28/07—published 5/23/07, effective 6/27/07]
- [Filed 8/8/08, Notice 5/21/08—published 8/27/08, effective 10/1/08]
- [Filed Emergency ARC 7911B, IAB 7/1/09, effective 7/1/09]
- [Filed ARC 9034B (Notice ARC 8854B, IAB 6/16/10), IAB 8/25/10, effective 9/29/10]
- [Filed ARC 9033B (Notice ARC 8807B, IAB 6/2/10), IAB 8/25/10, effective 9/29/10]
- [Filed ARC 0037C (Notice ARC 9869B, IAB 11/30/11), IAB 3/7/12, effective 4/11/12]
- [Filed ARC 0630C (Notice ARC 0469C, IAB 11/28/12), IAB 3/6/13, effective 4/10/13]
- [Filed ARC 1895C (Notice ARC 1743C, IAB 11/26/14), IAB 3/4/15, effective 4/8/15]
- [Filed ARC 1991C (Notice ARC 1902C, IAB 3/4/15), IAB 5/13/15, effective 6/17/15]
- [Filed ARC 2051C (Notice ARC 1916C, IAB 3/18/15), IAB 7/8/15, effective 8/12/15]
- [Filed Emergency After Notice ARC 2332C (Notice ARC 2176C, IAB 9/30/15), IAB 12/23/15, effective 12/23/15]
- [Filed ARC 2982C (Notice ARC 2818C, IAB 11/23/16), IAB 3/15/17, effective 4/19/17]
- [Filed ARC 3986C (Notice ARC 3780C, IAB 5/9/18), IAB 8/29/18, effective 10/3/18]
- [Filed ARC 4079C (Notice ARC 3867C, IAB 7/4/18), IAB 10/10/18, effective 11/14/18]

CHAPTER 10
GENERAL INDUSTRY SAFETY AND HEALTH RULES

[Prior to 9/24/86, Labor, Bureau of [530]]

[Prior to 10/7/98, see 347—Ch 10]

875—10.1(88) Definitions. As used in these rules, unless the context clearly requires otherwise:

“*Part*” means 875—Chapter 10, Iowa Administrative Code.

“*Standard*” means a standard which requires conditions, or the adoption or use of one or more practices, means, methods, operations, or processes, reasonably necessary or appropriate to provide safe or healthful employment and places of employment.

875—10.2(88) Applicability of standards.

10.2(1) None of the standards in this chapter shall apply to working conditions of employees with respect to which federal agencies other than the United States Department of Labor, exercise statutory authority to prescribe or enforce standards or regulations affecting occupational safety or health.

10.2(2) If a particular standard is specifically applicable to a condition, practice, means, method, operation, or process, it shall prevail over any different general standard which might otherwise be applicable to the same condition, practice, means, method, operation, or process.

10.2(3) However, any standard shall apply according to its terms to any employment and place of employment in any industry, even though particular standards are also prescribed for the industry, as in 1910.12, 1910.261, 1910.262, 1910.263, 1910.264, 1910.265, 1910.266, 1910.267, and 1910.268 of 29 CFR 1910, to the extent that none of such particular standards applies.

10.2(4) In the event a standard protects on its face a class of persons larger than employees, the standard shall be applicable under this part only to employees and their employment and places of employment.

10.2(5) An employer who is in compliance with any standard in this part shall be deemed to be in compliance with the requirement of Iowa Code section 88.4, but only to the extent of the condition, practice, means, method, operation or process covered by the standard.

875—10.3(88) Incorporation by reference. The standards of agencies of the U.S. Government, and organizations which are not agencies of the U.S. Government which are incorporated by reference in this chapter have the same force and effect as other standards in this chapter. Only mandatory provisions (i.e., provisions containing the word “shall” or other mandatory language) of standards incorporated by reference are adopted under the Act.

875—10.4(88) Exception for hexavalent chromium exposure in metal and surface finishing job shops. Prior to December 31, 2008, for employers that comply with the requirements of this rule, the labor commissioner shall enforce respiratory protection provisions only with respect to employees who fall into one of the six categories outlined in Paragraph 4, Appendix A, 29 CFR 1910.1026, except that the phrase “Exhibit B to this Agreement” shall refer to Exhibit B, Appendix A, 29 CFR 1910.1026. This exception is limited to the narrow circumstances outlined below and shall expire on May 31, 2010.

10.4(1) Eligibility. An employer’s facility is eligible for this exception if the employer is a member of the Surface Finishing Industry Council or the facility is a surface-finishing or metal-finishing job shop that sells plating or anodizing services to other companies.

10.4(2) Participation. To be covered by this exception, eligible employers must complete and submit a Declaration of Participation via mail to the Labor Commissioner, 1000 East Grand Avenue, Des Moines, Iowa 50319, or via facsimile to (515)281-7995. Declarations of Participation must be postmarked or received on or before April 7, 2007. Each declaration shall apply only to one facility. Declaration of Participation forms are available at www.iowaworkforce.org/labor/iosh/index.html or by calling (515)242-5870.

10.4(3) Applicability. This exception applies only to surface- and metal-finishing operations within covered facilities.

10.4(4) Feasible engineering controls. Participating employers must implement feasible engineering controls necessary to reduce hexavalent chromium levels at their facilities to or below five micrograms per cubic meter of air calculated as an eight-hour, time-weighted average by December 31, 2008. In fulfilling this obligation, participating employers may select from the engineering and work practice controls listed in Exhibit A, Appendix A, 29 CFR 1910.1026, or may adopt other controls.

10.4(5) Employee training. Participating employers shall train their employees in accordance with the provisions of 29 CFR 1910.1026(l)(2). Using language the employees can understand, participating employers will also train their employees on the provisions of this exception no later than June 7, 2007.

10.4(6) Compliance and monitoring. Participating employers shall comply with the requirements set forth in Paragraphs 3 and 4, Appendix A, 29 CFR 1910.1026, except that as used in Appendix A:

- a. The acronym “OSHA” shall refer to the labor commissioner;
- b. The word “Company” shall refer to employers participating in this exception;
- c. The word “Agreement” shall refer to this rule; and
- d. The phrase “Exhibit B to this Agreement” shall refer to Exhibit B, Appendix A, 29 CFR 1910.1026.

875—10.5 and 10.6 Reserved.

875—10.7(88) Definitions and requirements for a nationally recognized testing laboratory. The federal regulations adopted at 29 CFR, Chapter XVII, Part 1910, regulation 1910.7 and Appendix A, as published at 53 Fed. Reg. 12120 (April 12, 1988) and amended at 53 Fed. Reg. 16838 (May 11, 1988), 54 Fed. Reg. 24333 (June 7, 1989) and 65 Fed. Reg. 46818 (July 31, 2000) are adopted by reference.

875—10.8 to 10.11 Reserved.

875—10.12(88) Construction work.

10.12(1) Standards. The standards prescribed in 875—Chapter 26 are adopted as occupational safety and health standards and shall apply, according to the provisions thereof, to every employment and place of employment of every employee engaged in construction work. Each employer shall protect the employment and places of employment of each employee engaged in construction work by complying with the provisions of 875—Chapter 26.

10.12(2) Definition. For the purpose of this rule, “*construction work*” means work for construction, alteration, or repair including painting and redecorating, and where applicable, the erection of new electrical transmission and distribution lines and equipment, and the alteration, conversion, and improvement of the existing transmission and distribution lines and equipment. This incorporation by reference of 875—Chapter 26 (Part 1926) is not intended to include references to interpretative rules having relevance to the application of the construction safety Act, but having no relevance to the application of Iowa Code chapter 88.

875—10.13 to 10.18 Reserved.

875—10.19(88) Special provisions for air contaminants.

10.19(1) Asbestos, tremolite, anthophyllite, and actinolite dust. Reserved.

10.19(2) Vinyl chloride. Rule 1910.1017 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to vinyl chloride in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to vinyl chloride which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(3) Acrylonitrile. Rule 1910.1045 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to acrylonitrile in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to acrylonitrile which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(4) Inorganic arsenic. Rule 1910.1018 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to inorganic arsenic in every employment

and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to inorganic arsenic which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(5) Rescinded, effective 6/10/87.

10.19(6) *Lead*. Rescinded IAB 8/5/92, effective 8/5/92.

10.19(7) *Ethylene oxide*. Rule 1910.1047 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to ethylene oxide in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to ethylene oxide which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(8) *Benzene*. Rule 1910.1028 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to benzene in every place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to benzene which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(9) *Formaldehyde*. Rule 1910.1048 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to formaldehyde in every place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to formaldehyde which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(10) *Methylene chloride*. Rule 1910.1052 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to methylene chloride in every employment and place of employment covered by 875—10.12(88) in lieu of any different standard on exposure to methylene chloride which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

875—10.20(88) Adoption by reference. The rules beginning at 1910.20 and continuing through 1910, as adopted by the United States Secretary of Labor shall be the rules for implementing Iowa Code chapter 88. This rule adopts the Federal Occupational Safety and Health Standards of 29 CFR, Chapter XVII, Part 1910 as published at 37 Fed. Reg. 22102 to 22324 (October 18, 1972) and as amended at:

37 Fed. Reg. 23719 (November 8, 1972)
37 Fed. Reg. 24749 (November 21, 1972)
38 Fed. Reg. 3599 (February 8, 1973)
38 Fed. Reg. 9079 (April 10, 1973)
38 Fed. Reg. 10932 (May 3, 1973)
38 Fed. Reg. 14373 (June 1, 1973)
38 Fed. Reg. 16223 (June 21, 1973)
38 Fed. Reg. 19030 (July 17, 1973)
38 Fed. Reg. 27048 (September 28, 1973)
38 Fed. Reg. 28035 (October 11, 1973)
38 Fed. Reg. 33397 (December 4, 1973)
39 Fed. Reg. 1437 (January 9, 1974)
39 Fed. Reg. 3760 (January 29, 1974)
39 Fed. Reg. 6110 (February 19, 1974)
39 Fed. Reg. 9958 (March 15, 1974)
39 Fed. Reg. 19468 (June 3, 1974)
39 Fed. Reg. 35896 (October 4, 1974)
39 Fed. Reg. 41846 (December 3, 1974)
39 Fed. Reg. 41848 (December 3, 1974)
40 Fed. Reg. 3982 (January 27, 1975)
40 Fed. Reg. 13439 (March 26, 1975)
40 Fed. Reg. 18446 (April 28, 1975)
40 Fed. Reg. 23072 (May 28, 1975)
40 Fed. Reg. 23743 (June 2, 1975)
40 Fed. Reg. 24522 (June 9, 1975)

40 Fed. Reg. 27369 (June 27, 1975)
40 Fed. Reg. 31598 (July 28, 1975)
41 Fed. Reg. 11504 (March 19, 1976)
41 Fed. Reg. 13352 (March 30, 1976)
41 Fed. Reg. 35184 (August 20, 1976)
41 Fed. Reg. 46784 (October 22, 1976)
41 Fed. Reg. 55703 (December 21, 1976)
42 Fed. Reg. 2956 (January 14, 1977)
42 Fed. Reg. 3304 (January 18, 1977)
42 Fed. Reg. 45544 (September 9, 1977)
42 Fed. Reg. 46540 (September 16, 1977)
42 Fed. Reg. 37668 (July 22, 1977)
43 Fed. Reg. 11527 (March 17, 1978)
43 Fed. Reg. 19624 (May 5, 1978)
43 Fed. Reg. 27394 (June 23, 1978)
43 Fed. Reg. 27434 (June 23, 1978)
43 Fed. Reg. 28472 (June 30, 1978)
43 Fed. Reg. 28473 (June 30, 1978)
43 Fed. Reg. 31330 (July 21, 1978)
43 Fed. Reg. 35032 (August 8, 1978)
43 Fed. Reg. 45809 (October 3, 1978)
43 Fed. Reg. 49744 (October 24, 1978)
43 Fed. Reg. 51759 (November 7, 1978)
43 Fed. Reg. 53007 (November 14, 1978)
43 Fed. Reg. 56893 (December 5, 1978)
43 Fed. Reg. 57602 (December 8, 1978)
44 Fed. Reg. 5447 (January 26, 1979)
44 Fed. Reg. 50338 (August 28, 1979)
44 Fed. Reg. 60981 (October 23, 1979)
44 Fed. Reg. 68827 (November 30, 1979)
45 Fed. Reg. 6713 (January 29, 1980)
45 Fed. Reg. 8594 (February 8, 1980)
45 Fed. Reg. 12417 (February 26, 1980)
45 Fed. Reg. 35277 (May 23, 1980)
45 Fed. Reg. 41634 (June 20, 1980)
45 Fed. Reg. 54333 (August 15, 1980)
45 Fed. Reg. 60703 (September 12, 1980)
46 Fed. Reg. 4056 (January 16, 1981)
46 Fed. Reg. 6288 (January 21, 1981)
46 Fed. Reg. 24557 (May 1, 1981)
46 Fed. Reg. 32022 (June 19, 1981)
46 Fed. Reg. 40185 (August 7, 1981)
46 Fed. Reg. 2632 (August 21, 1981)
46 Fed. Reg. 42632 (August 21, 1981)
46 Fed. Reg. 45333 (September 11, 1981)
46 Fed. Reg. 60775 (December 11, 1981)
47 Fed. Reg. 39161 (September 7, 1982)
47 Fed. Reg. 51117 (November 12, 1982)
47 Fed. Reg. 53365 (November 26, 1982)
48 Fed. Reg. 2768 (January 21, 1983)
48 Fed. Reg. 9641 (March 8, 1983)
48 Fed. Reg. 9776 (March 8, 1983)

48 Fed. Reg. 29687 (June 28, 1983)
49 Fed. Reg. 881 (January 6, 1984)
49 Fed. Reg. 4350 (February 3, 1984)
49 Fed. Reg. 5321 (February 10, 1984)
49 Fed. Reg. 25796 (June 22, 1984)
50 Fed. Reg. 1050 (January 9, 1985)
50 Fed. Reg. 4648 (February 1, 1985)
50 Fed. Reg. 9800 (March 12, 1985)
50 Fed. Reg. 36992 (September 11, 1985)
50 Fed. Reg. 37353 (September 13, 1985)
50 Fed. Reg. 41494 (October 11, 1985)
50 Fed. Reg. 51173 (December 13, 1985)
51 Fed. Reg. 22733 (June 20, 1986)
51 Fed. Reg. 24325 (July 3, 1986)
51 Fed. Reg. 25053 (July 10, 1986)
51 Fed. Reg. 33033 (September 18, 1986)
51 Fed. Reg. 33260 (September 19, 1986)
51 Fed. Reg. 34560 (September 29, 1986)
51 Fed. Reg. 45663 (December 19, 1986)
52 Fed. Reg. 16241 (May 4, 1987)
52 Fed. Reg. 17753 (May 12, 1987)
52 Fed. Reg. 34562 (September 11, 1987)
52 Fed. Reg. 36026 (September 25, 1987)
52 Fed. Reg. 36387 (September 28, 1987)
52 Fed. Reg. 46291 (December 4, 1987)
52 Fed. Reg. 49624 (December 31, 1987)
53 Fed. Reg. 6629 (March 2, 1988)
53 Fed. Reg. 8352 (March 14, 1988)
53 Fed. Reg. 11436 (April 6, 1988)
53 Fed. Reg. 12120 (April 12, 1988)
53 Fed. Reg. 16838 (May 11, 1988)
53 Fed. Reg. 17695 (May 18, 1988)
53 Fed. Reg. 27346 (July 20, 1988)
53 Fed. Reg. 27960 (July 26, 1988)
53 Fed. Reg. 34736 (September 8, 1988)
53 Fed. Reg. 35625 (September 14, 1988)
53 Fed. Reg. 37080 (September 23, 1988)
53 Fed. Reg. 38162 (September 29, 1988)
53 Fed. Reg. 39581 (October 7, 1988)
53 Fed. Reg. 45080 (November 8, 1988)
53 Fed. Reg. 47188 (November 22, 1988)
53 Fed. Reg. 49981 (December 13, 1988)
54 Fed. Reg. 2920 (January 19, 1989)
54 Fed. Reg. 6888 (February 15, 1989)
54 Fed. Reg. 9317 (March 6, 1989)
54 Fed. Reg. 12792 (March 28, 1989)
54 Fed. Reg. 28054 (July 5, 1989)
54 Fed. Reg. 29274 (July 11, 1989)
54 Fed. Reg. 29545 (July 13, 1989)
54 Fed. Reg. 30704 (July 21, 1989)
54 Fed. Reg. 31456 (July 28, 1989)
54 Fed. Reg. 31765 (August 1, 1989)

54 Fed. Reg. 36687 (September 1, 1989)
54 Fed. Reg. 36767 (September 5, 1989)
54 Fed. Reg. 37531 (September 11, 1989)
54 Fed. Reg. 41364 (October 6, 1989)
54 Fed. Reg. 46610 (November 6, 1989)
54 Fed. Reg. 47513 (November 15, 1989)
54 Fed. Reg. 49971 (December 4, 1989)
54 Fed. Reg. 50372 (December 6, 1989)
54 Fed. Reg. 52024 (December 20, 1989)
55 Fed. Reg. 3146 (January 30, 1990)
55 Fed. Reg. 3300 (January 31, 1990)
55 Fed. Reg. 3723 (February 5, 1990)
55 Fed. Reg. 4998 (February 13, 1990)
55 Fed. Reg. 7967 (March 6, 1990)
55 Fed. Reg. 12110 (March 30, 1990)
55 Fed. Reg. 12819 (April 6, 1990)
55 Fed. Reg. 13696 (April 11, 1990)
55 Fed. Reg. 14073 (April 13, 1990)
55 Fed. Reg. 19259 (May 9, 1990)
55 Fed. Reg. 25094 (June 10, 1990)
55 Fed. Reg. 26431 (June 28, 1990)
55 Fed. Reg. 32014 (August 6, 1990)
55 Fed. Reg. 38677 (September 20, 1990)
55 Fed. Reg. 46053 (November 1, 1990)
55 Fed. Reg. 46949 (November 8, 1990)
55 Fed. Reg. 50686 (December 10, 1990)
56 Fed. Reg. 15832 (April 18, 1991)
56 Fed. Reg. 24686 (May 31, 1991)
56 Fed. Reg. 43700 (September 4, 1991)
56 Fed. Reg. 64175 (December 6, 1991)
57 Fed. Reg. 6403 (February 24, 1992)
57 Fed. Reg. 7847 (March 4, 1992)
57 Fed. Reg. 7878 (March 5, 1992)
57 Fed. Reg. 22307 (May 27, 1992)
57 Fed. Reg. 24330 (June 8, 1992)
57 Fed. Reg. 24701 (June 10, 1992)
57 Fed. Reg. 27160 (June 18, 1992)
57 Fed. Reg. 29204 (July 1, 1992)
57 Fed. Reg. 29206 (July 1, 1992)
57 Fed. Reg. 35666 (August 10, 1992)
57 Fed. Reg. 42388 (September 14, 1992)
58 Fed. Reg. 4549 (January 14, 1993)
58 Fed. Reg. 15089 (March 19, 1993)
58 Fed. Reg. 16496 (March 29, 1993)
58 Fed. Reg. 21778 (April 23, 1993)
58 Fed. Reg. 34845 (June 29, 1993)
58 Fed. Reg. 35308 (June 30, 1993)
58 Fed. Reg. 35340 (June 30, 1993)
58 Fed. Reg. 40191 (July 27, 1993)
59 Fed. Reg. 4435 (January 31, 1994)
59 Fed. Reg. 6169 (February 9, 1994)
59 Fed. Reg. 16360 (April 6, 1994)

59 Fed. Reg. 26115 (May 19, 1994)
59 Fed. Reg. 33661 (June 30, 1994)
59 Fed. Reg. 33910 (July 1, 1994)
59 Fed. Reg. 36699 (July 19, 1994)
59 Fed. Reg. 40729 (August 9, 1994)
59 Fed. Reg. 41057 (August 10, 1994)
59 Fed. Reg. 43270 (August 22, 1994)
59 Fed. Reg. 51741 (October 12, 1994)
59 Fed. Reg. 65948 (December 22, 1994)
60 Fed. Reg. 9624 (February 21, 1995)
60 Fed. Reg. 11194 (March 1, 1995)
60 Fed. Reg. 33344 (June 28, 1995)
60 Fed. Reg. 33984 (June 29, 1995)
60 Fed. Reg. 47035 (September 8, 1995)
60 Fed. Reg. 52859 (October 11, 1995)
61 Fed. Reg. 5508 (February 13, 1996)
61 Fed. Reg. 9230 (March 7, 1996)
61 Fed. Reg. 9583 (March 8, 1996)
61 Fed. Reg. 19548 (May 2, 1996)
61 Fed. Reg. 21228 (May 9, 1996)
61 Fed. Reg. 31430 (June 20, 1996)
61 Fed. Reg. 43456 (August 23, 1996)
61 Fed. Reg. 56831 (November 4, 1996)
62 Fed. Reg. 1600 (January 10, 1997)
62 Fed. Reg. 29668 (June 2, 1997)
62 Fed. Reg. 40195 (July 25, 1997)
62 Fed. Reg. 42018 (August 4, 1997)
62 Fed. Reg. 42666 (August 8, 1997)
62 Fed. Reg. 43581 (August 14, 1997)
62 Fed. Reg. 48175 (September 15, 1997)
62 Fed. Reg. 54383 (October 20, 1997)
62 Fed. Reg. 65203 (December 11, 1997)
62 Fed. Reg. 66276 (December 18, 1997)
63 Fed. Reg. 1269 (January 8, 1998)
63 Fed. Reg. 13339 (March 19, 1998)
63 Fed. Reg. 17093 (April 8, 1998)
63 Fed. Reg. 20098 (April 23, 1998)
63 Fed. Reg. 33467 (June 18, 1998)
63 Fed. Reg. 50729 (September 22, 1998)
63 Fed. Reg. 66038 (December 1, 1998)
63 Fed. Reg. 66270 (December 1, 1998)
64 Fed. Reg. 13700 (March 22, 1999)
64 Fed. Reg. 13908 (March 23, 1999)
64 Fed. Reg. 22552 (April 27, 1999)
65 Fed. Reg. 76567 (December 7, 2000)
66 Fed. Reg. 5324 (January 18, 2001)
66 Fed. Reg. 18191 (April 6, 2001)
67 Fed. Reg. 67961 (November 7, 2002)
68 Fed. Reg. 75780 (December 31, 2003)
69 Fed. Reg. 7363 (February 17, 2004)
69 Fed. Reg. 31881 (June 8, 2004)
69 Fed. Reg. 46993 (August 4, 2004)

70 Fed. Reg. 53929 (September 13, 2005)
 70 Fed. Reg. 1140 (January 5, 2005)
 71 Fed. Reg. 10373 (February 28, 2006)
 71 Fed. Reg. 36008 (June 23, 2006)
 71 Fed. Reg. 63242 (October 30, 2006)
 72 Fed. Reg. 7190 (February 14, 2007)
 72 Fed. Reg. 64428 (November 15, 2007)
 72 Fed. Reg. 71068 (December 14, 2007)
 73 Fed. Reg. 75583 (December 12, 2008)
 68 Fed. Reg. 32638 (June 2, 2003)
 74 Fed. Reg. 46355 (September 9, 2009)
 74 Fed. Reg. 40447 (August 11, 2009)
 75 Fed. Reg. 12685 (March 17, 2010)
 76 Fed. Reg. 33606 (June 8, 2011)
 76 Fed. Reg. 75786 (December 5, 2011)
 77 Fed. Reg. 17764 (March 26, 2012)
 76 Fed. Reg. 80738 (December 27, 2011)
 77 Fed. Reg. 37598 (June 22, 2012)
 77 Fed. Reg. 46949 (August 7, 2012)
 78 Fed. Reg. 9313 (February 8, 2013)
 78 Fed. Reg. 69549 (November 20, 2013)
 79 Fed. Reg. 20629 (April 11, 2014)
 79 Fed. Reg. 56960 (September 24, 2014)
 80 Fed. Reg. 60036 (October 5, 2015)
 81 Fed. Reg. 16090 (March 25, 2016)
 81 Fed. Reg. 16861 (March 25, 2016)
 81 Fed. Reg. 82981 (November 18, 2016)
 82 Fed. Reg. 2735 (January 9, 2017)
 83 Fed. Reg. 19948 (May 7, 2018)

[**ARC 7699B**, IAB 4/8/09, effective 5/13/09; **ARC 8088B**, IAB 9/9/09, effective 10/14/09; **ARC 8395B**, IAB 12/16/09, effective 1/20/10; **ARC 8522B**, IAB 2/10/10, effective 3/17/10; **ARC 8997B**, IAB 8/11/10, effective 9/15/10; **ARC 9755B**, IAB 9/21/11, effective 10/26/11; **ARC 0173C**, IAB 6/13/12, effective 7/18/12; **ARC 0282C**, IAB 8/22/12, effective 9/26/12; **ARC 0726C**, IAB 5/1/13, effective 6/5/13; **ARC 0898C**, IAB 8/7/13, effective 9/11/13; **ARC 1509C**, IAB 6/25/14, effective 7/30/14; **ARC 1531C**, IAB 7/9/14, effective 8/13/14; **ARC 1803C**, IAB 12/24/14, effective 1/28/15; **ARC 2595C**, IAB 6/22/16, effective 7/27/16; **ARC 2959C**, IAB 3/1/17, effective 4/5/17; **ARC 3721C**, IAB 3/28/18, effective 5/11/18; **ARC 4071C**, IAB 10/10/18, effective 11/14/18]

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