State of Iowa

Iowa Administrative Code Supplement

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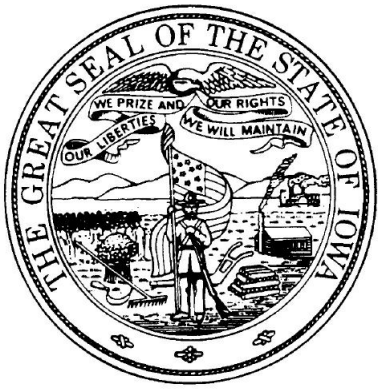

STEPHANIE A. HOFF
ADMINISTRATIVE CODE EDITOR

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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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

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Iowa Finance Authority[265]

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Replace Chapter 36
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AGING, DEPARTMENT ON[17]

Prior to 5/20/87, see Commission on the Aging[20]
Delay: Effective date (June 24, 1987) of Chapters 1 to 18 delayed 70 days pursuant to Iowa Code section 17A.4(5) by the Administrative Rules Review Committee at their June 9, 1987, meeting.
[Prior to 1/27/10, see Elder Affairs Department[321]]

CHAPTER 12
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CHAPTER 28
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CHAPTER 4
DEPARTMENT PLANNING RESPONSIBILITIES

[Prior to 5/20/87, see Aging, Commission on the[20] Chs 3 to 5]
[Prior to 1/27/10, see Elder Affairs Department[321] Ch 4]

17—4.1(231) Definitions. Words and phrases as used in this chapter are as defined in 17—Chapter 1 unless the context indicates otherwise. The following definitions also apply to this chapter:

"Days" means calendar days unless otherwise indicated. If a term refers to a date on which a document or response is due to the department and the due date occurs on a holiday or weekend, then the due date shall be the next business day.

"Entity" means any public or private nonprofit agency or organization or a unit of general purpose local government.

"Indian" means a person who is a member of an Indian tribal organization or recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

"Indian tribal organization" means the recognized governing body of any Indian tribe; or any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities.

"State plan on aging" means a document developed in accordance with the Older Americans Act that is submitted to the Administration on Aging every two, three or four years, with updates as necessary, in order to receive Older Americans Act grants.

"Unit of general purpose local government" means either (1) the government of a county, municipality, township, metropolitan area, or region within the state recognized for areawide planning that functions as a political subdivision of the state whose authority is general and not limited to only one function or combination of related functions and has a population of 100,000 or more, or (2) an Indian tribal organization.

[**ARC 9863B**, IAB 11/30/11, effective 11/1/11]

17—4.2(231) State plan on aging.

4.2(1) *Authority.* The Iowa department on aging is designated as the sole state unit on aging in Iowa for developing and administering a state plan on aging or state plan amendment pursuant to the federal Older Americans Act. The Iowa commission on aging is designated as the policymaking body of the sole state unit on aging in Iowa and is authorized to approve or disapprove a state plan or state plan amendment developed by the department.

4.2(2) *State plan on aging.* The department shall develop for commission consideration a two-, three-, or four-year state plan on aging in compliance with the Older Americans Act and Iowa Code chapter 231. The department shall develop the state plan on aging in accordance with the procedures and associated instructions, guidance, and direction specified by the Administration on Aging.

4.2(3) *State plan amendment.* The department may, in its discretion, develop and submit to the commission for consideration an amendment to the state plan on aging at any time.

4.2(4) *State plan on aging and state plan amendment review process.* Once the department develops the state plan on aging or state plan amendment, the department shall comply with the following chronological review and comment process:

a. The department shall hold at least one public hearing on the proposed state plan or state plan amendment; and

b. The department shall submit the state plan or state plan amendment to the commission for consideration. The commission shall approve or disapprove the state plan or state plan amendment after reviewing the plan and public comments; and

c. The department shall submit a state plan or state plan amendment approved by the commission to the governor for approval and signature; and

d. The department shall submit a state plan or state plan amendment approved by the governor to the Administration on Aging for approval at least 45 days before the effective date of the state plan or state plan amendment.

4.2(5) *State plan on aging or state plan amendment not approved.* If a state plan or state plan amendment is not approved by the commission, the governor, or the Administration on Aging, the department may, in its discretion, table or revise the proposed state plan or state plan amendment. If the department revises the proposed state plan or state plan amendment, the department shall follow the comment and approval process outlined in subrule 4.2(4).

4.2(6) *Technical changes to state plan on aging.* The commission or the governor may, in either party's discretion, make technical corrections to a submitted state plan or state plan amendment prior to approving it.

[**ARC 9863B**, IAB 11/30/11, effective 11/1/11]

17—4.3(231) Planning and service areas.

4.3(1) *Designation.* The Older Americans Act requires the department to develop a plan dividing the state into distinct planning and service areas and to submit the plan to the commission for consideration.

4.3(2) *Change in designation.* The department may, in its discretion, submit a plan to the commission to change existing planning and service area designations for any of the following reasons:

a. A change or reduction in the number of planning and service areas is mandated by state or federal law;

b. A change occurs in the geographical distribution of older individuals in the state;

c. A change occurs in the incidence of the need for or in the distribution of resources and services outlined in the Older Americans Act;

d. A change occurs in the distribution of older individuals who have greatest economic or social need or who are Indians residing in such areas;

e. A change occurs in the location of units of general purpose local government within the state;

f. A change occurs in the boundaries of existing areas within the state which were drawn for the planning or administration of supportive service programs; or

g. Any other relevant factors as determined by the department.

4.3(3) *Designation requirements for units of general purpose local government.* The department may, in its discretion, recommend to the commission for its consideration designation of any unit of general purpose local government as a planning and service area.

4.3(4) *Process to designate or change planning and service areas.* The department's submission to the commission of a plan to divide the state into distinct planning and service areas or change an existing plan shall be acted upon by the commission only after affected parties have been provided notice and an opportunity to be heard as required by the Older Americans Act.

a. Notice.

(1) The department shall send by certified mail, return receipt requested, a written notice of intent to designate planning and service area boundaries or change existing planning and service area boundaries by mailing said notice to all area agency on aging executive directors and board chairs. The department shall also publish a notice in at least one newspaper of statewide circulation and one newspaper circulated in each county located within the affected planning and service area(s) to provide notice to affected parties, including older individuals, individuals with disabilities, service providers, and units of general purpose local government. Notice shall also be provided by posting the notice on the department's Web site, www.aging.iowa.gov.

(2) The notice shall document the need to designate planning and service area boundaries or change existing planning and service area boundaries and provide a process for submitting written comments to the department for consideration by the commission.

b. Public hearing.

(1) The department shall hold at least one public hearing to obtain comments and provide information on the plan to designate planning and service area boundaries or change existing planning and service area boundaries within 90 days of providing notice pursuant to paragraph 4.3(4)*"a."*

(2) Information provided by the department at the public hearing shall include, but not be limited to, the proposed planning and service area boundary designations or changes, the reason(s) for the designations or changes, legal authority to designate or change planning and service area boundaries, identification of affected individuals or groups of individuals, and procedures for appealing the proposed planning and service area designations or changes.

(3) Instructions for providing written comments to the department regarding the proposed planning and service area designations or changes shall be provided at the public hearing and shall be posted on the department's Web site, www.aging.iowa.gov.

4.3(5) *Review of comments.* The department shall review all public comments received and provide a summary for the commission's review.

4.3(6) *Department submission of proposed recommendation to the commission.* The department shall submit to the commission for consideration a proposed recommendation regarding the designation of or change to planning and service areas.

4.3(7) *Commission approval or disapproval of proposed designation of or change to planning and service areas.* The commission may, in its discretion, approve or disapprove the department's proposed recommendation to divide the state into distinct planning and service areas or change existing designations. If the commission disapproves the department's proposed recommendation, the department shall develop an alternate recommendation for commission consideration after notice and an opportunity for public comment as provided in subrule 4.3(4). The commission's final decision shall be posted on the department's Web site, www.aging.iowa.gov. The commission's final decision is other agency action for the purposes of Iowa Code section 17A.19.

4.3(8) *State appeal of commission decision.* A party aggrieved or adversely affected by the commission's final decision may seek judical review in accordance with Iowa Code section 17A.19. Such party shall serve a copy of the petition for judicial review upon the Director, Department on Aging, 510 East 12th Street, Suite 2, Des Moines, Iowa 50319-9025.

4.3(9) *Federal appeal of commission's decision.* An adversely affected party may appeal, in writing, the commission's decision regarding a planning and service area designation or change to the Assistant Secretary for Aging of the Administration on Aging, Washington, DC 20201, on the basis of the facts and merits of the matter that is the subject of the action or proceeding or on procedural grounds within 30 days of the commission's final decision. Written requests shall state: (1) the decision for which an appeal is being made, and (2) the legal name(s), address(es), telephone number(s), and e-mail address(es) of the individual or entity requesting the appeal. A copy of this request shall also be mailed to the Director, Department on Aging, 510 E. 12th Street, Suite 2, Des Moines, Iowa 50319. All questions regarding the federal appeal process should be addressed to the Assistant Secretary for Aging at the address provided above.

4.3(10) *Official designation.* Official designation of or change to a planning and service area shall not occur until the final disposition of all appeals.

[**ARC 9863B**, IAB 11/30/11, effective 11/1/11]

17—4.4(231) Area agencies on aging.

4.4(1) *Designation.* The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements. The department may, in its discretion, designate one area agency on aging to serve more than one planning and service area.

4.4(2) *Designation requirements for units of general purpose local government.* Whenever the department designates a new area agency on aging after the date of enactment of the Older Americans Act Amendments of 1984 or dedesignates an existing area agency on aging, the department shall give the right of first refusal to a unit of general purpose local government if:

a. The unit of general purpose local government can meet the requirements established to serve as an area agency on aging pursuant to state and federal law; and

b. The unit of general purpose local government's geographical boundaries and the geographical boundaries of the planning and service area are reasonably contiguous.

4.4(3) *Qualifications to serve.* Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and Iowa Code chapter 231. An area agency on aging shall be any one of the following:

a. An established office of aging operating within a planning and service area;

b. Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an area agency on aging by the chief elected official of such unit;

c. Any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for such purpose;

d. Any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such agency, which for designation purposes is under the supervision or direction of the department and which can and will engage only in the planning or provision of a broad range of supportive services or nutrition services within such planning and service area; or

e. Any other entity authorized by the Older Americans Act.

4.4(4) *Process to designate area agency on aging.*

a. The department shall send by certified mail, return receipt requested, a written notice of intent to designate an area agency on aging by mailing said notice to all area agency on aging executive directors and board chairs. The department shall also publish a notice in at least one newspaper of statewide circulation and one newspaper circulated in each county located within the affected planning and service area(s) to provide notice to affected parties, including older individuals, individuals with disabilities, service providers, and units of general purpose local government. Notice shall also be provided by posting the notice on the department's Web site, www.aging.iowa.gov.

b. The notice shall provide information regarding the department's intent to designate an area agency on aging and to accept requests for applications to serve as an area agency on aging in the affected planning and service area(s). The notice shall be posted and published at least 60 days prior to the request for application submission deadline.

c. The department shall hold at least one public hearing pursuant to the following process:

(1) The department shall hold at least one public hearing to obtain comments and provide information on the plan to designate an area agency on aging within 90 days of providing notice pursuant to paragraph 4.4(4)*"a."*

(2) Information provided by the department at the public hearing shall include, but not be limited to, the proposed designation, the reasons for designation, legal authority to designate, identification of affected individuals or groups of individuals, and procedures for appeal.

(3) Instructions for providing written comments to the department regarding the proposed designation of an area agency on aging shall be provided at the public hearing and shall be posted on the department's Web site, www.aging.iowa.gov.

d. Any entity meeting the qualification requirements outlined in subrule 4.4(3) may submit an application to serve as an area agency on aging.

e. If an area agency on aging is dedesignated pursuant to rule 17—4.6(231), the department shall use a request for application process to designate a new area agency on aging for the affected planning and service area.

f. The department may, in its discretion, require applicants to submit to an on-site assessment as part of the request for application review process.

4.4(5) *Department submission of proposed recommendation for designation of area agency on aging to the commission.* Following the review of the application(s), the department shall develop and submit to the commission for consideration a proposed recommendation regarding the designation of an area agency on aging for each planning and service area.

4.4(6) *Commission approval or disapproval of proposed designation of area agency on aging.* The commission may, in its discretion, approve or disapprove the department's proposed recommendation to designate an area agency on aging. If the commission disapproves the department's proposed recommendation, the department shall develop an alternate recommendation for commission consideration after notice and an opportunity for public comment as provided in subrule 4.4(4).

The final decision shall be made available on the department's Web site, www.aging.iowa.gov. The commission's final decision is other agency action for the purposes of Iowa Code section 17A.19.

4.4(7) *State appeal of commission decision.* A party aggrieved or adversely affected by the commission's final decision may seek judical review in accordance with Iowa Code section 17A.19. Such party shall serve a copy of the petition for judicial review upon the Director, Department on Aging, 510 East 12th Street, Suite 2, Des Moines, Iowa 50319-9025.

4.4(8) *Official designation.* An entity shall be designated the area agency on aging upon the commission's acceptance of the department's proposed recommendation for designation, the commission's approval of the area agency on aging area plan, and execution of the associated contract between the department and the area agency on aging. Official designation of an area agency on aging shall not occur until final disposition of all appeals.
[**ARC 9863B**, IAB 11/30/11, effective 11/1/11]

17—4.5(231) Continuity of services in the event of appeal of designation. To ensure continuity of services in the affected planning and service area(s) while the commission's final decision regarding designation of an area agency on aging is on appeal, the existing area agency on aging shall provide services unless the department, in its discretion, elects to do any of the following individually or in combination:

1. Temporarily perform the responsibilities of the area agency on aging;
2. Assign the responsibilities of the area agency on aging to any other area agency on aging; or
3. Assign the responsibilities of the area agency on aging to another entity that is in the planning and service area and is competent to provide area agency on aging services.

The department may also submit a written request to the Administration on Aging for an extension of the continuity of services plan pursuant to this rule. The request shall document the need for an extension to provide continuity of services in the affected planning and service area(s) until a successor area agency on aging is designated after appeal.
[**ARC 9863B**, IAB 11/30/11, effective 11/1/11]

17—4.6(231) Dedesignation of area agency on aging.

4.6(1) *Dedesignation.* The department may, in its discretion, initiate action to dedesignate an area agency on aging for any of the following reasons:

a. Substantial violation of grant terms and conditions or requirements and standards set forth in federal and state law or rules promulgated by the department or other agencies having jurisdiction.

b. Inadequate performance of the responsibilities outlined in the Older Americans Act, Iowa Code chapter 231 or department rules or any other law or regulation governing administration, operation and reporting for area agencies on aging.

c. The area agency on aging has been unable or is unwilling to take timely remedial action to correct cited deficiencies within the given time frame established by the department.

d. A change or reduction in the number of area agencies on aging is mandated by state or federal law.

e. A change occurs in the designation of the planning and service area served by the area agency on aging.

4.6(2) *Process to dedesignate an area agency on aging.* The department's submission to the commission of a plan to dedesignate an existing area agency on aging shall be acted upon by the commission only after affected parties have been provided notice and an opportunity to be heard as required by the Older Americans Act.

a. Notice.

(1) Notice to existing area agency on aging. The department shall send by certified mail, return receipt requested, a written notice of intent to dedesignate an area agency on aging by mailing said notice to the affected area agency on aging's executive director and board chair. The written notice shall contain the reasons for the proposed dedesignation, the applicable state or federal law(s) or administrative rule(s), and the dedesignation process.

(2) Notice to other affected parties. The department shall provide notice of intent to dedesignate an existing area agency on aging to all other area agencies on aging by mailing notice to their executive directors and board chairs. The department shall also publish a notice in at least one newspaper of statewide circulation and one newspaper circulated in each county located within the affected planning and service area(s) to provide notice to affected parties, including older individuals, individuals with disabilities, service providers, and units of general purpose local government. Notice shall be provided through the department's Web site, www.aging.iowa.gov. The notice shall document the need to dedesignate an existing area agency on aging and provide a process for submitting written comments to the department for consideration by the commission.

b. Public hearing.

(1) The department shall hold at least one public hearing to obtain comments and provide information on the plan to dedesignate an existing area agency on aging within 90 days of providing notice pursuant to paragraph 4.6(2)*"a."*

(2) Information provided by the department at the public hearing shall include, but not be limited to, the proposed plan to dedesignate, the reasons for dedesignation, legal authority to dedesignate, identification of affected individuals or groups of individuals, and procedures for appeal.

(3) Instructions for providing written comments to the department regarding the proposed plan to dedesignate an existing area agency on aging shall be provided at the public hearing and shall be posted on the department's Web site, www.aging.iowa.gov.

4.6(3) *Review of comments.* The department shall review all public comments received and provide a summary for the commission's review.

4.6(4) *Department submission of proposed recommendation to the commission.* The department shall submit to the commission for consideration a proposed recommendation regarding the dedesignation of an existing area agency on aging.

4.6(5) *Commission approval or disapproval of proposed recommendation to dedesignate an area agency on aging.* The commission may, in its discretion, approve or disapprove the department's proposed recommendation to dedesignate an existing area agency on aging. If the commission disapproves the department's proposed recommendation, the department shall develop an alternate recommendation for commission consideration after notice and an opportunity for public comment as provided in subrule 4.6(2). The commission's final decision shall be posted on the department's Web site, www.aging.iowa.gov. The commission's final decision is other agency action for the purposes of Iowa Code section 17A.19.

4.6(6) *Department action subsequent to dedesignation.* When an area agency on aging is dedesignated pursuant to this rule, the department shall:

a. Notify the area agency on aging in writing that it has been dedesignated pursuant to this rule;

b. Provide a written explanation of the grounds for dedesignation;

c. Provide written notice of the right to appeal dedesignation and the procedure to be used for appeal;

d. Notify the Administration on Aging in writing of the dedesignation; and

e. If necessary, implement a plan for continuity of services in the affected planning and service area(s).

4.6(7) *State appeal of commission decision.* A party aggrieved or adversely affected by the commission's final decision may seek judical review in accordance with Iowa Code section 17A.19. Such party shall serve a copy of the petition for judicial review upon the Director, Department on Aging, 510 East 12th Street, Suite 2, Des Moines, Iowa 50319-9025.

4.6(8) *Federal appeal of commission decision.* An adversely affected party may appeal, in writing, the commission's decision regarding dedesignation of an existing area agency on aging to the Assistant Secretary for Aging of the Administration on Aging, Washington, DC 20201, on the basis of the facts and merits of the matter that is the subject of the action or proceeding or on procedural grounds within 30 days of the commission's final decision. Written requests shall state: (1) the decision for which an appeal is being made, and (2) the legal name(s), address(es), telephone number(s), and e-mail address(es) of the individual or entity requesting the appeal. A copy of this request shall also be mailed to the

Director, Department on Aging, 510 East 12th Street, Suite 2, Des Moines, Iowa 50319. All questions regarding the federal appeal process should be addressed to the Assistant Secretary for Aging at the address provided above.

4.6(9) *Official dedesignation.* Official dedesignation shall not occur until the final disposition of all appeals.

[**ARC 9863B**, IAB 11/30/11, effective 11/1/11]

17—4.7(231) Continuity of services in the event of dedesignation or appeal of dedesignation. To ensure continuity of services in the affected planning and service area(s) while the commission's final decision regarding dedesignation of an area agency on aging is on appeal, the department may, in its discretion, elect to do any of the following individually or in combination:

1. Temporarily perform the responsibilities of the area agency on aging;
2. Assign the responsibilities of the area agency on aging to the existing area agency on aging;
3. Assign the responsibilities of the area agency on aging to any other area agency on aging; or
4. Assign the responsibilities of the area agency on aging to another entity that is in the planning and service area and is competent to provide area agency on aging services.

The department may also submit a written request to the Administration on Aging for an extension of the continuity of services plan pursuant to this rule. The request shall document the need for an extension to provide continuity of services in the affected planning and service area(s) until a successor area agency on aging is designated after appeal.

[**ARC 9863B**, IAB 11/30/11, effective 11/1/11]

17—4.8(231) Severability clause. Should any rule, subrule, paragraph, phrase, sentence or clause of this chapter be declared invalid or unconstitutional for any reason, the remainder of this chapter shall not be affected thereby.

[**ARC 9863B**, IAB 11/30/11, effective 11/1/11]

These rules are intended to implement Iowa Code chapter 231 and 2011 Iowa Acts, House File 45.

[Filed 5/20/82, Notice 3/17/82—published 6/9/82, effective 7/14/82]
[Filed 12/17/82, Notice 10/13/82—published 1/5/83, effective 2/9/83]
[Filed 5/1/87, Notice 2/25/87—published 5/20/87, effective 6/24/87][1]
[Filed 2/1/91, Notice 11/28/90—published 2/20/91, effective 3/27/91]
[Filed 3/7/96, Notice 1/31/96—published 3/27/96, effective 5/1/96]
[Filed 2/21/06, Notice 11/23/05—published 3/15/06, effective 5/1/06]
[Filed 6/12/08, Notice 3/26/08—published 7/2/08, effective 8/6/08]
[Filed Emergency ARC 8489B, IAB 1/27/10, effective 1/7/10]
[Filed Emergency ARC 9863B, IAB 11/30/11, effective 11/1/11]

[1] Effective date of Ch 4 delayed 70 days by the Administrative Rules Review Committee.

CHAPTER 2
DEFINITIONS

[Prior to 2/20/02, see 193F—Chapter 1]

193F—2.1(543D) Applicability. The following definitions shall be applicable to the rules of the real estate appraiser examining board.

"Appraisal Foundation" means the Appraisal Foundation established on November 30, 1987, as a not-for-profit corporation under the laws of Illinois to develop qualifications and criteria for the appraisal profession.

"AQB" means the Appraiser Qualifications Board of the Appraisal Foundation.

"ASB" means the Appraisal Standards Board of the Appraisal Foundation.

"Associate real property appraiser" or *"associate appraiser"* means an individual who has registered with the board as an associate real property appraiser, as defined in Iowa Code section 543D.2(5), and who is training to become a certified residential or certified general real property appraiser.

"Certified appraiser" means an individual who has been certified in one of the following two classifications:

1. The certified residential real property appraiser classification, which is limited to the appraisal of one to four residential units without regard to transaction value.
2. The certified general real property appraiser classification, which applies to the appraisal of all types of real property.

"FIRREA" means the Financial Institutions Reform Recovery and Enforcement Act of 1989.

"Knowingly" means done with awareness and deliberateness.

"Law" means the "Iowa Voluntary Appraisal Standards and Appraiser Certification Law of 1989," Iowa Code chapter 543D.

"USPAP" means the Uniform Standards of Professional Appraisal Practice published by the Appraisal Foundation.

This rule is intended to implement Iowa Code section 543D.2.

[**ARC 9865B**, IAB 11/30/11, effective 1/4/12]

[Filed 8/1/91, Notice 5/29/91—published 8/21/91, effective 9/25/91]
[Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 2/7/96]
[Filed 4/30/99, Notice 3/24/99—published 5/19/99, effective 6/23/99]
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[Filed 11/2/07, Notice 8/29/07—published 11/21/07, effective 12/26/07]
[Filed ARC 9865B (Notice ARC 9716B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]

CHAPTER 10
RECIPROCITY

[Prior to 2/20/02, see 193F—Chapter 5]

193F—10.1(543D) Nonresident certification by reciprocity.

10.1(1) A nonresident of Iowa seeking certification in this state shall apply on forms provided by the board and pay the appropriate fee required in rule 193F—12.1(543D).

10.1(2) The board may issue a reciprocal certificate to a nonresident individual who is certified and demonstrates good standing in another state. An appraiser who is listed in good standing on the National Registry of the Appraisal Subcommittee satisfies the requirement that good standing be demonstrated and does not need to submit additional documentation. An appraiser who is not listed in good standing on the National Registry of the Appraisal Subcommittee must supply an official letter of good standing issued by the licensing board of the appraiser's resident state and bearing its seal. An appraiser may verify the appraiser's status on the National Registry of the Appraisal Subcommittee by accessing the Web site at www.asc.gov.

10.1(3) A reciprocal certified appraiser shall comply with all provisions of Iowa law and rules.

10.1(4) Reciprocal certified appraisers shall be required to pay the federal registry fee as required in rule 193F—12.3(543D).

10.1(5) The board may, at its discretion, request work product from an applicant for certification by reciprocity for good cause shown, such as an applicant's having a prior history in Iowa that includes a disciplinary investigation or disciplinary action. If work product is requested, the appraiser shall be subject to the process set forth in 193F—subrule 3.5(2) and shall pay the appropriate fee as required in 193F—12.1(543D).

193F—10.2(543D) Nonresident temporary practice.

10.2(1) The board will recognize, on a temporary basis and for a maximum of two assignments per year, the certification of an appraiser issued by another state.

10.2(2) The appraiser must register with the board and identify the property(ies) to be appraised, the name and address of the client and the estimated length of time the appraiser will be in the state. The appraiser must demonstrate good standing to be considered for a temporary practice permit. An appraiser who is listed in good standing on the National Registry of the Appraisal Subcommittee satisfies the requirement that good standing be demonstrated and does not need to submit additional documentation. An appraiser who is not listed in good standing on the National Registry of the Appraisal Subcommittee must supply an official letter of good standing issued by the licensing board of the appraiser's resident state and bearing its seal. An appraiser may verify the appraiser's status on the National Registry of the Appraisal Subcommittee by accessing the Web site at www.asc.gov. Registration shall be on a form provided by the board and submitted to the board office prior to the performance of the appraisal. The appraiser shall pay the appropriate fee as required in 193F—12.1(543D).

10.2(3) An appraiser holding an inactive or lapsed certificate as a real estate appraiser in Iowa may apply for a temporary practice permit if the appraiser holds an active, unexpired certificate as a real estate appraiser in good standing in another jurisdiction and is otherwise eligible for a temporary practice permit.

10.2(4) An appraiser who was previously a registered associate or certified appraiser in Iowa whose Iowa registration or certificate has been revoked or surrendered in connection with a disciplinary investigation or proceeding is ineligible to apply for a temporary practice permit in Iowa.

10.2(5) The board may deny an application for a temporary practice permit if the applicant has been disciplined in Iowa or another jurisdiction, a disciplinary investigation or proceeding is pending in Iowa, the person has been convicted of a crime that is a ground for discipline in Iowa, or it appears the applicant is applying for a temporary permit because the applicant would not qualify to renew or reinstate in active status in Iowa and the application for a temporary permit is made primarily to compromise compliance with Iowa laws and rules.

10.2(6) An appraiser holding an inactive or lapsed Iowa certificate who applies to reinstate to active status in Iowa shall not be given credit for any fees paid during the biennial period for one or more temporary practice permits.

10.2(7) An appraiser holding a license to practice as a real estate appraiser in another jurisdiction may practice in Iowa without applying for a temporary practice permit or paying any fees as long as the appraiser does not perform appraisal services in Iowa for which certification is required by state or federal law, rule or policy.

10.2(8) The board must receive and approve an application for a temporary practice permit before the applicant is eligible to practice in Iowa under a temporary practice permit. Applicants are encouraged to submit applications by e-mail or facsimile to avoid the possible delays of mail service, because the board will not approve an application with a retroactive start date. The board shall grant or deny all applications for temporary practice permits as quickly as reasonably feasible and no later than five days of receipt of a completed application. Applicants shall use the form prescribed by the board. Applicants disclosing discipline or criminal convictions shall attach documentation from which the board can determine if the discipline or criminal history would be a ground to deny the application. Falsification of information or failure to disclose material information shall be a ground to deny the application and may form the basis to deny any subsequent application or an application to reinstate a lapsed or inactive Iowa certificate.
[**ARC 9865B**, IAB 11/30/11, effective 1/4/12]

These rules are intended to implement Iowa Code sections 543D.10 and 543D.11.

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CHAPTER 11
CONTINUING EDUCATION
[Prior to 2/20/02, see 193F—Chapter 6]

193F—11.1(272C,543D) Definitions. For the purpose of these rules, the following definitions shall apply:

"Approved program" means a continuing education program, course, or activity that satisfies the standards set forth in these rules and has received advance approval of the board pursuant to these rules.

"Approved provider" means a person or an organization that has been approved by the board to conduct continuing education programs pursuant to these rules.

"Board" means the Iowa real estate appraiser examining board.

"Continuing education" means education which is obtained by a person certified to practice real estate appraising in order to maintain, improve, or expand skills and knowledge obtained prior to initial certification or registration, or to develop new and relevant skills and knowledge, all as a condition of renewal.

"Credit hour" means the value assigned by the board to a continuing education program.

"Distance education" means any education process based on the geographical separation of student and instructor. "Distance education" includes computer-generated programs, webinars, and home-study/correspondence programs.

"Guest speaker" means an individual who teaches an appraisal education program on a one-time-only or very limited basis and who possesses a unique depth of knowledge and experience in the subject matter.

"Home-study/correspondence program," as that term relates to Iowa Code section 543D.16(2), refers to self-study programs which are not generally approved by the Appraisal Qualifications Board for continuing education credit because such courses do not usually provide a reciprocal environment where the student has verbal or written communication with the instructor. The statutory limitation on correspondence and home study courses does not apply to interactive programs that are approved by the Appraisal Qualifications Board and AQB-approved delivery mechanisms.

"Hour" means 50 minutes of instruction.

"Live instruction" means an educational program delivered in a classroom setting where both the student and the instructor are present in the same room.

[**ARC 9865B**, IAB 11/30/11, effective 1/4/12]

193F—11.2(272C,543D) Continuing education requirements.

11.2(1) Certified residential, certified general and associate appraisers must demonstrate compliance with the following continuing education requirements as a condition of biennial renewal:

a. A minimum of 28 credit hours in approved continuing education programs must be acquired during the two-year renewal period. Carryover hours from a previous renewal period are not allowed.

b. The purpose of continuing education is to ensure that the appraiser participates in a program that maintains and increases the appraiser's skill, knowledge and competency in real estate appraising. Credit may be granted for educational offerings that are consistent with the purpose of continuing education. A minimum of 14 of the required 28 credit hours must involve courses that address one or more of the following subject areas: real estate appraisal law and rules, report writing, cost approach, sales approach, income approach, economic principles, legal considerations in appraisal, real estate markets and analysis, highest and best use analysis, appraisal math and statistics, site value, valuation of partial interests or appraisal ethics.

c. Appraisers must successfully complete the seven-hour National USPAP Update Course, or its equivalent, each two-year renewal cycle. Equivalency shall be determined through the AQB Course Approval Program or by an alternate method established by the AQB. USPAP continuing education credit shall be awarded only when the class is instructed by an AQB-certified instructor(s) and when the class is instructed by at least one state-certified residential or state-certified general appraiser. Individuals who are credentialed in more than one jurisdiction shall not have to take more than one seven-hour

National USPAP Update Course within a two-calendar-year period for the purposes of meeting AQB criteria.

11.2(2) A maximum of 14 of the required 28 credit hours may be acquired in approved distance education programs.

11.2(3) A maximum of 14 of the required 28 credit hours may be claimed by an instructor for teaching one or more approved continuing education programs in an amount equal to the credit hours approved for attendees. Instructors claiming such credit must teach the appraisal course during the renewal cycle in which credit is claimed and may not claim the course more than once in the renewal cycle. The board may request supportive documentation to ascertain course content and to verify the date(s), time, place and hours taught.

11.2(4) An applicant seeking to renew an initial certificate or registration issued less than 185 days prior to renewal is not required to report any continuing education. An applicant seeking to renew an initial certificate or registration issued for 185 days to 365 days prior to renewal must demonstrate completion of at least 14 credit hours, including 7 credit hours of the most recent National USPAP Update. An applicant seeking to renew an initial certificate or registration issued 365 days prior to renewal or more must demonstrate completion of at least 28 credit hours, including 7 credit hours of the most recent National USPAP Update.

11.2(5) Prior to reactivation of a certified general registration or a certified residential registration, a certified credential holder in inactive or lapsed status must complete all required continuing education hours that would have been required if the certified credential holder was in active status. The required hours must also include the most recent edition of a 7-hour National USPAP Update Course. Waivers may not be granted to credential holders who have failed to meet the continuing education requirements.

11.2(6) During each two-year renewal period, a continuing education program may be taken for credit only once, except USPAP courses.

11.2(7) Successful completion of a continuing education program requires 90 percent attendance. Continuing education credits shall not be granted to attendees who are present for less than 90 percent of the scheduled class meeting.

11.2(8) An applicant may claim continuing education credits earned in a state that has a continuing education requirement for renewal of a real estate appraisal certificate if the program is approved by the appraisal certification board of that state or the Appraiser Qualifications Board for continuing education purposes. All other programs must be approved upon application to the board pursuant to rules 193F—11.4(272C,543D), 193F—11.5(272C,543D) and 193F—11.6(272C,543D).

11.2(9) A person certified or registered to practice real estate appraising in Iowa shall be deemed to have complied with Iowa's continuing education requirements for periods in which the person is a resident of another state or district having continuing education requirements for real estate appraising and meets all requirements of that state or district. Waivers may not be granted to credential holders who have failed to meet the continuing education requirements. Deferrals may not be granted to credential holders, except in the case of persons returning from active military duty. Credential holders returning from active military duty may be placed in active status for a period of up to 90 days pending completion of all continuing education requirements. To qualify, the credential holder must submit a request in writing and provide a copy of the military orders.

[**ARC 7774B**, IAB 5/20/09, effective 6/24/09; **ARC 9865B**, IAB 11/30/11, effective 1/4/12]

193F—11.3(272C,543D) Hardship and disability provisions. Rescinded IAB 5/20/09, effective 6/24/09.

193F—11.4(272C,543D) Minimum program qualifications.

11.4(1) Continuing education programs, as a condition of board approval, must provide a formal program of learning that contributes to the growth in the professional knowledge and professional competence of real estate appraisers.

11.4(2) Continuing education programs dealing with the following subject areas that are integrally related to appraisal topics will generally be acceptable:

a. Ad valorem taxation;
b. Agriculture production and economics;
c. Agronomy/soil;
d. Arbitrations;
e. Business courses related to the practice of real estate appraisal;
f. Construction estimating;
g. Cost approach;
h. Ethics and standards of professional practice;
i. Income approach;
j. Land use planning, zoning and taxation;
k. Litigation;
l. Management, leasing, brokerage time sharing;
m. Property development;
n. Real estate appraisal law and rules;
o. Real estate appraisal (valuations/evaluations);
p. Real estate law, easements, and legal interests;
q. Real estate financing and investment;
r. Real estate appraisal-related computer applications;
s. Real estate securities and syndication;
t. Real property exchange;
u. Production economics;
v. Sales approach;
w. USPAP.

11.4(3) The following programs will not be acceptable:

a. Sales promotion or other meetings held in conjunction with the appraiser's general business;
b. Time devoted to breakfast, lunch or dinner;
c. A program certified by the use of a challenge examination. The required number of hours must be completed to receive credit hours;
d. Meetings that are a normal part of the in-house staff or employee training;
e. Distance education programs which are not tested and successfully completed;
f. Programs that do not provide at least three credit hours.

11.4(4) Continuing education credit will be granted only for whole hours, with a minimum of 50 minutes constituting one hour. For example, 100 minutes of continuous instruction would count as two credit hours; however, more than 50 minutes but less than 100 minutes of continuous instruction would only count as one hour.

11.4(5) Continuing education credit may be approved for university or college courses in qualifying topics according to the following formula: Each semester hour of credit shall equal 15 credit hours and each quarter hour of credit shall equal 10 credit hours.

[**ARC 9865B**, IAB 11/30/11, effective 1/4/12]

193F—11.5(272C,543D) Standards for provider and program approval. Providers and programs must satisfy the following minimum standards in order to be preapproved in accordance with the procedures established in rule 193F—11.4(272C,543D) and in order to maintain approved status.

11.5(1) The program must be taught or developed by individuals who have the education, training and experience to be considered experts in the subject matter of the program and competent in the use of teaching methods appropriate to the program.

11.5(2) Live instruction programs must be taught by instructors who have successfully completed an instructor development workshop within 24 months preceding board approval of the program.

11.5(3) In determining whether an instructor is qualified to teach a particular program, the board will consider whether the instructor has an ability to teach and an in-depth knowledge of the subject matter.

11.5(4) An instructor may demonstrate the ability to teach by meeting one or more of the following criteria:

a. Hold a bachelor's degree or higher in education from an accredited college (attach a copy of transcripts);

b. Hold a current teaching credential or certificate in any real estate or real estate-related fields (attach copy);

c. Hold a certificate of completion in the area of instruction from an instructor institute, workshop or school that is sponsored by a member of the Appraisal Foundation (detail specific teaching experiences);

d. Hold a full-time current appointment to the faculty of an accredited college;

e. Other, as the board may determine.

11.5(5) An instructor may demonstrate in-depth knowledge of the program's subject matter by meeting one or more of the following criteria:

a. Hold a bachelor's degree or higher from an accredited college with a major in a field of study directly related to the subject matter of the course the instructor proposes to teach, such as business, economics, accounting, real estate or finance (attach copy of transcript);

b. Hold a bachelor's degree or higher from an accredited college and have five years of appraisal experience related to the subject matter of the course the instructor proposes to teach (attach copy of transcript and document how the instructor's experience is related to the subject matter the instructor proposes to teach);

c. Hold a generally recognized professional real property appraisal designation or be a sponsor member of the Appraisal Foundation;

d. Other, as the board may determine.

11.5(6) As of January 1, 2004, only AQB-certified USPAP instructors, listed on the Web site of the Appraisal Foundation may teach the national USPAP courses including the 15-hour tested prelicense course and the 7-hour continuing education course.

11.5(7) Course content and materials must be accurate, consistent with currently accepted standards relating to the program's subject matter and updated no later than 30 days after the effective date of a change in standards, laws or rules.

11.5(8) Programs must have an appropriate means of written evaluation by participants. Evaluations shall include the relevance of the materials, effectiveness of presentation, content, facilities, and such additional features as are appropriate to the nature of the program.

11.5(9) No part of any course shall be used to solicit memberships in organizations, recruit appraisers for affiliation with any organization or advertise the merits of any organization or sell any product or service.

11.5(10) Providers must clearly inform prospective participants of the number of credit hours preapproved by the board for each program and all applicable policies concerning registration, payment, refunds, attendance requirements and examination grading.

11.5(11) Procedures must be in place to monitor whether the person receiving credit hours is the person who attended or completed the program.

11.5(12) Providers must be accessible to students during normal business hours to answer questions and provide assistance as necessary.

11.5(13) Providers must comply with or demonstrate exemption from the provisions of Iowa Code sections 714.14 to 714.25.

11.5(14) Providers must designate a coordinator in charge of each program who will act as the board's contact on all compliance issues.

11.5(15) Programs shall not offer more than eight credit hours in a single day.

11.5(16) Providers shall not provide any information to the board, the public or prospective students which is misleading in nature. For example, providers may not refer to themselves as a "college" or "university" unless qualified as such under Iowa law.

11.5(17) Providers must establish and maintain for a period of five years complete and detailed records on the programs successfully attended by each Iowa participant.

11.5(18) Providers must issue an individual certificate of attendance to each participant upon successful completion of the program. The certificate must be no larger than 8½″ × 11″ and must

include the provider name and number, program name and number, name of attendee, date program was completed, number of approved credit hours, and the signature of the coordinator or other person authorized by the board.

11.5(19) Program providers and instructors are solely responsible for the accuracy of all program materials, instruction and examinations. Board approval of a provider or program is not an assurance or warranty of accuracy and shall not be explicitly or implicitly marketed or advertised as such.

193F—11.6(272C,543D) Acceptable distance education courses. Distance education is an education process based on the geographical separation of student and instructor. A distance education course is acceptable to meet class hour requirements if:

11.6(1) The course provides interaction. Interaction is a reciprocal environment in which the student has verbal or written communication with the instructor; and

11.6(2) Content approval is obtained from the AQB, a state licensing jurisdiction, or an accredited college, community college, or university that offers distance education programs and is approved or accredited by the Commission on Colleges, a regional or national accreditation association, or by an accrediting agency that is recognized by the U.S. Secretary of Education. Nonacademic credit college courses provided by a college shall be approved by the AQB or the state licensing jurisdiction; and

11.6(3) Course delivery mechanism approval is obtained from one of the following sources:

a. AQB-approved organizations providing approval of course design and delivery; or

b. A college that qualifies for content approval pursuant to subrule 11.6(2) that awards academic credit for the distance education course; or

c. A qualifying college for content approval with a distance education delivery program that approves the course design and delivery that incorporate interactivity.

193F—11.7(272C,543D) Applications for approval of providers and programs. Applications for approval of providers and programs must be submitted on forms prescribed by the board. Board approval is effective for 24 months, including the month of approval.

11.7(1) Approval must be obtained for each program separately.

11.7(2) A nonrefundable fee of $50 must be submitted for each program except for programs that have been approved by the Appraiser Qualifications Board.

11.7(3) All required forms and attachments must be submitted for approval at least 30 days prior to the first offering of each program. The board will approve or deny each program, in whole or part, within 15 days of the date the board receives the fee and fully completed application.

11.7(4) Application forms will request information including, but not limited to, the following:

a. Program description;

b. Program purpose;

c. Difficulty level;

d. Learning objectives for each major topic that specify the level of knowledge or competency the student should demonstrate upon completing the program;

e. Description of the instructional methods utilized to accomplish the learning objective;

f. Identifying information for all guest speakers or instructors and such documentation as is necessary to verify compliance with the instructor qualifications described in subrule 11.5(5);

g. Copies of all instructor and student program materials;

h. Copies of all examinations and a description of all grading procedures;

i. A description of the diagnostic assessment method(s) used when examinations are not given;

j. Copies of prospective brochures or narrative descriptions of the program as will be advertised to prospective students;

k. Such information as needed to verify compliance with board rules;

l. The name, address, telephone number, fax number and E-mail address for the program's coordinator;

m. Such other information as the board deems reasonably needed for informed decision making.

11.7(5) The board shall assign each provider and program a number. This number shall be placed on all correspondence with the board, all subsequent applications by the same provider, and all certificates of attendance issued to participants.

193F—11.8(272C,543D) Waiver of application fees. Application fees may be waived for approved programs sponsored by a federal, state, or local governmental agency when the program is offered at no cost or at a nominal cost to participants. A request for waiver of application fees should be made by the provider or certificate holder at the time the application is filed with the board.

193F—11.9(272C,543D) Continuing education committee. Upon majority vote of the board, the board chairperson may appoint, on an annual basis, a continuing education committee to approve or deny, in whole or part, applications for provider and program approval and hardship and disability waivers pursuant to rule 193F—11.3(272C,543D), and credits claimed by appraisers on certification renewal forms. The committee shall be comprised of three members of the board, at least two of whom are appraisers. Alternatively, the board chairperson may delegate to the executive secretary authority to approve or deny course applications subject to the applicant's right to a hearing as provided for in rule 193F—11.12(272C,543D).

193F—11.10(272C,543D) Appraiser request for preapproval of continuing education programs. An appraiser seeking credit for attendance and participation in a program which is to be conducted by a provider not accredited or otherwise approved by the board shall apply for approval to the board at least 15 days in advance of the commencement of the activity. The board shall approve or deny the application in writing. Application for prior approval of a continuing education activity shall include the following fee and information:

1. Application fee of $25;
2. School, firm, organization or person conducting the program;
3. Location of the program;
4. Title and hour-by-hour outline of the program, course or activity;
5. Credit hours requested for approval;
6. Date of program; and
7. Principal instructor(s).

193F—11.11(272C,543D) Appraiser request for postapproval of continuing education program. An appraiser seeking credit for attendance and participation in a program that was not conducted by an approved provider or approved by the licensing authority in another state or otherwise approved by the board shall submit to the board a request for credit for the program. Within 15 days after receipt of the request, the board shall advise the requester in writing whether the program is approved and the number of hours allowed. Appraisers not complying with the requirement of this rule may be denied credit for the program. Application for postapproval of a continuing education program shall include the following fee and information:

1. Application fee of $25;
2. School, firm, organization or person conducting the program;
3. Location of the program;
4. Title of program and description of program;
5. Credit hours requested for approval;
6. Dates of program;
7. Principal instructor(s); and
8. Verification of attendance.

193F—11.12(272C,543D) Review of provider or program. The board on its own motion or upon receipt of a complaint or negative evaluation may monitor or review any approved program or provider and, upon evidence of significant variation in the program presented from the program approved, a violation of board rules, or material misstatement or omission in the application form, may withdraw

approval of the provider or program and disallow all or any part of the approved hours granted to the provider. The provider, as a condition of approval, agrees to allow the board or its authorized representatives to monitor ongoing compliance with board rules through means including, but not limited to, unannounced attendance at programs.

193F—11.13(272C,543D) Hearings. In the event of denial, in whole or in part, of any application for approval of a continuing education program or provider, or credit for a continuing education program, or withdrawal of approval of a continuing education program or provider, the provider or appraiser shall have the right, within 20 days after the sending of the notification of the denial or withdrawal by ordinary mail, to request, in writing, a hearing which shall be held within 60 days after receipt of the written request for hearing. The hearing shall be conducted by the board, a panel of the board, or a qualified administrative law judge designated by the board. If the hearing is conducted by a panel of the board or an administrative law judge, a transcript of the hearing shall be presented to the board with the proposed decision. The decision of the board, or the decision of the panel of the board or an administrative law judge after adoption or amendment by the board, shall be final.

These rules are intended to implement Iowa Code sections 543D.5, 543D.9 and 543D.16 and chapter 272C.

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CHAPTER 43
COMMUNITY HOUSING AND SERVICES FOR PERSONS WITH DISABILITIES REVOLVING LOAN PROGRAM

265—43.1(16) Purpose. Through its community housing and services for persons with disabilities revolving loan program, the authority seeks to further the availability of affordable housing and supportive services for Medicaid waiver-eligible individuals with behaviors that provide significant barriers to accessing traditional rental and supportive service opportunities. Loans from the community housing and services for persons with disabilities revolving loan program fund are to be used to provide financing to construct permanent supportive housing or develop infrastructure in which to provide supportive services, including through new construction, acquisition and rehabilitation of existing housing or infrastructure, or conversion or adaptive reuse. This chapter is intended to implement Iowa Code section 16.5(1) and 2011 Iowa Acts, House File 649, section 50.

Pursuant to 2011 Iowa Acts, House File 649, section 50, housing provided through a project under this chapter is exempt from the requirements of Iowa Code chapter 135O, Boarding Homes.
[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12]

265—43.2(16) Definitions. When used in this chapter, unless the context otherwise requires:

"Authority" means the Iowa finance authority.

"Department" means the Iowa department of human services.

"HOME" means the HOME Investment Partnership Program, authorized by the Cranston-Gonzalez National Affordable Housing Act of 1990.

"Infrastructure" means the building and permanent improvements necessary for the support of Medicaid waiver-eligible individuals.

"Medicaid waiver-eligible" means eligible to receive 19 United States Code Section 1915(c) home- and community-based services waivers under Iowa Administrative Code 441—Chapter 83.

"Permanent supportive housing" means a community-based dwelling that has supportive services for persons with disabilities. This type of supportive housing enables special needs populations to live as independently as possible in a permanent setting.

"PMIC" means psychiatric medical institutions for children.

"Program" means the community housing and services for persons with disabilities revolving loan program.
[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12]

265—43.3(16) Award of loan funds. It is the authority's intent to award loans under the program to those applicants that meet all of the requirements of this chapter and the published underwriting standards of the loan program. When an applicant for loan funds also qualifies for HOME program funds, the project must satisfy all application requirements of the HOME program adopted by the authority pursuant to rule 265—39.6(16). The authority intends to award the available funds under this program each year if applicants meet all applicable requirements.
[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12]

265—43.4(16) Application process. The authority anticipates that it will, at least annually, publicize the approximate amount of funds available under this program for the applicable fiscal year on the authority's Web site at www.iowafinanceauthority.gov. Any unallocated or recovered funds, or payments of interest and principal, or any combination thereof, may be awarded or may be carried over to the next year's cycle of loans at the discretion of the authority. The authority will take such applications from time to time and will analyze and award loans to applicants on an ongoing basis, beginning on or after September 1, 2011. It is the position of the authority that such flexibility in taking and reviewing applications and making awards will best serve to develop and expand community housing and services for Medicaid waiver-eligible individuals.

Applicants may apply for joint funding of a project using both HOME program funds and funds loaned pursuant to this chapter.
[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12]

265—43.5(16) Program guidelines. For-profit and nonprofit sponsors are eligible to apply for assistance under this program based on the following program guidelines; however, prior to submission of the loan application, a service provider must receive approval of a service plan to benefit the Medicaid waiver-eligible individuals who reside in the project. The service provider may apply for the loan fund; however, the service provider does not have to be the applicant for the loan fund. If the service provider is not the loan applicant, a memorandum of understanding must exist between the loan applicant and the service provider which shows an obligation on behalf of the service provider to deliver services to the Medicaid waiver-eligible individuals residing in the project and which shows that the loan applicant is obligated to offer housing to the Medicaid waiver-eligible individuals who need the services provided by the service provider.

43.5(1) Projects eligible for assistance must meet the following criteria:

a. Written approval must be obtained from the department for the proposed project prior to application for loan funds.

b. In order to be approved by the department, the project must demonstrate all of the following components:

(1) The project serves one of the following Medicaid waiver-eligible populations:

1. Individuals who are currently underserved in community settings, including individuals who are physically aggressive or have behaviors that are difficult to manage or individuals who meet the PMIC level of care; or

2. Individuals who are currently placed out of state by the department; or

3. Individuals who are currently receiving care in an Iowa-licensed health care facility.

(2) A plan to provide each Medicaid waiver-eligible individual with crisis stabilization services to ensure that the individual's behavioral issues are appropriately addressed by the provider.

(3) Policies and procedures that prohibit discharge of the Medicaid waiver-eligible individual from the waiver services provided by the project provider unless an alternative placement that is acceptable to the individual or the individual's guardian is identified.

c. In order to be approved by the department for application for funding for development of infrastructure in which to provide supportive services under this chapter, a project shall include all of the following components:

(1) Provision of services to Medicaid waiver-eligible individuals who meet the PMIC level of care.

(2) Policies and procedures that prohibit discharge of the Medicaid waiver-eligible individual from the waiver services provided by the project provider unless an alternative placement that is acceptable to the individual or the individual's guardian is identified.

43.5(2) The following types of activities are eligible for assistance:

a. Acquisition and rehabilitation.

b. New construction.

c. Such other similar activities as may be determined by the authority to fall within the guidelines and purposes established for this program.

43.5(3) Assistance will be provided upon the following terms and conditions:

a. Generally, the minimum loan amount is $50,000, and the maximum loan amount is $500,000. The maximum loan term and amortization period are each 30 years.

b. The debt service ratio must be at least 1.25:1 for the authority's first mortgage, as calculated by the authority. In addition, the loan-to-value ratio of the project, as calculated by the authority, will be considered. Notwithstanding the above, the authority may, in its sole discretion, accept a lower debt service ratio based on the final underwriting of the project.

c. Interest rates will be set by the authority, in its sole discretion.

d. Loans shall be secured by a first mortgage, to the extent possible. Construction financing may be awarded to projects.

e. Recipients of assistance must agree to observe several covenants and restrictions all in accordance with such loan and mortgage documents as may be required by the authority under this program.

f. The recipient must provide adequate evidence that its title in the real estate on which the project is to be located is a marketable title pursuant to Iowa Land Title Examination Standards, or other applicable law. Adequate evidence of marketable title is demonstrated by either (1) a title opinion of an attorney authorized to practice law in Iowa showing that the loan recipient has marketable title, or (2) a title guaranty certificate issued by the title guaranty division of the Iowa finance authority showing the recipient as the guaranteed.

g. Recipients must execute such documents and instruments and must provide such information, certificates and other items as determined necessary by the authority, in its sole discretion, in connection with any assistance.

43.5(4) Loan fees.

a. Loan fees are as follows:

(1) Application fee – 0.3 percent of loan amount.

(2) Commitment fee (construction period) – 1.0 percent of loan amount.

(3) Commitment fee (permanent loan) – 2.0 percent of loan amount.

(4) Inspection fee (construction loan) – 0.5 percent of loan amount.

b. The authority may, in limited cases, reduce such fees if necessary in connection with assistance provided under this program. Such decision will be made in the sole discretion of the authority.

[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12]

265—43.6(16) Authority analysis of applications. Authority staff will analyze and underwrite each potential project and will make recommendations for funding assistance to the authority board of directors. Authority staff will use such procedures and processes in its underwriting and analysis as it deems necessary and appropriate in connection with furthering the purposes of this program. In addition, the authority anticipates that, because of the complex nature of each transaction and the particular set of circumstances attributable to each particular application/transaction, the terms and conditions of loans will vary from project to project. The authority will make available its general operating procedures and guidelines for this program.

[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12]

265—43.7(16) Discretion of authority board. The authority board of directors has the sole and final discretion to award or not to award assistance and to approve final loan terms.

[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12]

265—43.8(16) Closing/advance of funds. If all requirements of the authority are not met in accordance with any time frames set by the authority and to the complete satisfaction of the authority, all in the sole discretion of the authority, the authority may determine to cease work on an approved project and, accordingly, not advance any funds for such project.

[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12]

These rules are intended to implement Iowa Code section 16.5(1) and 2011 Iowa Acts, House File 649, section 50.

[Filed Emergency ARC 9690B, IAB 8/24/11, effective 8/18/11]

[Filed ARC 9878B (Notice ARC 9692B, IAB 8/24/11), IAB 11/30/11, effective 1/4/12]

HUMAN SERVICES DEPARTMENT[441]

Rules transferred from Social Services Department[770] to Human Services Department[498], see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.
Rules transferred from agency number [498] to [441] to conform with the reorganization numbering scheme in general, IAC Supp. 2/11/87.

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PREAMBLE

These rules describe the assessment of the fee authorized by Iowa Code section 249A.21. The rules explain how the fee is determined and paid, and under what conditions collection of the fee will be terminated.

441—36.1(249A) Assessment of fee. Intermediate care facilities for the mentally retarded (ICFs/MR) licensed in Iowa under 481—Chapter 64 shall pay a monthly fee to the department. Effective January 1, 2008, the fee shall equal 5.5 percent of the total revenue of the facility for the facility's preceding fiscal year divided by the number of months of facility operation during the preceding fiscal year.

441—36.2(249A) Determination and payment of fee for facilities certified to participate in the Medicaid program. For facilities certified to participate in the Medicaid program, the fee shall be determined and paid as follows:

36.2(1) The assessment for each facility fiscal year shall be based on the financial and statistical report for the facility's preceding fiscal year submitted pursuant to rule 441—82.5(249A), as adjusted pursuant to 441—subrules 82.5(10) and 82.17(1).

36.2(2) The department shall notify each facility of the amount of the fee assessed for each fiscal year following submission of the financial and statistical report for the facility's preceding fiscal year. The fee is subject to adjustment based on adjustments to the financial and statistical report.

36.2(3) The department shall deduct the monthly amount due from medical assistance payments to the facility. The department shall also deduct from medical assistance payments any additional amount due for past months as a result of an adjustment to the assessment.

36.2(4) Rescinded IAB 6/4/08, effective 5/15/08.

441—36.3(249A) Determination and payment of fee for facilities not certified to participate in the Medicaid program. For facilities not certified to participate in the Medicaid program, the fee shall be determined and paid as follows:

36.3(1) Any licensed ICF/MR in Iowa that is not certified to participate in the Medicaid program shall submit Form 470-0030, Financial and Statistical Report, as required for participating facilities by rule 441—82.5(249A), for purposes of determining the amount of the assessment. The department may audit and adjust the reports submitted, as provided for participating facilities in 441—subrules 82.5(10) and 82.17(1).

36.3(2) The assessment for each facility fiscal year shall be based on the financial and statistical report for the facility's preceding fiscal year as submitted and audited pursuant to subrule 36.3(1).

36.3(3) The department shall notify each facility of the amount of the fee assessed for each fiscal year following submission of the financial and statistical report for the facility's preceding fiscal year. The fee is subject to adjustment based on adjustments to the financial and statistical report.

36.3(4) The facility shall pay the assessed fee to the department on or before the fifteenth day of each month. Any additional amount due for past months as the result of an adjustment to the initial assessment is due 30 days after the department notifies the facility of the additional amount.

441—36.4(249A) Termination of fee assessment. If federal financial participation to match the assessed fee becomes unavailable under federal law, the assessment terminates on the date the federal statutory, regulatory, or interpretive change takes effect.

441—36.5 Reserved.

These rules are intended to implement Iowa Code section 249A.21.

DIVISION II
QUALITY ASSURANCE ASSESSMENT FOR NURSING FACILITIES

PREAMBLE

These rules describe the nursing facility quality assurance assessment authorized by Iowa Code chapter 249L. The rules explain how the assessment is determined and paid.
[**ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9892B**, IAB 11/30/11, effective 2/1/12]

441—36.6(249L) Assessment.

36.6(1) *Applicability.* All nursing facilities as defined in Iowa Code section 135C.1 that are free-standing facilities or are operated by a hospital licensed pursuant to Iowa Code chapter 135B shall pay a quarterly assessment to the department, as determined under this division, with the exception of:

a. Nursing facilities operated by the state.

b. Non-state government-owned or government-operated nursing facilities.

c. Distinct-part skilled nursing units and swing-bed units operated by a hospital.

36.6(2) *Assessment level.* Effective July 1, 2012, the assessment level for each nursing facility shall be determined on an annual basis and shall be effective for the state fiscal year.

a. Effective July 1, 2011, nursing facilities with 46 or fewer licensed beds are required to pay a quality assurance assessment of $1 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2012, the number of licensed beds on file with the department of inspections and appeals as of May 1 of each year shall be used to determine the assessment level for the following state fiscal year.

b. Nursing facilities designated as continuing care retirement centers (CCRCs) by the insurance division of the Iowa department of commerce are required to pay a quality assurance assessment of $1 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2012, continuing care retirement center designations as of May 1 of each year shall be used to determine the assessment level for the following state fiscal year.

c. Nursing facilities with annual Iowa Medicaid patient days of 26,500 or more are required to pay a quality assurance assessment of $1 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2012, the annual number of Iowa Medicaid patient days reported in the most current cost report submitted to the Iowa Medicaid enterprise as of May 1 of each year shall be used to determine the assessment level for the following state fiscal year.

d. All other nursing facilities are required to pay a quality assurance assessment of $5.26 per non-Medicare patient day.
[**ARC 8258B**, IAB 11/4/09, effective 1/1/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9892B**, IAB 11/30/11, effective 2/1/12]

441—36.7(249L) Determination and payment of assessment. The assessment shall be determined and paid as follows:

36.7(1) Each nursing facility shall pay the quality assurance assessment to the department on a quarterly basis. The facility shall:

a. Use Form 470-4836, Nursing Facility Quality Assurance Assessment Calculation Worksheet, to calculate the quarterly assessment amount due.

b. Submit Form 470-4836 and the quarterly assessment payment no later than 30 days following the end of each calendar quarter.

36.7(2) The facility shall calculate the amount of the quarterly assessment due by multiplying the facility's total non-Medicare patient days for the preceding quarter by the applicable assessment level as determined in subrule 36.6(2).

36.7(3) If the department determines that a nursing facility has underpaid or overpaid the quality assurance assessment, the department shall notify the nursing facility of the amount of the unpaid quality assurance assessment or refund due. Such amount shall be due or refunded within 30 days of the issuance of the notice.

36.7(4) A nursing facility that fails to pay the quality assurance assessment within the time frame specified above shall pay a penalty in the amount of 1.5 percent of the quality assurance assessment amount owed for each month or portion of a month that the payment is overdue.

a. If the facility substantiates good cause beyond the facility's control for failure to comply with payment of the quality assurance assessment, the department shall waive the penalty or a portion of the penalty. For purposes of this subrule, "good cause" shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

b. Requests for a good cause waiver must be submitted to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, Des Moines, Iowa 50315, within 30 days of notice to the facility that the penalty is due.

36.7(5) For facilities certified to participate in the Medicaid program, the department shall deduct the quarterly amount due from Medicaid payments to the facility if the department has not received the quality assurance assessment amount due by the last day of the month in which the payment is due. The department shall also withhold an amount equal to the penalty owed from any payment due.

[**ARC 8258B**, IAB 11/4/09, effective 1/1/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9892B**, IAB 11/30/11, effective 2/1/12]

441—36.8 and **36.9** Reserved.

These rules are intended to implement Iowa Code chapter 249L.

DIVISION III
HEALTH CARE ACCESS ASSESSMENT FOR HOSPITALS

PREAMBLE

These rules describe the hospital health care access assessment authorized by Iowa Code chapter 249M. The rules explain how the assessment is determined and paid.

[**ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9892B**, IAB 11/30/11, effective 2/1/12]

441—36.10(249M) Application of assessment.

36.10(1) *Participating hospitals.* For the purpose of the health care access assessment program, a "participating hospital" is defined as a non-state-owned hospital licensed under Iowa Code chapter 135B that is paid on a prospective payment system basis by Medicare and the medical assistance programs for inpatient and outpatient services.

36.10(2) *Assessment.* Participating hospitals are required to pay a quarterly health care access assessment equal to 1.26 percent of net patient revenue as specified in the hospital's fiscal year 2008 Medicare cost report. "Net patient revenue" means all revenue reported for acute patient care and services but does not include:

a. Contractual adjustments,

b. Charity care,

c. Bad debt,

d. Medicare revenue, or

e. Other revenue derived from sources other than hospital operations including but not limited to:

(1) Nonoperating revenue,

(2) Other operating revenue,

(3) Skilled nursing facility revenue,

(4) Physician revenue, and

(5) Long-term care revenue.

[**ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9892B**, IAB 11/30/11, effective 2/1/12]

441—36.11(249M) Determination and payment of assessment. The assessment shall be determined and paid as follows:

36.11(1) The department shall calculate the annual amount of the health care access assessment as 1.26 percent of net patient revenue as specified in the participating hospital's fiscal year 2008 Medicare cost report. The annual amount shall be divided by four to calculate the quarterly amount.

36.11(2) Each participating hospital shall pay the health care access assessment to the department on a quarterly basis. The hospital shall submit the quarterly assessment payment no later than 30 days following the end of each calendar quarter.

36.11(3) A participating hospital shall retain and preserve the Medicare cost report and financial statements used to prepare the cost report for a period of three years.

36.11(4) If the department determines that a participating hospital has underpaid or overpaid the health care access assessment, the department shall notify the hospital of the amount of the unpaid health care access assessment or refund due. Such amount shall be due or refunded within 30 days of the issuance of the notice.

36.11(5) A participating hospital that fails to pay the health care access assessment within the time frame specified in subrule 36.11(2) shall pay a penalty in the amount of 1.5 percent of the health care access assessment amount owed for each month or portion of a month that the payment is overdue.

a. If the department determines that good cause is shown for failure to comply with payment of the health care access assessment, the department shall waive the penalty or a portion of the penalty.

b. Requests for a good cause waiver must be submitted to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, Des Moines, Iowa 50315, within 30 days of notice to the facility that the penalty is due.

36.11(6) The department shall deduct the quarterly amount due from Medicaid payments to the participating hospital if the department has not received the health care access assessment by the last day of the month in which the payment is due. The department shall also withhold an amount equal to the penalty owed from any payment due.

[**ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9892B**, IAB 11/30/11, effective 2/1/12]

441—36.12(249M) Termination of health care access assessment. If the federal government fully funds Iowa's medical assistance program, if federal law changes to negatively impact the assessment program as determined by the department, or if a federal audit determines the assessment program is invalid, the assessment shall terminate on the date the federal statutory, regulatory, or interpretive change takes effect.

[**ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9892B**, IAB 11/30/11, effective 2/1/12]

These rules are intended to implement Iowa Code chapter 249M.

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TITLE VIII
MEDICAL ASSISTANCE

CHAPTER 75
CONDITIONS OF ELIGIBILITY

[Ch 75, 1973 IDR, renumbered as Ch 90]
[Prior to 7/1/83, Social Services[770] Ch 75]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
GENERAL CONDITIONS OF ELIGIBILITY, COVERAGE GROUPS, AND SSI-RELATED PROGRAMS

441—75.1(249A) Persons covered.

75.1(1) *Persons receiving refugee cash assistance.* Medical assistance shall be available to all recipients of refugee cash assistance. Recipient means a person for whom a refugee cash assistance (RCA) payment is received and includes persons deemed to be receiving RCA. Persons deemed to be receiving RCA are:

a. Persons denied RCA because the amount of payment would be less than $10.

b. Rescinded IAB 7/30/08, effective 10/1/08.

c. Persons who are eligible in every respect for refugee cash assistance (RCA) as provided in 441—Chapter 60, but who do not receive RCA because they did not make application for the assistance.

75.1(2) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(3) *Persons who are ineligible for Supplemental Security Income (SSI) because of requirements that do not apply under Title XIX of the Social Security Act.* Medicaid shall be available to persons who would be eligible for SSI except for an eligibility requirement used in that program which is specifically prohibited under Title XIX.

75.1(4) *Beneficiaries of Title XVI of the Social Security Act (supplemental security income for the aged, blind and disabled) and mandatory state supplementation.* Medical assistance will be available to all beneficiaries of the Title XVI program and those receiving mandatory state supplementation.

75.1(5) *Persons receiving care in a medical institution who were eligible for Medicaid as of December 31, 1973.* Medicaid shall be available to all persons receiving care in a medical institution who were Medicaid members as of December 31, 1973. Eligibility of these persons will continue as long as they continue to meet the eligibility requirements for the applicable assistance programs (old-age assistance, aid to the blind or aid to the disabled) in effect on December 31, 1973.

75.1(6) *Persons who would be eligible for supplemental security income (SSI), state supplementary assistance (SSA), or the family medical assistance program (FMAP) except for their institutional status.* Medicaid shall be available to persons receiving care in a medical institution who would be eligible for SSI, SSA, or FMAP if they were not institutionalized.

75.1(7) *Persons receiving care in a medical facility who would be eligible under a special income standard.*

a. Subject to paragraphs *"b"* and *"c"* below, Medicaid shall be available to persons who:

(1) Meet level of care requirements as set forth in rules 441—78.3(249A), 441—81.3(249A), and 441—82.7(249A).

(2) Receive care in a hospital, nursing facility, psychiatric medical institution, intermediate care facility for the mentally retarded, or Medicare-certified skilled nursing facility.

(3) Have gross countable monthly income that does not exceed 300 percent of the federal supplemental security income benefits for one.

(4) Either meet all supplemental security income (SSI) eligibility requirements except for income or are under age 21. FMAP policies regarding income and age do not apply when determining eligibility for persons under the age of 21.

b. For all persons in this coverage group, income shall be considered as provided for SSI-related coverage groups under subrule 75.13(2). In establishing eligibility for persons aged 21 or older for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2).

c. Eligibility for persons in this group shall not exist until the person has been institutionalized for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins. A "period of 30 days" is defined as being from 12 a.m. of the day of admission to the medical institution, and ending no earlier than 12 midnight of the thirtieth day following the beginning of the period.

(1) A person who enters a medical institution and who dies prior to completion of the 30-day period shall be considered to meet the 30-day period provision.

(2) Only one 30-day period is required to establish eligibility during a continuous stay in a medical institution. Discharge during a subsequent month, creating a partial month of care, does not affect eligibility for that partial month regardless of whether the eligibility determination was completed prior to discharge.

(3) A temporary absence of not more than 14 full consecutive days during which the person remains under the jurisdiction of the institution does not interrupt the 30-day period. In order to remain "under the jurisdiction of the institution" a person must first have been physically admitted to the institution.

75.1(8) *Certain persons essential to the welfare of Title XVI beneficiaries.* Medical assistance will be available to the person living with and essential to the welfare of a Title XIX beneficiary provided the essential person was eligible for medical assistance as of December 31, 1973. The person will continue to be eligible for medical assistance as long as the person continues to meet the definition of "essential person" in effect in the public assistance program on December 31, 1973.

75.1(9) *Individuals receiving state supplemental assistance.* Medical assistance shall be available to all recipients of state supplemental assistance as authorized by Iowa Code chapter 249. Medical assistance shall also be available to the individual's dependent relative as defined in 441—subrule 51.4(4).

75.1(10) *Individuals under age 21 living in a licensed foster care facility or in a private home pursuant to a subsidized adoption arrangement for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for foster care payment for a child pursuant to Iowa Code section 234.35 and rule 441—156.20(234) or has negotiated an adoption assistance agreement for a child pursuant to rule 441—201.5(600), medical assistance shall be available to the child if:

a. The child lives in Iowa and is not otherwise eligible under a category for which federal financial participation is available; or

b. The child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act, notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A).

75.1(11) *Individuals living in a court-approved subsidized guardianship home for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for a subsidized guardianship payment for a child pursuant to 441—Chapter 204, medical assistance will be available to the child under this subrule if the child is living in a court-approved subsidized guardianship home and either:

a. The child lives in Iowa and is not eligible for medical assistance under a category for which federal financial participation is available due to reasons other than:

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements; or

b. Notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A), the child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act due to reasons other than:

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements.

75.1(12) *Persons ineligible due to October 1, 1972, social security increase.* Medical assistance will be available to individuals and families whose assistance grants were canceled as a result of the increase in social security benefits October 1, 1972, as long as these individuals and families would be eligible for an assistance grant if the increase were not considered.

75.1(13) *Persons who would be eligible for supplemental security income or state supplementary assistance but for social security cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions:

a. They were entitled to and received concurrently in any month after April 1977 supplemental security income and social security or state supplementary assistance and social security, and

b. They subsequently lost eligibility for supplemental security income or state supplementary assistance, and

c. They would be eligible for supplemental security income or state supplementary assistance if all of the social security cost-of-living increases which they and their financially responsible spouses, parents, and dependent children received since they were last eligible for and received social security and supplemental security income (or state supplementary assistance) concurrently were deducted from their income. Spouses, parents, and dependent children are considered financially responsible if their income would be considered in determining the applicant's eligibility.

75.1(14) *Family medical assistance program (FMAP).* Medicaid shall be available to children who meet the provisions of rule 441—75.54(249A) and to the children's specified relatives who meet the provisions of subrule 75.54(2) and rule 441—75.55(249A) if the following criteria are met.

a. In establishing eligibility of specified relatives for this coverage group, resources are considered in accordance with the provisions of rule 441—75.56(249A) and shall not exceed $2,000 for applicant households or $5,000 for member households. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded.

b. Income is considered in accordance with rule 441—75.57(249A) and does not exceed needs standards established in rule 441—75.58(249A).

c. Rescinded IAB 11/1/00, effective 1/1/01.

75.1(15) *Child medical assistance program (CMAP).* Medicaid shall be available to persons under the age of 21 if the following criteria are met:

a. Financial eligibility shall be determined for the family size of which the child is a member using the income standards in effect for the family medical assistance program (FMAP) unless otherwise specified. Income shall be considered as provided in rule 441—75.57(249A). Additionally, the earned income disregards as provided in paragraphs 75.57(2)*"a," "b," "c,"* and *"d"* shall be allowed for those persons whose income is considered in establishing eligibility for the persons under the age of 21 and whose needs must be included in accordance with paragraph 75.58(1)*"a"* but who are not eligible for Medicaid. Resources of all persons in the eligible group, regardless of age, shall be disregarded. Unless a family member is voluntarily excluded in accordance with the provisions of rule 441—75.59(249A), family size shall be determined as follows:

(1) If the person under the age of 21 is pregnant and the pregnancy has been verified in accordance with rule 441—75.17(249A), the unborn child (or children if more than one) is considered a member of the family for purposes of establishing the number of persons in the family.

(2) A "man-in-the-house" who is not married to the mother of the unborn child is not considered a member of the unborn child's family for the purpose of establishing the number of persons in the family. His income and resources are not automatically considered, regardless of whether or not he is the legal or natural father of the unborn child. However, income and resources made available to the mother of the unborn child by the "man-in-the-house" shall be considered in determining eligibility for the pregnant individual.

(3) Unless otherwise specified, when the person under the age of 21 is living with a parent(s), the family size shall consist of all family members as defined by the family medical assistance program in accordance with paragraph 75.57(8)*"c"* and subrule 75.58(1).

Application for Medicaid shall be made by the parent(s) when the person is residing with them. A person shall be considered to be living with the parent(s) when the person is temporarily absent from the parent's(s') home as defined in subrule 75.53(4). If the person under the age of 21 is married or has been married, the needs, income and resources of the person's parent(s) and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person is living with a spouse the family size shall consist of that person, the spouse and any of their children, including any unborn children.

(5) Siblings under the age of 21 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this rule unless one sibling is married or has been married, in which case, the married sibling shall be considered separately unless the marriage was annulled.

(6) When a person is residing in a household in which some members are receiving FMAP under the provisions of subrule 75.1(14) or MAC under the provisions of subrule 75.1(28), and when the person is not included in the FMAP or MAC eligible group, the family size shall consist of the person and all other family members as defined above except those in the FMAP or MAC eligible group.

b. Rescinded IAB 9/6/89, effective 11/1/89.

c. Rescinded IAB 11/1/89, effective 1/1/90.

d. A person is eligible for the entire month in which the person's twenty-first birthday occurs unless the birthday falls on the first day of the month.

e. Living with a specified relative as provided in subrule 75.54(2) shall not be considered when determining eligibility for persons under this coverage group.

75.1(16) *Children receiving subsidized adoption payments from states providing reciprocal medical assistance benefits.* Medical assistance shall be available to children under the age of 21 for whom an adoption assistance agreement with another state is in effect if all of the following conditions are met:

a. The child is residing in Iowa in a private home with the child's adoptive parent or parents.

b. Benefits funded under Title IV-E of the Social Security Act are not being paid for the child by any state.

c. Another state currently has an adoption assistance agreement in effect for the child.

d. The state with the adoption assistance agreement:

(1) Is a member of the interstate compact on adoption and medical assistance (ICAMA); and

(2) Provides medical assistance benefits pursuant to a program funded under Title XIX of the Social Security Act, under the optional group at Section 1902(a)(10)(A)(ii)(VIII) of the Act, to children residing in that state (at least until age 18) for whom there is a state adoption assistance agreement in effect with the state of Iowa other than under Title IV-E of the Social Security Act.

75.1(17) *Persons who meet the income and resource requirements of the cash assistance programs.* Medicaid shall be available to the following persons who meet the income and resource guidelines of supplemental security income or refugee cash assistance, but who are not receiving cash assistance:

a. Aged and blind persons, as defined at subrule 75.13(2).

b. Disabled persons, as defined at rule 441—75.20(249A).

In establishing eligibility for children for this coverage group based on eligibility for SSI, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2) or as under refugee cash assistance.

75.1(18) *Persons eligible for waiver services.* Medicaid shall be available to recipients of waiver services as defined in 441—Chapter 83.

75.1(19) *Persons and families terminated from aid to dependent children (ADC) prior to April 1, 1990, due to discontinuance of the $30 or the $30 and one-third earned income disregards.* Rescinded IAB 6/12/91, effective 8/1/91.

75.1(20) *Newborn children.* Medicaid shall be available without an application to newborn children of women who are determined eligible for Medicaid for the month of the child's birth or for three-day emergency services for labor and delivery for the child's birth. Effective April 1, 2009, eligibility begins with the month of the birth and continues through the month of the first birthday as long as the child remains an Iowa resident.

a. The department shall accept any written or verbal statement as verification of the newborn's birth date unless the birth date is questionable.

b. In order for Medicaid to continue after the month of the first birthday, a redetermination of eligibility shall be completed.

75.1(21) *Persons and families ineligible for the family medical assistance program (FMAP) in whole or in part because of child or spousal support.* Medicaid shall be available for an additional four months to persons and families who become ineligible for FMAP because of income from child support, alimony, or contributions from a spouse if the person or family member received FMAP in at least three of the six months immediately preceding the month of cancellation.

a. The four months of extended Medicaid coverage begin the day following termination of FMAP eligibility.

b. When ineligibility is determined to occur retroactively, the extended Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted.

c. Rescinded IAB 10/11/95, effective 10/1/95.

75.1(22) *Refugee spenddown participants.* Rescinded IAB 10/11/95, effective 10/1/95.

75.1(23) *Persons who would be eligible for supplemental security income or state supplementary assistance but for increases in social security benefits because of elimination of the actuarial reduction formula and cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions. They:

a. Were eligible for a social security benefit in December of 1983.

b. Were eligible for and received a widow's or widower's disability benefit and supplemental security income or state supplementary assistance for January of 1984.

c. Became ineligible for supplemental security income or state supplementary assistance because of an increase in their widow's or widower's benefit which resulted from the elimination of the reduction factor in the first month in which the increase was paid and in which a retroactive payment of that increase for prior months was not made.

d. Have been continuously eligible for a widow's or widower's benefit from the first month the increase was received.

e. Would be eligible for supplemental security income or state supplementary assistance benefits if the amount of the increase from elimination of the reduction factor and any subsequent cost-of-living adjustments were disregarded.

f. Submit an application prior to July 1, 1988, on Form 470-0442, Application for Medical Assistance or State Supplementary Assistance.

75.1(24) *Postpartum eligibility for pregnant women.* Medicaid shall continue to be available, without an application, for 60 days beginning with the last day of pregnancy and throughout the remaining days of the month in which the 60-day period ends, to a woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for Medicaid for the month in which the pregnancy ended.

a. Postpartum Medicaid shall only be available to a woman who is not eligible for another coverage group after the pregnancy ends.

b. The woman shall not be required to meet any income or resource criteria during the postpartum period.

c. When the sixtieth day is not on the last day of the month the woman shall be eligible for Medicaid for the entire month.

75.1(25) *Persons who would be eligible for supplemental security income or state supplementary assistance except that they receive child's social security benefits based on disability.* Medical assistance shall be available to persons who receive supplemental security income (SSI) or state supplementary assistance (SSA) after their eighteenth birthday because of a disability or blindness which began before age 22 and who would continue to receive SSI or SSA except that they become entitled to or receive an increase in social security benefits from a parent's account.

75.1(26) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(27) *Widows and widowers who are no longer eligible for supplemental security income or state supplementary assistance because of the receipt of social security benefits.* Medicaid shall be available to widows and widowers who meet the following conditions:

a. They have applied for and received or were considered recipients of supplemental security income or state supplementary assistance.

b. They apply for and receive Title II widow's or widower's insurance benefits or any other Title II old age or survivor's benefits, if eligible for widow's or widower's benefits.

c. Rescinded IAB 5/1/91, effective 4/11/91.

d. They were not entitled to Part A Medicare hospital insurance benefits at the time of application and receipt of Title II old age or survivor's benefits. They are not currently entitled to Part A Medicare hospital insurance benefits.

e. They are no longer eligible for supplemental security income or state supplementary assistance solely because of the receipt of their social security benefits.

75.1(28) *Pregnant women, infants and children (Mothers and Children (MAC)).* Medicaid shall be available to all pregnant women, infants (under one year of age) and children who have not attained the age of 19 if the following criteria are met:

a. Income.

(1) Family income shall not exceed 300 percent of the federal poverty level for pregnant women and for infants (under one year of age). Family income shall not exceed 133 percent of the federal poverty level for children who have attained one year of age but who have not attained 19 years of age. Income to be considered in determining eligibility for pregnant women, infants, and children shall be determined according to family medical assistance program (FMAP) methodologies except that the three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply. "Family income" is the income remaining after disregards and deductions have been applied as provided in rule 441—75.57(249A).

(2) Moneys received as a lump sum, except as specified in subrules 75.56(4) and 75.56(7) and paragraphs 75.57(8)*"b"* and *"c,"* shall be treated in accordance with paragraphs 75.57(9)*"b"* and *"c."*

(3) Unless otherwise specified, when the person under the age of 19 is living with a parent or parents, the family size shall consist of all family members as defined by the family medical assistance program.

Application for Medicaid shall be made by the parents when the person is residing with them. A person shall be considered to be living with the parents when the person is temporarily absent from the parent's home as defined in subrule 75.53(4). If the person under the age of 19 is married or has been married, the needs, income and resources of the person's parents and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person under the age of 19 is living with a spouse, the family size shall consist of that person, the spouse, and any of their children.

(5) Siblings under the age of 19 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this subrule unless one sibling is married or has been married, in which case the married sibling shall be considered separately unless the marriage was annulled.

b. For pregnant women, resources shall not exceed $10,000 per household. In establishing eligibility for infants and children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for pregnant women for this coverage group, resources shall be considered in accordance with department of public health 641—subrule 75.4(2).

c. Rescinded IAB 9/6/89, effective 11/1/89.

d. Eligibility for pregnant women under this rule shall begin no earlier than the first day of the month in which conception occurred and in accordance with 441—76.5(249A).

e. The unborn child (children if more than one fetus exists) shall be considered when determining the number of persons in the household.

f. An infant shall be eligible through the month of the first birthday unless the birthday falls on the first day of the month. A child shall be eligible through the month of the nineteenth birthday unless the birthday falls on the first day of the month.

g. Rescinded IAB 11/1/89, effective 1/1/90.

h. When determining eligibility under this coverage group, living with a specified relative as specified at subrule 75.54(2) and the student provisions specified in subrule 75.54(1) do not apply.

i. A woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for assistance under this coverage group for the month in which her pregnancy ended shall be entitled to receive Medicaid through the postpartum period in accordance with subrule 75.1(24).

j. If an infant loses eligibility under this coverage group at the time of the first birthday due to an inability to meet the income limit for children or if a child loses eligibility at the time of the nineteenth birthday, but the infant or child is receiving inpatient services in a medical institution, Medicaid shall continue under this coverage group for the duration of the time continuous inpatient services are provided.

75.1(29) *Persons who are entitled to hospital insurance benefits under Part A of Medicare (Qualified Medicare Beneficiary program).* Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part A and B premiums, coinsurance and deductibles, providing the following conditions are met:

a. The person's monthly income does not exceed 100 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(1) The amount of income shall be determined as under the federal Supplemental Security Income (SSI) program.

(2) Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty line is published.

b. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits. The amount of resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4).

c. The effective date of eligibility is the first of the month after the month of decision.

75.1(30) *Presumptive eligibility for pregnant women.* A pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid, based only on her statements regarding family income, shall be eligible for ambulatory prenatal care. Eligibility shall continue until the last day of the month following the month of the presumptive eligibility determination unless the pregnant woman is determined to be ineligible for Medicaid during this period based on a Medicaid application filed either before the presumptive eligibility determination or during this period. In this case, presumptive eligibility shall end on the date Medicaid ineligibility is determined. A pregnant woman who files a Medicaid application but withdraws that application before eligibility is determined has not been determined ineligible for Medicaid. The pregnant woman shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. The qualified provider shall complete Form 470-2629, Presumptive Medicaid Income Calculation, in order to establish that the pregnant woman's family income is within the prescribed limits of the Medicaid program.

If the pregnant woman files a Medicaid application in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, Medicaid shall continue until a decision of ineligibility is made on the application. Payment of claims for ambulatory prenatal care services provided to a pregnant woman under this subrule is not dependent upon a finding of Medicaid eligibility for the pregnant woman.

a. A qualified provider is defined as a provider who is eligible for payment under the Medicaid program and who meets all of the following criteria:

(1) Provides one or more of the following services:

1. Outpatient hospital services.
2. Rural health clinic services (if contained in the state plan).
3. Clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician.

(2) Has been specifically designated by the department in writing as a qualified provider for the purposes of determining presumptive eligibility on the basis of the department's determination that the provider is capable of making a presumptive eligibility determination based on family income.

(3) Meets one of the following:

1. Receives funds under the Migrant Health Centers or Community Health Centers (subsection 329 or subsection 330 of the Public Health Service Act) or the Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act) or the Health Services for Urban Indians Program (Title V of the Indian Health Care Improvement Act).

2. Participates in the program established under the Special Supplemental Food Program for Women, Infants, and Children (subsection 17 of the Child Nutrition Act of 1966) or the Commodity Supplemental Food Program (subsection 4(a) of the Agriculture and Consumer Protection Act of 1973).

3. Participates in a state perinatal program.

4. Is an Indian health service office or a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act.

b. The provider shall complete Form 470-2579, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations, and submit it to the department for approval in order to become certified as a provider qualified to make presumptive eligibility determinations. Once the provider has been approved as a provider qualified to make presumptive Medicaid eligibility determinations, Form 470-2582, Memorandum of Understanding Between the Iowa Department of Human Services and a Qualified Provider, shall be signed by the provider and the department.

c. Once the qualified provider has made a presumptive eligibility determination for a pregnant woman, the provider shall:

(1) Contact the department to obtain a state identification number for the pregnant woman who has been determined presumptively eligible.

(2) Notify the department in writing of the determination within five working days after the date the presumptive determination is made. A copy of the Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), shall be used for this purpose.

(3) Inform the pregnant woman in writing, at the time the determination is made, that if she chose not to apply for Medicaid on the Health Services Application, Form 470-2927 or 470-2927(S), she has until the last day of the month following the month of the preliminary determination to file an application with the department. A Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580, shall be issued by the qualified provider for this purpose.

(4) Forward copies of the Health Services Application, Form 470-2927 or 470-2927(S), to the appropriate offices for eligibility determinations if the pregnant woman indicated on the application that she was applying for any of the other programs listed on the application. These copies shall be forwarded within two working days from the date of the presumptive determination.

d. In the event that a pregnant woman needing prenatal care does not appear to be presumptively eligible, the qualified provider shall inform the pregnant woman that she may file an application at the local department office if she wishes to have a formal determination made.

e. Presumptive eligibility shall end under any of the following conditions:

(1) The woman fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

(2) The woman files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and has been found ineligible for Medicaid.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

f. The adequate and timely notice requirements and appeal rights associated with an application that is filed pursuant to rule 441—76.1(249A) shall apply to an eligibility determination made on the Medicaid application. However, notice requirements and appeal rights of the Medicaid program shall not apply to a woman who is:

(1) Issued a presumptive eligibility decision by a qualified provider.

(2) Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the woman fails to file an application by the last day of the month following the month of the initial presumptive eligibility determination.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

g. A woman shall not be determined to be presumptively eligible for Medicaid more than once per pregnancy.

75.1(31) *Persons and families canceled from the family medical assistance program (FMAP) due to the increased earnings of the specified relative in the eligible group.* Medicaid shall be available for a period of up to 12 additional months to families who are canceled from FMAP as provided in subrule 75.1(14) because the specified relative of a dependent child receives increased income from employment.

For the purposes of this subrule, "family" shall mean individuals living in the household whose needs and income were included in determining the FMAP eligibility of the household members at the time that the FMAP benefits were terminated. "Family" also includes those individuals whose needs and income would be taken into account in determining the FMAP eligibility of household members if the household were applying in the current month.

a. Increased income from employment includes:

(1) Beginning employment.

(2) Increased rate of pay.

(3) Increased hours of employment.

b. In order to receive transitional Medicaid coverage under these provisions, an FMAP family must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred.

c. The 12 months' Medicaid transitional coverage begins the day following termination of FMAP eligibility.

d. When ineligibility is determined to occur retroactively, the transitional Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted, unless the provisions of paragraph *"f"* below apply.

e. Rescinded IAB 8/12/98, effective 10/1/98.

f. Transitional Medicaid shall not be allowed under these provisions when it has been determined that the member received FMAP in any of the six months immediately preceding the month of cancellation as the result of fraud. Fraud shall be defined in accordance with Iowa Code Supplement section 239B.14.

g. During the transitional Medicaid period, assistance shall be terminated at the end of the first month in which the eligible group ceases to include a child, as defined by the family medical assistance program.

h. If the family receives transitional Medicaid coverage during the entire initial six-month period and the department has received, by the twenty-first day of the fourth month, a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), Medicaid shall continue for an additional six months, subject to paragraphs *"g"* and *"i"* of this subrule.

(1) If the department does not receive a completed form by the twenty-first day of the fourth month, assistance shall be canceled.

(2) A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1)*"f"* and 75.57(2)*"l."*

i. Medicaid shall end at the close of the first or fourth month of the additional six-month period if any of the following conditions exists:

(1) The department does not receive a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), by the twenty-first day of the first month or the fourth month of the additional six-month period as required in paragraph 75.1(31)*"h,"* unless the family establishes good cause for failure to report on a timely basis. Good cause shall be established when the family demonstrates that one or more of the following conditions exist:

1. There was a serious illness or death of someone in the family.

2. There was a family emergency or household disaster, such as a fire, flood, or tornado.

3. The family offers a good cause beyond the family's control.

4. There was a failure to receive the department's notification for a reason not attributable to the family. Lack of a forwarding address is attributable to the family.

(2) The specified relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to an involuntary loss of employment, illness, or there were instances when problems could negatively impact the client's achievement of self-sufficiency as described at 441—subrule 93.133(4).

(3) It is determined that the family's average gross earned income, minus child care expenses for the children in the eligible group necessary for the employment of the specified relative, during the immediately preceding three-month period exceeds 185 percent of the federal poverty level as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

j. These provisions apply to specified relatives defined at paragraph 75.55(1)*"a,"* including:

(1) Any parent who is in the home. This includes parents who are included in the eligible group as well as those who are not.

(2) A stepparent who is included in the eligible group and who has assumed the role of the caretaker relative due to the absence or incapacity of the parent.

(3) A needy specified relative who is included in the eligible group.

k. The timely notice requirements as provided in 441—subrule 76.4(1) shall not apply when it is determined that the family failed to meet the eligibility criteria specified in paragraph *"g"* or *"i"* above. Transitional Medicaid shall be terminated beginning with the first month following the month in which the family no longer met the eligibility criteria. An adequate notice shall be provided to the family when any adverse action is taken.

75.1(32) *Persons and families terminated from refugee cash assistance (RCA) because of income earned from employment.* Refugee medical assistance (RMA) shall be available as long as the eight-month limit for the refugee program is not exceeded to persons who are receiving RMA and who are canceled from the RCA program solely because a member of the eligible group receives income from employment.

a. An RCA recipient shall not be required to meet any minimum program participation time frames in order to receive RMA coverage under these provisions.

b. A person who returns to the home after the family became ineligible for RCA may be included in the eligible group for RMA coverage if the person was included on the assistance grant the month the family became ineligible for RCA.

75.1(33) *Qualified disabled and working persons.* Medicaid shall be available to cover the cost of the premium for Part A of Medicare (hospital insurance benefits) for qualified disabled and working persons.

a. Qualified disabled and working persons are persons who meet the following requirements:

(1) The person's monthly income does not exceed 200 percent of the federal poverty level applicable to the family size involved.

(2) The person's resources do not exceed twice the maximum amount allowed under the supplemental security income (SSI) program.

(3) The person is not eligible for any other Medicaid benefits.

(4) The person is entitled to enroll in Medicare Part A of Title XVIII under Section 1818A of the Social Security Act (as added by Section 6012 of OBRA 1989).

b. The amount of the person's income and resources shall be determined as under the SSI program.

75.1(34) *Specified low-income Medicare beneficiaries.* Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part B premium, provided the following conditions are met:

a. The person's monthly income exceeds 100 percent of the federal poverty level but is less than 120 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

b. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.

c. The amount of income and resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

d. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(35) *Medically needy persons.*

a. Coverage groups. Subject to other requirements of this chapter, Medicaid shall be available to the following persons:

(1) Pregnant women. Pregnant women who would be eligible for FMAP-related coverage groups except for excess income or resources. For FMAP-related programs, pregnant women shall have the unborn child or children counted in the household size as if the child or children were born and living with them.

(2) FMAP-related persons under the age of 19. Persons under the age of 19 who would be eligible for an FMAP-related coverage group except for excess income.

(3) CMAP-related persons under the age of 21. Persons under the age of 21 who would be eligible in accordance with subrule 75.1(15) except for excess income.

(4) SSI-related persons. Persons who would be eligible for SSI except for excess income or resources.

(5) FMAP-specified relatives. Persons whose income or resources exceed the family medical assistance program's limit and who are a specified relative as defined at subrule 75.55(1) living with a child who is determined dependent.

b. Resources and income of all persons considered.

(1) Resources of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35)*"b"*(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility of adults. Resources of all specified relatives and of all potentially eligible individuals living together shall be disregarded in determining eligibility of children. Income of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35)*"b"*(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility.

(2) The amount of income of the responsible relative that has been counted as available to an FMAP household or SSI individual shall not be considered in determining the countable income for the medically needy eligible group.

(3) The resource determination shall be according to subrules 75.5(3) and 75.5(4) when one spouse is expected to reside at least 30 consecutive days in a medical institution.

c. Resources.

(1) The resource limit for adults in SSI-related households shall be $10,000 per household.

(2) Disposal of resources for less than fair market value by SSI-related applicants or members shall be treated according to policies specified in rule 441—75.23(249A).

(3) The resource limit for FMAP- or CMAP-related adults shall be $10,000 per household. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered according to department of public health 641—subrule 75.4(2).

(4) The resources of SSI-related persons shall be treated according to SSI policies.

(5) When a resource is jointly owned by SSI-related persons and FMAP-related persons, the resource shall be treated according to SSI policies for the SSI-related person and according to FMAP policies for the FMAP-related persons.

d. Income. All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted shall be considered in determining initial and continuing eligibility.

(1) Income policies specified in subrules 75.57(1) through 75.57(8) and paragraphs 75.57(9)*"b," "c," "g," "h,"* and *"i"* regarding treatment of earned and unearned income are applied to FMAP-related and CMAP-related persons when determining initial eligibility and for determining continuing eligibility unless otherwise specified. The three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply to medically needy persons.

(2) Income policies as specified in federal SSI regulations regarding treatment of earned and unearned income are applied to SSI-related persons when determining initial and continuing eligibility.

(3) The monthly income shall be determined prospectively unless actual income is available.

(4) The income for the certification period shall be determined by adding both months' net income together to arrive at a total.

(5) The income for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

e. Medically needy income level (MNIL).

(1) The MNIL is based on 133 1/3 percent of the schedule of basic needs, as provided in subrule 75.58(2), with households of one treated as households of two, as follows:

Number of Persons	1	2	3	4	5	6	7	8	9	10
MNIL	$483	$483	$566	$666	$733	$816	$891	$975	$1058	$1158

Each additional person $116

(2) When determining household size for the MNIL, all potential eligibles and all individuals whose income is considered as specified in paragraph 75.1(35)*"b"* shall be included unless the person has been excluded according to the provisions of rule 441—75.59(249A).

(3) The MNIL for the certification period shall be determined by adding both months' MNIL to arrive at a total.

The MNIL for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

(4) The total net countable income for the certification period shall be compared to the total MNIL for the certification period based on family size as specified in subparagraph (2).

If the total countable net income is equal to or less than the total MNIL, the medically needy individuals shall be eligible for Medicaid.

If the total countable net income exceeds the total MNIL, the medically needy individuals shall not be eligible for Medicaid unless incurred medical expenses equal or exceed the difference between the net income and the MNIL.

(5) Effective date of approval. Eligibility during the certification period or the retroactive certification period shall be effective as of the first day of the first month of the certification period or the retroactive certification period when the medically needy income level (MNIL) is met.

f. Verification of medical expenses to be used in spenddown calculation. The applicant or member shall submit evidence of medical expenses that are for noncovered Medicaid services and for covered services incurred prior to the certification period to the department on a claim form, which shall be completed by the medical provider. In cases where the provider is uncooperative or where returning to the provider would constitute an unreasonable requirement on the applicant or member, the form shall be completed by the worker. Verification of medical expenses for the applicant or member that are covered Medicaid services and occurred during the certification period shall be submitted by the provider to the Iowa Medicaid enterprise on a claim form. The applicant or member shall inform the provider of the applicant's or member's spenddown obligation at the time services are rendered or at the time the applicant or member receives notification of a spenddown obligation. Verification of allowable expenses incurred for transportation to receive medical care as specified in rule 441—78.13(249A) shall be verified on Form 470-0394, Medical Transportation Claim.

Applicants who have not established that they met spenddown in the current certification period shall be allowed 12 months following the end of the certification period to submit medical expenses for that

period or 12 months following the date of the notice of decision when the certification period had ended prior to the notice of decision.

g. Spenddown calculation.

(1) Medical expenses that are incurred during the certification period may be used to meet spenddown. Medical expenses incurred prior to a certification period shall be used to meet spenddown if not already used to meet spenddown in a previous certification period and if all of the following requirements are met. The expenses:

1. Remain unpaid as of the first day of the certification period.

2. Are not Medicaid-payable in a previous certification period or the retroactive certification period.

3. Are not incurred during any prior certification period with the exception of the retroactive period in which the person was conditionally eligible but did not meet spenddown.

Notwithstanding numbered paragraphs "1" through "3" above, paid medical expenses from the retroactive period can be used to meet spenddown in the retroactive period or in the certification period for the two months immediately following the retroactive period.

(2) Order of deduction. Spenddown shall be adjusted when a bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a bill for a covered service incurred prior to the certification period is subsequently received. Spenddown shall also be adjusted when a bill for a noncovered Medicaid service is subsequently received with a service date prior to the Medicaid-covered service. Spenddown shall be adjusted when an unpaid bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a paid bill for a covered service incurred in the certification period is subsequently received with a service date prior to the date of the notice of spenddown status.

If spenddown has been met and a bill is received with a service date after spenddown has been met, the bill shall not be deducted to meet spenddown.

Incurred medical expenses, including those reimbursed by a state or political subdivision program other than Medicaid, but excluding those otherwise subject to payment by a third party, shall be deducted in the following order:

1. Medicare and other health insurance premiums, deductibles, or coinsurance charges.

EXCEPTION: When some of the household members are eligible for full Medicaid benefits under the Health Insurance Premium Payment Program (HIPP), as provided in rule 441—75.21(249A), the health insurance premium shall not be allowed as a deduction to meet the spenddown obligation of those persons in the household in the medically needy coverage group.

2. An average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed residential care facility shall be allowed as a deduction for spenddown. These personal care services include assistance with activities of daily living such as preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring, eating, and managing medication.

The average statewide monthly standard deduction for personal care services shall be based on the average per day rate of health care costs associated with residential care facilities participating in the state supplementary assistance program for a 30.4-day month as computed in the Compilation of Various Costs and Statistical Data (Category: All; Type of Care: Residential Care Facility; Location: All; Type of Control: All). The average statewide standard deduction for personal care services used in the medically needy program shall be updated and effective the first day of the first month beginning two full months after the release of the Compilation of Various Costs and Statistical Data for the previous fiscal year.

3. Medical expenses for necessary medical and remedial services that are recognized under state law but not covered by Medicaid, chronologically by date of submission.

4. Medical expenses for acupuncture, chronologically by date of submission.

5. Medical expenses for necessary medical and remedial services that are covered by Medicaid, chronologically by date of submission.

(3) When incurred medical expenses have reduced income to the applicable MNIL, the individuals shall be eligible for Medicaid.

(4) Medical expenses reimbursed by a public program other than Medicaid prior to the certification period shall not be considered a medical deduction.

h. Medicaid services. Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:

(1) Care in a nursing facility or an intermediate care facility for the mentally retarded.

(2) Care in an institution for mental disease.

(3) Care in a Medicare-certified skilled nursing facility.

i. Reviews. Reviews of eligibility shall be made for SSI-related, CMAP-related, and FMAP-related medically needy members with a zero spenddown as often as circumstances indicate but in no instance shall the period of time between reviews exceed 12 months.

SSI-related, CMAP-related, and FMAP-related medically needy persons shall complete Form 470-3118 or 470-3118(S), Medicaid Review, as part of the review process when requested to do so by the department.

j. Redetermination. When an SSI-related, CMAP-related, or FMAP-related member who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility shall be completed to change the member's eligibility to a two-month certification with spenddown. This redetermination shall be effective the month the income exceeds the MNIL or the first month following timely notice.

(1) The Health Services Application, Form 470-2927 or 470-2927(S), or the Health and Financial Support Application, Form 470-0462 or Form 470-0466(Spanish), shall be used to determine eligibility for SSI-related medically needy when an SSI recipient has been determined to be ineligible for SSI due to excess income or resources in one or more of the months after the effective date of the SSI eligibility decision.

(2) All eligibility factors shall be reviewed on redeterminations of eligibility.

k. Recertifications. A new application shall be made when the certification period has expired and there has been a break in assistance as defined at rule 441—75.25(249A). When the certification period has expired and there has not been a break in assistance, the person shall use the Medicaid Review, Form 470-3118 or 470-3118(S), to be recertified.

l. Disability determinations. An applicant receiving social security disability benefits under Title II of the Social Security Act or railroad retirement benefits based on the Social Security Act definition of disability by the Railroad Retirement Board shall be deemed disabled without any further determination. In other cases under the medically needy program, the department shall conduct an independent determination of disability unless the applicant has been denied supplemental security income benefits based on lack of disability and does not allege either (1) a disabling condition different from or in addition to that considered by the Social Security Administration, or (2) that the applicant's condition has changed or deteriorated since the most recent Social Security Administration determination.

(1) In conducting an independent determination of disability, the department shall use the same criteria required by federal law to be used by the Social Security Administration of the United States Department of Health and Human Services in determining disability for purposes of Supplemental Security Income under Title XVI of the Social Security Act. The disability determination services bureau of the division of vocational rehabilitation shall make the initial disability determination on behalf of the department.

(2) For an independent determination of disability, the applicant or the applicant's authorized representative shall complete, sign and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

1. Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or
2. Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

(3) In connection with any independent determination of disability, the department shall determine whether reexamination of the person's medical condition will be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms as required in subparagraph (2).

75.1(36) *Expanded specified low-income Medicare beneficiaries.* As long as 100 percent federal funding is available under the federal Qualified Individuals (QI) Program, Medicaid benefits to cover the cost of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

a. The person is not otherwise eligible for Medicaid.

b. The person's monthly income is at least 120 percent of the federal poverty level but is less than 135 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

c. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.

d. The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

e. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(37) *Home health specified low-income Medicare beneficiaries.* Rescinded IAB 10/30/02, effective 1/1/03.

75.1(38) *Continued Medicaid for disabled children from August 22, 1996.* Medical assistance shall be available to persons who were receiving SSI as of August 22, 1996, and who would continue to be eligible for SSI but for Section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193).

75.1(39) *Working persons with disabilities.*

a. Medical assistance shall be available to all persons who meet all of the following conditions:

(1) They are disabled as determined pursuant to rule 441—75.20(249A), except that being engaged in substantial gainful activity will not preclude a determination of disability.

(2) They are less than 65 years of age.

(3) They are members of families (including families of one) whose income is less than 250 percent of the most recently revised official federal poverty level for the family. Family income shall include gross income of all family members, less supplemental security income program disregards, exemptions, and exclusions, including the earned income disregards.

(4) They receive earned income from employment or self-employment or are eligible under paragraph *"c."*

(5) They would be eligible for medical assistance under another coverage group set out in this rule (other than the medically needy coverage groups at subrule 75.1(35)), disregarding all income, up to $10,000 of available resources, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account. For this purpose, disability shall be determined as under subparagraph (1) above.

(6) They have paid any premium assessed under paragraph *"b"* below.

b. Eligibility for a person whose gross income is greater than 150 percent of the federal poverty level for an individual is conditional upon payment of a premium. Gross income includes all earned and unearned income of the conditionally eligible person. A monthly premium shall be assessed at the time of application and at the annual review. The premium amounts and the federal poverty level increments above 150 percent of the federal poverty level used to assess premiums will be adjusted annually on August 1.

(1) Beginning with the month of application, the monthly premium amount shall be established based on projected average monthly income. The monthly premium established shall not be increased for any reason before the next eligibility review. The premium shall not be reduced due to a change in the federal poverty level but may be reduced or eliminated prospectively before the next eligibility review if a reduction in projected average monthly income is verified.

(2) Eligible persons are required to complete and return Form 470-3118 or 470-3118(S), Medicaid Review, with income information during the twelfth month of the annual enrollment period to determine the premium to be assessed for the next 12-month enrollment period.

(3) Premiums shall be assessed as follows:

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
150% of Federal Poverty Level	$34
165% of Federal Poverty Level	$44
180% of Federal Poverty Level	$54
200% of Federal Poverty Level	$65
225% of Federal Poverty Level	$75
250% of Federal Poverty Level	$86
300% of Federal Poverty Level	$106
350% of Federal Poverty Level	$127
400% of Federal Poverty Level	$148
450% of Federal Poverty Level	$169
550% of Federal Poverty Level	$209
650% of Federal Poverty Level	$250
750% of Federal Poverty Level	$292
850% of Federal Poverty Level	$335
1000% of Federal Poverty Level	$399
1150% of Federal Poverty Level	$469
1300% of Federal Poverty Level	$560
1480% of Federal Poverty Level	$660

(4) Eligibility is contingent upon the payment of any assessed premiums. Medical assistance eligibility shall not be made effective for a month until the premium assessed for the month is paid. The premium must be paid within three months of the month of coverage or of the month of initial billing, whichever is later, for the person to be eligible for the month.

(5) When the department notifies the applicant of the amount of the premiums, the applicant shall pay any premiums due as follows:

1. The premium for each month is due the fourteenth day of the month the premium is to cover. EXCEPTIONS: The premium for the month of initial billing is due the fourteenth day of the following month; premiums for any months prior to the month of initial billing are due on the fourteenth day of the third month following the month of billing.

2. If the fourteenth day falls on a weekend or a state holiday, payment is due the first working day following the holiday or weekend.

3. When any premium payment due in the month it is to cover is not received by the due date, Medicaid eligibility shall be canceled.

(6) Payments received shall be applied in the following order:

1. To the month in which the payment is received if the premium for the current calendar month is unpaid.

2. To the following month when the payment is received after a billing statement has been issued for the following month.

3. To prior months when a full payment has not been received. Payments shall be applied beginning with the most recent unpaid month before the current calendar month, then the oldest unpaid prior month and forward until all prior months have been paid.

4. When premiums for all months above have been paid, any excess shall be held and applied to any months for which eligibility is subsequently established, as specified in numbered paragraphs "1," "2," and "3" above, and then to future months when a premium becomes due.

5. Any excess on an inactive account shall be refunded to the client after two calendar months of inactivity or of a zero premium or upon request from the client.

(7) An individual's case may be reopened when Medicaid eligibility is canceled for nonpayment of premium. However, the premium must be paid in full within the calendar month following the month the payment was due for reopening.

(8) Premiums may be submitted in the form of money orders or personal checks to the address printed on the return envelope enclosed with Form 470-3902, MEPD Billing Statement.

(9) Once an individual is canceled from Medicaid due to nonpayment of premiums, the individual must reapply to establish Medicaid eligibility unless the reopening provisions of this subrule apply.

(10) When a premium due in the month it is to cover is not received by the due date, a notice of decision will be issued to cancel Medicaid. The notice will include reopening provisions that apply if payment is received and appeal rights.

(11) Form 470-3694, Billing Statement, shall be used for billing and collection.

c. Members in this coverage group who become unable to work due to a change in their medical condition or who lose employment shall remain eligible for a period of six months from the month of the change in their medical condition or loss of employment as long as they intend to return to work and continue to meet all other eligibility criteria under this subrule. Members shall submit Form 470-4856, MEPD Intent to Return to Work, to report on the end of their employment and their intent to return to employment.

d. For purposes of this subrule, the following definitions apply:

"Assistive technology" is the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas that include education, rehabilitation, technology devices and assistive technology services.

"Assistive technology accounts" include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology devices or assistive technology services. Assistive technology accounts must be held separate from other accounts and funds and must be used to purchase, lease or otherwise acquire assistive technology, assistive technology services or assistive technology devices for the working person with a disability when a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist has established the medical necessity of the device, technology, or service and determined the technology, device, or service can reasonably be expected to enhance the individual's employment.

"Assistive technology device" is any item, piece of equipment, product system or component part, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities or address or eliminate architectural, communication, or other barriers confronted by persons with disabilities.

"Assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

"Family," if the individual is under 18 and unmarried, includes parents living with the individual, siblings under 18 and unmarried living with the individual, and children of the individual who live with the individual. If the individual is 18 years of age or older, or married, "family" includes the individual's spouse living with the individual and any children living with the individual who are under 18 and unmarried. No other persons shall be considered members of an individual's family. An individual living alone or with others not listed above shall be considered to be a family of one.

"Medical savings account" means an account exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220).

"Retirement account" means any retirement or pension fund or account, listed in Iowa Code section 627.6(8)*"f"* as exempt from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account.

75.1(40) *People who have been screened and found to need treatment for breast or cervical cancer.*

a. Medical assistance shall be available to people who:

(1) Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and have been found to need treatment for either breast or cervical cancer (including a precancerous condition);

(2) Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. Section 300gg(c)(1)), and are not eligible for medical assistance under Iowa Code section 249A.3(1); and

(3) Are under the age of 65.

b. Eligibility established under paragraph *"a"* continues until the person is:

(1) No longer receiving treatment for breast or cervical cancer;

(2) No longer under the age of 65; or

(3) Covered by creditable coverage or eligible for medical assistance under Iowa Code section 249A.3(1).

c. Presumptive eligibility. A person who has been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, who has been found to need treatment for either breast or cervical cancer (including a precancerous condition), and who is determined by a qualified provider to be presumptively eligible for medical assistance under paragraph *"a"* shall be eligible for medical assistance until the last day of the month following the month of the presumptive eligibility determination if no Medicaid application is filed in accordance with rule 441—76.1(249A) by that day or until the date of a decision on a Medicaid application filed in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, whichever is earlier.

The person shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. Presumptive eligibility shall begin no earlier than the date the qualified Medicaid provider determines eligibility.

Payment of claims for services provided to a person under this paragraph is not dependent upon a finding of Medicaid eligibility for the person.

(1) A provider who is qualified to determine presumptive eligibility is defined as a provider who:

1. Is eligible for payment under the Medicaid program; and
2. Either:

- Has been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department of public health; or
- Has a cooperative agreement with the department of public health under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program; and

3. Has made application and has been specifically designated by the department in writing as a qualified provider for the purpose of determining presumptive eligibility under this rule.

(2) The provider shall complete Form 470-3864, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT), and submit it to the department for approval in order to be designated as a provider qualified to make presumptive eligibility determinations. Once the department has approved the provider's application, the provider and the department shall sign Form 470-3865, Memorandum of Understanding with a Qualified Provider for People with Breast or

Cervical Cancer Treatment. When both parties have signed the memorandum, the department shall designate the provider as a qualified provider and notify the provider.

(3) When a qualified provider has made a presumptive eligibility determination for a person, the provider shall:

1. Contact the department to obtain a state identification number for the person who has been determined presumptively eligible.

2. Notify the department in writing of the determination within five working days after the date the presumptive eligibility determination is made. The provider shall use a copy of Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

3. Inform the person in writing, at the time the determination is made, that if the person has not applied for Medicaid on Form 470-2927 or 470-2927(S), Health Services Application, the person has until the last day of the month following the month of the preliminary determination to file the application with the department. The qualified provider shall use Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

4. Forward copies of Form 470-2927 or 470-2927(S), Health Services Application, to the appropriate department office for eligibility determination if the person indicated on the application that the person was applying for any of the other programs. The provider shall forward these copies and proof of screening for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program within two working days from the date of the presumptive eligibility determination.

(4) In the event that a person needing care does not appear to be presumptively eligible, the qualified provider shall inform the person that the person may file an application at the county department office if the person wishes to have an eligibility determination made by the department.

(5) Presumptive eligibility shall end under either of the following conditions:

1. The person fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

2. The person files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and is found ineligible for Medicaid.

(6) Adequate and timely notice requirements and appeal rights shall apply to an eligibility determination made on a Medicaid application filed pursuant to rule 441—76.1(249A). However, notice requirements and appeal rights of the Medicaid program shall not apply to a person who is:

1. Denied presumptive eligibility by a qualified provider.

2. Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the person fails to file an application by the last day of the month following the month of the presumptive eligibility determination.

(7) A new period of presumptive eligibility shall begin each time a person is screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, is found to need treatment for breast or cervical cancer, and files Form 470-2927 or 470-2927(S), Health Services Application, with a qualified provider.

75.1(41) *Persons eligible for family planning services under demonstration waiver.* Medical assistance for family planning services only shall be available as provided in this subrule.

a. Eligibility. The following are eligible for assistance under this coverage group if they are uninsured or have health insurance that does not include family planning services, are not otherwise enrolled in Medicaid (other than IowaCare), and are not enrolled in the Children's Health Insurance Program (HAWK-I):

(1) Women who were Medicaid members when their pregnancy ended and who are capable of bearing children but are not pregnant. Eligibility for these women extends for 12 consecutive months after the month when their 60-day postpartum period ends.

(2) Women who have reached childbearing age, are under 55 years of age, are capable of bearing children but are not pregnant, and have income that does not exceed 300 percent of the federal poverty level, as determined according to paragraph 75.1(41)*"c."*

(3) Men who are under 55 years of age, who are capable of fathering children, and who have income that does not exceed 300 percent of the federal poverty level, as determined according to paragraph 75.1(41)*"c."*

b. Application.

(1) Women eligible under subparagraph 75.1(41)*"a"*(1) are not required to file an application for assistance under this coverage group. The department will automatically redetermine eligibility pursuant to rule 441—76.11(249A) upon loss of other Medicaid eligibility within 12 months after the month when the 60-day postpartum period ends.

(2) A person requesting assistance based on subparagraph 75.1(41)*"a"*(2) or 75.1(41)*"a"*(3) shall file an application as required in rule 441—76.1(249A).

c. Determining income eligibility. The department shall determine the countable income of an applicant applying under subparagraph 75.1(41)*"a"*(2) or 75.1(41)*"a"*(3) as follows:

(1) Household size. The household size shall include the applicant or member, any dependent children as defined in 441—subrule 75.54(1) living in the same home as the applicant or member, and any spouse living in the same home as the applicant or member, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act.

(2) Earned income. All earned income as defined in 441—subrule 75.57(2) that is received by a member of the household shall be counted except for the earnings of a child who is a full-time student as defined in 441—paragraph 75.54(1)*"b."*

(3) Unearned income. The following unearned income of all household members shall be counted:

1. Unemployment compensation.
2. Child support.
3. Alimony.
4. Social security and railroad retirement benefits.
5. Worker's compensation and disability payments.
6. Benefits paid by the Department of Veterans Affairs to disabled members of the armed forces or survivors of deceased veterans.

(4) Deductions. Deductions from income shall be made for any payments made by household members for court-ordered child support, alimony, or spousal support to non-household members and as provided in 441—subrule 75.57(2).

(5) Disregard of changes. A person found to be income-eligible upon application or annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

d. Effective date. Assistance for family planning services under this coverage group shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. Notwithstanding 441—subrule 76.5(1), assistance shall not be available under this coverage group for any months preceding the month of application.

75.1(42) *Medicaid for independent young adults.* Medical assistance shall be available, as assistance related to the family medical assistance program, to a person who left a foster care placement on or after May 1, 2006, and meets all of the following conditions:

a. The person is at least 18 years of age and under 21 years of age.

b. On the person's eighteenth birthday, the person resided in foster care and Iowa was responsible for the foster care payment pursuant to Iowa Code section 234.35.

c. The person is not a mandatory household member or receiving Medicaid benefits under another coverage group.

d. The person has income below 200 percent of the most recently revised federal poverty level for the person's household size.

(1) "Household" shall mean the person and any of the following people who are living with the person and are not active on another Medicaid case:

1. The person's own children;
2. The person's spouse; and
3. Any children of the person's spouse who are under the age of 18 and unmarried.

No one else shall be considered a member of the person's household. A person who lives alone or with others not listed above, including the person's parents, shall be considered a household of one.

(2) The department shall determine the household's countable income pursuant to rule 441—75.57(249A). Twenty percent of earned income shall be disregarded.

(3) A person found to be income-eligible upon application or upon annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

75.1(43) *Medicaid for children with disabilities.* Medical assistance shall be available to children who meet all of the following conditions on or after January 1, 2009:

a. The child is under 19 years of age.

b. The child is disabled as determined pursuant to rule 441—75.20(249A) based on the disability standards for children used for Supplemental Security Income (SSI) benefits under Title XVI of the Social Security Act, but without regard to any income or asset eligibility requirements of the SSI program.

c. The child is enrolled in any group health plan available through the employer of a parent living in the same household as the child if the employer contributes at least 50 percent of the total cost of annual premiums for that coverage. The parent shall enroll the child and pay any employee premium required to maintain coverage for the child.

d. The child's household has income at or below 300 percent of the federal poverty level applicable to a family of that size.

(1) For this purpose, the child's household shall include any of the following persons who are living with the child and are not receiving Medicaid on another case:

1. The child's parents.
2. The child's siblings under the age of 19.
3. The child's spouse.
4. The child's children.
5. The children of the child's spouse.

(2) Only those persons identified in subparagraph (1) shall be considered a member of the child's household. A person who receives medically needy coverage with a spenddown or limited benefits such as Medicare savings programs or family planning services only is not considered to be "receiving Medicaid" for the purposes of subparagraph (1). A child who lives alone or with persons not identified in subparagraph (1) shall be considered as having a household of one.

(3) For this purpose, the income of all persons included in the child's household shall be determined as provided for SSI-related groups under subrule 75.13(2).

(4) The federal poverty levels used to determine eligibility shall be revised annually on April 1.

75.1(44) *Presumptive eligibility for children.* Medical assistance shall be available to children under the age of 19 who are determined by a qualified entity to be presumptively eligible for medical assistance pursuant to this subrule.

a. Qualified entity. A "qualified entity" is an entity described in paragraphs (1) through (10) of the definition of the term at 42 CFR 435.1101, as amended to October 1, 2008, that:

(1) Has been determined by the department to be capable of making presumptive determinations of eligibility, and

(2) Has signed an agreement with the department as a qualified entity.

b. Application process. Families requesting assistance for children under this subrule shall apply with a qualified entity using the form specified in 441—paragraph 76.1(1)*"f."* The qualified entity shall use the department's Web-based system to make the presumptive eligibility determination, based on the information provided in the application.

(1) All presumptive eligibility applications shall be forwarded to the department for a full Medicaid or HAWK-I eligibility determination, regardless of the child's presumptive eligibility status.

(2) The date a valid application was received by the qualified entity establishes the date of application for purposes of determining the effective date of Medicaid or HAWK-I eligibility unless the qualified entity received the application on a weekend or state holiday. Applications received by the

qualified entity on a weekend or a state holiday shall be considered to be received on the first business day following the weekend or state holiday.

(3) The qualified entity shall issue Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, to inform the applicant of the decision on the application as soon as possible but no later than within two working days after the date the determination is made.

(4) Timely and adequate notice requirements and appeal rights of the Medicaid program shall not apply to presumptive eligibility decisions made by a qualified entity.

c. Eligibility requirements. To be determined presumptively eligible for medical assistance, a child shall meet the following eligibility requirements.

(1) Age. The child must be under the age of 19.

(2) Household income. Household income must be less than 300 percent of the federal poverty level for a household of the same size. For this purpose, the household shall include the applicant child and any sibling (of whole or half blood, or adoptive), spouse, parent, or stepparent living with the applicant child. This determination shall be based on the household's gross income, with no deductions, diversions, or disregards.

(3) Citizenship or qualified alien status. The child must be a citizen of the United States or a qualified alien as defined in subrule 75.11(2).

(4) Iowa residency. The child must be a resident of Iowa.

(5) Prior presumptive eligibility. A child shall not be determined presumptively eligible more than once in a 12-month period. The first month of the 12-month period begins with the month the application is received by the qualified entity.

d. Period of presumptive eligibility. Presumptive eligibility shall begin with the date that presumptive eligibility is determined and shall continue until the earliest of the following dates:

(1) The last day of the next calendar month;

(2) The day the child is determined eligible for Medicaid;

(3) The last day of the month that the child is determined eligible for HAWK-I; or

(4) The day the child is determined ineligible for Medicaid and HAWK-I. Withdrawal of the Medicaid or HAWK-I application before eligibility is determined shall not affect the child's eligibility during the presumptive period.

e. Services covered. Children determined presumptively eligible under this subrule shall be entitled to all Medicaid-covered services, including early and periodic screening, diagnosis, and treatment (EPSDT) services. Payment of claims for Medicaid services provided to a child during the presumptive eligibility period, including EPSDT services, is not dependent upon a determination of Medicaid or HAWK-I eligibility by the department.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.6.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 7833B**, IAB 6/3/09, effective 8/1/09; **ARC 7929B**, IAB 7/1/09, effective 7/1/09; **ARC 7931B**, IAB 7/1/09, effective 7/1/09; **ARC 8095B**, IAB 9/9/09, effective 10/14/09; **ARC 8260B**, IAB 11/4/09, effective 1/1/10; **ARC 8261B**, IAB 11/4/09, effective 10/15/09; **ARC 8439B**, IAB 1/13/10, effective 3/1/10; **ARC 8503B**, IAB 2/10/10, effective 1/13/10; **ARC 8713B**, IAB 5/5/10, effective 8/1/10; **ARC 8897B**, IAB 6/30/10, effective 9/1/10; **ARC 9581B**, IAB 6/29/11, effective 8/3/11; **ARC 9647B**, IAB 8/10/11, effective 8/1/11]

441—75.2(249A) Medical resources. Medical resources include health and accident insurance, eligibility for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare), and other resources for meeting the cost of medical care which may be available to the member. These resources must be used when reasonably available.

75.2(1) The department shall approve payment only for those services or that part of the cost of a given service for which no medical resources exist unless pay and chase provisions as defined in rule 441—75.25(249A) are applicable.

a. Persons who have been approved by the Social Security Administration for Supplemental Security Income shall complete Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information, and return it to the department.

b. Persons eligible for Part B of the Medicare program shall make assignment to the department on Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information.

75.2(2) As a condition of eligibility for medical assistance, a person who has the legal capacity to execute an assignment shall do all of the following:

a. Assign to the department any rights to payments of medical care from any third party to the extent that payment has been made under the medical assistance program. The applicant's signature on any form listed in 441—subrule 76.1(1) shall constitute agreement to the assignment. The assignment shall be effective for the entire period for which medical assistance is paid.

b. Cooperate with the department in obtaining third-party payments. The member or one acting on the member's behalf shall:

(1) File a claim or submit an application for any reasonably available medical resource, and

(2) Cooperate in the processing of the claim or application.

c. Cooperate with the department in identifying and providing information to assist the department in pursuing any third party who may be liable to pay for medical care and services available under the medical assistance program.

75.2(3) Good cause for failure to cooperate in the filing or processing of a claim or application shall be considered to exist when the member, or one acting on behalf of a minor, or of a legally incompetent adult member, is physically or mentally incapable of cooperation. Good cause shall be considered to exist when cooperation is reasonably anticipated to result in:

a. Physical or emotional harm to the member for whom medical resources are being sought.

b. Physical or emotional harm to the parent or payee, acting on the behalf of a minor, or of a legally incompetent adult member, for whom medical resources are being sought.

75.2(4) Failure to cooperate as required in subrule 75.2(2) without good cause as defined in subrule 75.2(3) shall result in the termination of medical assistance benefits. The department shall make the determination of good cause based on information and evidence provided by the member or by one acting on the member's behalf.

a. The medical assistance benefits of a minor or a legally incompetent adult member shall not be terminated for failure to cooperate in reporting medical resources.

b. When a parent or payee acting on behalf of a minor or legally incompetent adult member fails to file a claim or application for reasonably available medical resources or fails to cooperate in the processing of a claim or application without good cause, the medical assistance benefits of the parent or payee shall be terminated.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5 and 249A.6.

[**ARC 7546B**, IAB 2/11/09, effective 4/1/09; **ARC 8503B**, IAB 2/10/10, effective 1/13/10; **ARC 8785B**, IAB 6/2/10, effective 8/1/10]

441—75.3(249A) Acceptance of other financial benefits. An applicant or member shall take all steps necessary to apply for and, if entitled, accept any income or resources for which the applicant or member may qualify, unless the applicant or member can show an incapacity to do so. Sources of benefits may be, but are not limited to, annuities, pensions, retirement or disability benefits, veterans' compensation and pensions, old-age, survivors, and disability insurance, railroad retirement benefits, black lung benefits, or unemployment compensation.

75.3(1) When it is determined that the supplemental security income (SSI)-related applicant or member may be entitled to other cash benefits, the department shall send a Notice Regarding Acceptance of Other Benefits, Form 470-0383, to the applicant or member.

75.3(2) The SSI-related applicant or member must express an intent to apply or refuse to apply for other benefits within ten calendar days from the date the notice is issued. A signed refusal to apply or failure to return the form shall result in denial of the application or cancellation of Medicaid unless the applicant or member is mentally or physically incapable of filing the claim for other cash benefits.

75.3(3) When the SSI-related applicant or member is physically or mentally incapable of filing the claim for other cash benefits, the department shall request the person acting on behalf of the member to pursue the potential benefits.

75.3(4) The SSI-related applicant or member shall cooperate in applying for the other benefits. Failure to timely secure the other benefits shall result in cancellation of Medicaid.

EXCEPTION: An applicant or member shall not be required to apply for supplementary security income to receive Medicaid under subrule 75.1(17).

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

441—75.4(249A) Medical assistance lien.

75.4(1) When the medical assistance program pays for a member's medical care or expenses, the department shall have a lien upon all monetary claims which the member may have against third parties for those expenses. Monetary claims shall include medical malpractice claims for injuries sustained on or after July 1, 2011. The lien shall be to the extent of the medical assistance payments only.

a. A lien is not effective unless the department files a notice of lien with the clerk of the district court in the county where the member resides and with the member's attorney when the member's eligibility for medical assistance is established. The notice of lien shall be filed before the third party has concluded a final settlement with the member, the member's attorney, or other representative.

b. The third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final.

(1) A compromise, including, but not limited to, notification, settlement, waiver or release of a claim, does not defeat the department's lien except pursuant to the written agreement of the director or the director's designee under which the department would receive less than full reimbursement of the amounts it expended.

(2) A settlement, award, or judgment structured in any manner not to include medical expenses or an action brought by a member or on behalf of a member which fails to state a claim for recovery of medical expenses does not defeat the department's lien if there is any recovery on the member's claim.

c. All notifications to the department required by law shall be directed to the Iowa Medicaid Enterprise, Revenue Collection Unit, P.O. Box 36475, Des Moines, Iowa 50315. Notification shall be considered made as of the time the notification is deposited so addressed, postage prepaid, in the United States Postal Service system.

75.4(2) The department may pursue its rights to recover either directly from any third party or from any recovery obtained by or on behalf of any member. If a member incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department has a lien under this section, upon the receipt of the judgment or settlement of the total claim, of which the lien for medical assistance payments is a part, the court costs and reasonable attorney fees shall first be deducted from this total judgment or settlement. One-third of the remaining balance shall then be deducted and paid to the member. From the remaining balance, the lien of the department shall be paid. Any amount remaining shall be paid to the member. An attorney acting on behalf of a member for the purpose of enforcing a claim to which the department has a lien shall not collect from the member any amount as attorney fees which is in excess of the amount which the attorney customarily would collect on claims not subject to this rule. The department will provide computer-generated documents or claim forms describing the services for which it has paid upon request of any affected member or the member's attorney. The documents may also be provided to a third party where necessary to establish the extent of the department's claim.

75.4(3) In those cases where appropriate notification is not given to the department or where the department's recovery rights are otherwise adversely affected by an action of the member or one acting on the member's behalf, medical assistance benefits shall be terminated. The medical assistance benefits of a minor child or a legally incompetent adult member shall not be terminated. Subsequent eligibility for medical assistance benefits shall be denied until an amount equal to the unrecovered claim has been reimbursed to the department or the individual produces documentation of incurred medical expense equal to the amount of the unrecovered claim. The incurred medical expense shall not be paid by the medical assistance program.

a. The client, or one acting on the client's behalf, shall provide information and verification as required to establish the availability of medical or third-party resources.

b. Rescinded IAB 9/4/91, effective 11/1/91.

c. The client or person acting on the client's behalf shall complete Form 470-2826, Supplemental Insurance Questionnaire, in a timely manner at the time of application, when any change in medical resources occurs during the application period, and when any changes in medical resources occur after the application is approved.

A report shall be considered timely when made within ten days from:

(1) The date that health insurance begins, changes, or ends.

(2) The date that eligibility begins for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare) and other resources.

(3) The date the client, or one acting on the client's behalf, files an insurance claim against an insured third party, for the payment of medical expenses that otherwise would be paid by Medicaid.

(4) The date the member, or one acting on the member's behalf, retains an attorney with the expectation of seeking restitution for injuries from a possibly liable third party, and the medical expenses resulting from those injuries would otherwise be paid by Medicaid.

(5) The date that the member, or one acting on the member's behalf, receives a partial or total settlement for the payment of medical expenses that would otherwise be paid by Medicaid.

The member may report the change in person, by telephone, by mail or by using the Ten-Day Report of Change, Form 470-0499 or 470-0499(S), which is mailed with the Family Investment Program warrants and is issued to the client when Medicaid applications are approved, when annual reviews are completed, when a completed Ten-Day Report of Change is submitted, and when the client requests a form.

d. The member, or one acting on the member's behalf, shall complete the Priority Leads Letter, Form 470-0398, when the department has reason to believe that the member has sustained an accident-related injury. Failure to cooperate in completing and returning this form, or in giving complete and accurate information, shall result in the termination of Medicaid benefits.

e. When the recovery rights of the department are adversely affected by the actions of a parent or payee acting on behalf of a minor or legally incompetent adult member, the Medicaid benefits of the parent or payee shall be terminated. When a parent or payee fails to cooperate in completing or returning the Priority Leads Letter, Form 470-0398, or the Supplemental Insurance Questionnaire, Form 470-2826, or fails to give complete and accurate information concerning the accident-related injuries of a minor or legally incompetent adult member, the department shall terminate the Medicaid benefits of the parent or payee.

f. The member, or one acting on the member's behalf, shall refund to the department from any settlement or payment received the amount of any medical expenses paid by Medicaid. Failure of the member to do so shall result in the termination of Medicaid benefits. In those instances where a parent or payee, acting on behalf of a minor or legally incompetent adult member, fails to refund a settlement overpayment to the department, the Medicaid benefits of the parent or payee shall be terminated.

75.4(4) Third party and provider responsibilities.

a. The health care services provider shall inform the department by appropriate notation on the Health Insurance Claim, Form CMS-1500, that other coverage exists but did not cover the service being billed or that payment was denied.

b. The health care services provider shall notify the department in writing by mailing copies of any billing information sent to a member, an attorney, an insurer or other third party after a claim has been submitted to or paid by the department.

c. An attorney representing an applicant for medical assistance or a past or present Medicaid member on a claim to which the department has filed a lien under this rule shall notify the department of the claim of which the attorney has actual knowledge, before filing a claim, commencing an action or negotiating a settlement offer. Actual knowledge shall include the notice to the attorney pursuant to subrule 75.4(1). The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the department at its state or local office location, is adequate legal notice of the claim.

75.4(5) Department's lien.

a. The department's liens are valid and binding on an attorney, insurer or other third party only upon notice by the department or unless the attorney, insurer or other third party has actual notice that the member is receiving medical assistance from the department and only to the extent that the attorney, insurer or third party has not made payment to the member or an assignee of the member prior to the notice.

Any information released to an attorney, insurer or other third party, by the health care services provider, that indicates that reimbursement from the state was contemplated or received, shall be construed as giving the attorney, insurer or other third party actual knowledge of the department's involvement. For example, information supplied by a health care services provider which indicates medical assistance involvement shall be construed as showing involvement by the department under Iowa Code section 249A.6. Payment of benefits by an insurer or third party pursuant to the rights of the lienholder in this rule discharges the attorney, insurer or other third party from liability to the member or the member's assignee to the extent of the payment to the department.

b. When the department has reason to believe that an attorney is representing a member on a claim to which the department filed a lien under this rule, the department shall issue notice to that attorney of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the attorney.

c. When the department has reason to believe that an insurer is liable for the costs of a member's medical expenses, the department shall issue notice to the insurer of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the insurer.

d. The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the attorney or insurer, is adequate legal notice of the department's subrogation rights.

75.4(6) For purposes of this rule, the term "third party" includes an attorney, individual, institution, corporation, or public or private agency which is or may be liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant for medical assistance or a past or present Medicaid member.

75.4(7) The department may enforce its lien by a civil action against any liable third party.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5, and 249A.6.

[**ARC 9696B**, IAB 9/7/11, effective 9/1/11; **ARC 9881B**, IAB 11/30/11, effective 1/4/12]

441—75.5(249A) Determination of countable income and resources for persons in a medical institution. In determining eligibility for any coverage group under rule 441—75.1(249A), certain factors must be considered differently for persons who reside in a medical institution. They are:

75.5(1) Determining income from property.

a. Nontrust property. Where there is nontrust property, unless the document providing income specifies differently, income paid in the name of one person shall be available only to that person. If payment of income is in the name of two persons, one-half is attributed to each. If payment is in the name of several persons, including a Medicaid client, a client's spouse, or both, the income shall be considered in proportion to the Medicaid client's or spouse's interest. If payment is made jointly to both spouses and no interest is specified, one-half of the couple's joint interest shall be considered available for each spouse. If the client or the client's spouse can establish different ownership by a preponderance of evidence, the income shall be divided in proportion to the ownership.

b. Trust property. Where there is trust property, the payment of income shall be considered available as provided in the trust. In the absence of specific provisions in the trust, the income shall be considered as stated above for nontrust property.

75.5(2) Division of income between married people for SSI-related coverage groups.

a. Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining eligibility for the institutionalized spouse.

b. Spouses institutionalized and living together. Partners in a marriage who are residing in the same room in a medical institution shall be treated as a couple until the first day of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple

for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together. When spouses are treated as a couple, the combined income of the couple shall not exceed twice the amount of the income limit established in subrule 75.1(7). Persons treated together as a couple for income must be treated together for resources and persons treated individually for income must be treated individually for resources.

Spouses residing in the same room in a medical institution may be treated as individuals effective the first day of the seventh calendar month. The income of each spouse shall not exceed the income limit established in subrule 75.1(7).

c. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. Their income shall be treated separately for eligibility. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together.

In the month of entry into a medical institution, income shall not exceed the amount of the income limit established in subrule 75.1(7).

75.5(3) Attribution of resources to institutionalized spouse and community spouse. The department shall determine the attribution of a couple's resources to the institutionalized spouse and to the community spouse when the institutionalized spouse is expected to remain in a medical institution at least 30 consecutive days on or after September 30, 1989, at the beginning of the first continuous period of institutionalization.

a. When determined. The department shall determine the attribution of resources between spouses at the earlier of the following:

(1) When either spouse requests that the department determine the attribution of resources at the beginning of the person's continuous stay in a medical facility prior to an application for Medicaid benefits. This request must be accompanied by Form 470-2577, Resources Upon Entering a Medical Facility, and necessary documentation.

(2) When the institutionalized spouse or someone acting on that person's behalf applies for Medicaid benefits. If the application is not made in the month of entry, the applicant shall also complete Form 470-2577 and provide necessary documentation.

b. Information required. The couple must provide the social security number of the community spouse. The attribution process shall include a match of the Internal Revenue Service data for both the institutionalized and community spouses.

c. Resources considered. The resources attributed shall include resources owned by both the community spouse and institutionalized spouse except for the following resources:

(1) The home in which the spouse or relatives as defined in 441—paragraph 41.22(3)*"a"* live (including the land that appertains to the home).

(2) Household goods, personal effects, and one automobile.

(3) The value of any burial spaces held for the purpose of providing a place for the burial of either spouse or any other member of the immediate family.

(4) Other property essential to the means of self-support of either spouse as to warrant its exclusion under the SSI program.

(5) Resources of a blind or disabled person who has a plan for achieving self-support as determined by division of vocational rehabilitation or the department of human services.

(6) For natives of Alaska, shares of stock held in a regional or a village corporation, during the period of 20 years in which the stock is inalienable, as provided in Section 7(h) and Section 8(c) of the Alaska Native Claims Settlement Act.

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act or other assistance provided pursuant to federal statute on account of a presidentially declared major disaster and interest

earned on these funds for the nine-month period beginning on the date these funds are received or for a longer period where good cause is shown.

(8) Any amount of underpayment of SSI or social security benefit due either spouse for one or more months prior to the month of receipt. This exclusion shall be limited to the first six months following receipt.

(9) A life insurance policy(ies) whose total face value is $1500 or less per spouse.

(10) An amount, not in excess of $1500 for each spouse that is separately identifiable and has been set aside to meet the burial and related expenses of that spouse. The amount of $1500 shall be reduced by an amount equal to the total face value of all insurance policies which are owned by the person or spouse and the total of any amounts in an irrevocable trust or other irrevocable arrangement available to meet the burial and related expenses of that spouse.

(11) Federal assistance paid for housing occupied by the spouse.

(12) Assistance from a fund established by a state to aid victims of crime for nine months from receipt when the client demonstrates that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.

(13) Relocation assistance provided by a state or local government to a client comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 which is subject to the treatment required by Section 216 of the Act.

d. Method of attribution. The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized spouse and the community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than $24,000, then $24,000 shall be protected for the community spouse. Also, when one-half of the resources attributed to the community spouse exceeds the maximum amount allowed as a community spouse resource allowance by Section 1924(f)(2)(A)(i) of the Social Security Act (42 U.S.C. § 1396r-5(f)(2)(A)(i)), the amount over the maximum shall be attributed to the institutionalized spouse. (The maximum limit is indexed annually according to the consumer price index.)

If the institutionalized spouse has transferred resources to the community spouse under a court order for the support of the community spouse, the amount transferred shall be the amount attributed to the community spouse if it exceeds the specified limits above.

e. Notice and appeal rights. The department shall provide each spouse a notice of the attribution results. The notice shall state that either spouse has a right to appeal the attribution if the spouse believes:

(1) That the attribution is incorrect, or

(2) That the amount of income generated by the resources attributed to the community spouse is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance.

If an attribution has not previously been appealed, either spouse may appeal the attribution upon the denial of an application for Medicaid benefits based on the attribution.

f. Appeals. Hearings on attribution decisions shall be governed by procedures in 441—Chapter 7. If the hearing establishes that the community spouse's resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance, there shall be substituted an amount adequate to provide the minimum monthly maintenance needs allowance.

(1) To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse. For an applicant who became an institutionalized spouse on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse pursuant to 75.16(2)*"d"* shall be treated as countable income of the community spouse when the attribution decision was made on or after February 8, 2006.

(2) The amount of resources adequate to provide the community spouse minimum maintenance needs allowance shall be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the monthly maintenance needs allowance and other countable income not generated by either spouse's countable resources.

(3) The resources necessary to provide the minimum maintenance needs allowance shall be based on the maintenance needs allowance as provided by these rules at the time of the filing of the appeal.

(4) To receive the substituted allowance, the applicant shall be required to obtain one estimate of the cost of the annuity.

(5) The estimated cost of an annuity shall be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the estimated cost of an annuity. If the amount of resources previously attributed for the community spouse is greater than the estimated cost of an annuity, there shall be no substitution for the cost of the annuity, and the attribution will remain as previously determined.

(6) The applicant shall not be required to purchase this annuity as a condition of Medicaid eligibility.

(7) If the appellant provides a statement from an insurance company that it will not provide an estimate due to the potential annuitant's age, the amount to be set aside shall be determined using the following calculation: The difference between the community spouse's gross monthly income not generated by countable resources (times 12) and the minimum monthly maintenance needs allowance (times 12) shall be multiplied by the annuity factor for the age of the community spouse in the Table for an Annuity for Life published at the end of Iowa Code chapter 450. This amount shall be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.5(3)*"f"*(5).

75.5(4) Consideration of resources of married people.

a. One spouse in a medical facility who entered the facility on or after September 30, 1989.

(1) Initial month. When the institutionalized spouse is expected to stay in a medical facility less than 30 consecutive days, the resources of both spouses shall be considered in determining initial Medicaid eligibility.

When the institutionalized spouse is expected to be in a medical facility 30 consecutive days or more, only the resources not attributed to the community spouse according to subrule 75.5(3) shall be considered in determining initial eligibility for the institutionalized spouse.

The amount of resources counted for eligibility for the institutionalized spouse shall be the difference between the couple's total resources at the time of application and the amount attributed to the community spouse under this rule.

(2) Ongoing eligibility. After the month in which the institutionalized spouse is determined eligible, no resources of the community spouse shall be deemed available to the institutionalized spouse during the continuous period in which the spouse is in an institution. Resources which are owned wholly or in part by the institutionalized spouse and which are not transferred to the community spouse shall be counted in determining ongoing eligibility. The resources of the institutionalized spouse shall not count for ongoing eligibility to the extent that the institutionalized spouse intends to transfer and does transfer the resources to the community spouse within 90 days unless unable to effect the transfer.

(3) Exception based on estrangement. When it is established by a disinterested third-party source that the institutionalized spouse is estranged from the community spouse, Medicaid eligibility will not be denied on the basis of resources when the applicant can demonstrate hardship.

The applicant can demonstrate hardship when the applicant is unable to obtain information about the community spouse's resources after exploring all legal means.

The applicant can also demonstrate hardship when resources attributed from the community spouse cause the applicant to be ineligible, but the applicant is unable to access these resources after exhausting legal means.

(4) Exception based on assignment of support rights. The institutionalized spouse shall not be ineligible by attribution of resources that are not actually available when:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse, or

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the state has the right to bring a support proceeding against a community spouse without an assignment.

b. One spouse in a medical institution prior to September 30, 1989. When one spouse is in the medical institution prior to September 30, 1989, only the resources of the institutionalized spouse shall count for eligibility according to SSI policies the month after the month of entry. In the month of entry, the resources of both spouses are countable toward the couple resource limit.

c. Spouses institutionalized and living together. The combined resources of both partners in a marriage who are residing in the same room in a medical institution shall be subject to the resource limit for a married couple until the first of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective with the seventh month if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together. Persons treated together as a couple for resources must be treated together for income and persons treated individually for resources must be treated individually for income. Effective the first of the seventh calendar month of continuous residence, they may be treated as individuals, with the resource limit for each spouse the limit for a single person.

d. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together.

In the month of entry into a medical institution, all resources of both spouses shall be combined and shall be subject to the resource limit for a married couple.

75.5(5) Consideration of resources for persons in a medical institution who have purchased and used a qualified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules in 191—Chapter 39 or 72.

a. Eligibility. A person may be eligible for medical assistance under this subrule if:

(1) The person is the beneficiary of a qualified long-term care insurance policy or is enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 39 or 72; and

(2) The person is eligible for medical assistance under 75.1(6), 75.1(7), or 75.1(18) except for excess resources; and

(3) The excess resources causing ineligibility under the listed coverage groups do not exceed the "asset adjustment" provided in this subrule.

b. Definition. "Asset adjustment" shall mean a $1 disregard of resources for each $1 that has been paid out under the person's qualified or approved long-term care insurance policy.

c. Estate recovery. An amount equal to the benefits paid out under a member's qualified or approved long-term care insurance policy will be exempt from recovery from the estate of the member or the member's spouse for payments made by the medical assistance program on behalf of the member.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4, and 249A.35and chapter 514H.

[**ARC 8443B**, IAB 1/13/10, effective 3/1/10]

441—75.6(249A) Entrance fee for continuing care retirement community or life care community. When an individual resides in a continuing care retirement community or life care community that collects an entrance fee on admission, the entrance fee paid shall be considered a resource available to the individual for purposes of determining the individual's Medicaid eligibility and the amount of benefits to the extent that:

1. The individual has the ability to use the entrance fee, or the contract between the individual and the community provides that the entrance fee may be used to pay for care should the individual's other resources or income be insufficient to pay for such care;

2. The individual is eligible for a refund of any remaining entrance fee when the individual dies or when the individual terminates the community contract and leaves the community; and

3. The entrance fee does not confer an ownership interest in the community.

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

441—75.7(249A) Furnishing of social security number. As a condition of eligibility, a person for whom Medicaid is being requested or received must furnish a social security account number or must furnish proof of application for the number if the social security number has not been issued or is not known and provide the number upon receipt. This requirement does not apply if the person refuses to obtain a social security number because of well-established religious objections. The term "well-established religious objections" means that the person is a member of a recognized religious sect or a division of a recognized religious sect and adheres to the tenets or teachings of the sect or division, and for that reason is conscientiously opposed to applying for or using a national identification number.

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

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

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

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

441—75.8(249A) Medical assistance corrective payments. If a decision by the department or the Social Security Administration following an appeal on a denied application for any of the categories of medical assistance eligibility set forth in rule 441—75.1(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular medical assistance coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

75.8(1) These bills must be for services covered by the medical assistance program as set forth in 441—Chapter 78.

75.8(2) Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

75.8(3) If a county relief agency has paid medical bills on the recipient's behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the recipient.

75.8(4) Recipients and county relief agencies shall file claims for payment under this subrule by submitting Form 470-2224, Verification of Paid Medical Bills, to the department. A supply of these forms is available from the county office. All requests for reimbursement shall be acted upon within 60 days of receipt of all Forms 470-2224 in the county office.

75.8(5) Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 7.

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

441—75.9(249A) Treatment of Medicaid qualifying trusts.

75.9(1) A Medicaid qualifying trust is a trust or similar legal device established, on or before August 10, 1993, other than by will by a person or that person's spouse under which the person may be the beneficiary of payments from the trust and the distribution of these payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person. Trusts or initial trust decrees established prior to April 7, 1986, solely for the benefit of a mentally retarded person who resides in an intermediate care facility for the mentally retarded, are exempt.

75.9(2) The amount of income and principal from a Medicaid qualifying trust that shall be considered available shall be the maximum amount that may be permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees for the distribution of the funds.

a. Trust income considered available shall be counted as income.

b. Trust principal (including accumulated income) considered available shall be counted as a resource, except where the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis. Where the trust limits the amount, the principal considered available over any particular period of time shall be counted as income for that period of time.

c. To the extent that the trust principal and income is available only for medical care, this principal or income shall not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it shall be used as a third party resource.

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

441—75.10(249A) Residency requirements. Residency in Iowa is a condition of eligibility for medical assistance.

75.10(1) *Definitions.*

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

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

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

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

a. Persons aged 21 and over.

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

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

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

1. That of the parent applying for Medicaid on the person's behalf, if the parents reside in separate states. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.
2. The parent's or legal guardian's state of residence at the time of placement. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.
3. The current state of residence of the parent or legal guardian who files the application if the person is institutionalized in the state. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.
4. The state of residence of the person who has been abandoned by the person's parents and does not have a legal guardian is the state in which the person is institutionalized.

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

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

b. Persons under age 21.

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

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

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

(4) For any person in an institution or foster home who is neither married nor emancipated, the state of residence is:

1. The parent's or legal guardian's state of residence at the time of placement. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.

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

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

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

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

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

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

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

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

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

441—75.11(249A) Citizenship or alienage requirements.

75.11(1) *Definitions.*

"Care and services necessary for the treatment of an emergency medical condition" means services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care for an emergency medical condition, provided the care and services are not related to an organ transplant procedure furnished on or after August 10, 1993. Payment for emergency medical services shall be limited to the day treatment is initiated for the emergency medical condition and the following two days.

"Emergency medical condition" means a medical condition of sudden onset (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

1. Placing the patient's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

"Federal means-tested program" means all federal programs that are means-tested with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.
2. Short-term, non-cash, in-kind emergency disaster relief.
3. Assistance or benefits under the National School Lunch Act.
4. Assistance or benefits under the Child Nutrition Act of 1966.
5. Public health assistance (not including any assistance under Title XIX of the Social Security Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.
6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Social Security Act for a parent or a child who would, in the absence of numbered paragraph "1," be eligible to have payments made on the child's behalf under such part, but only if the foster or adoptive parent (or parents) of the child is a qualified alien (as defined in Section 431).
7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general of the United States in the attorney general's sole and unreviewable discretion after consultation with appropriate federal agencies and departments, that:

- Deliver in-kind services at the community level, including through public or private nonprofit agencies;
- Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and
- Are necessary for the protection of life or safety.

8. Programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Services Act.
9. Means-tested programs under the Elementary and Secondary Education Act of 1965.
10. Benefits under the Head Start Act.
11. Benefits funded through an employment and training program of the U.S. Department of Labor.

"Qualified alien" means an alien:

1. Who is lawfully admitted for permanent residence in the United States under the Immigration and Nationality Act (INA);
2. Who is granted asylum in the United States under Section 208 of the INA;
3. Who is a refugee admitted to the United States under Section 207 of the INA;
4. Who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
5. Whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA as amended to December 20, 2010;
6. Who is granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;
7. Who is an Amerasian admitted to the United States as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V);
8. Who is a Cuban/Haitian entrant to the United States as described in 8 U.S.C. Section 1641(b)(7);
9. Who is a battered alien as described in 8 U.S.C. Section 1641(c);
10. Who is certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010;
11. Who is an American Indian born in Canada to whom Section 289 of the INA applies or is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e); or
12. Who is under the age of 21 and is lawfully residing in the United States as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii).

"Qualifying quarters" includes all of the qualifying quarters of coverage as defined under Title II of the Social Security Act worked by a parent of an alien while the alien was under age 18 and all of the qualifying quarters worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II

of the Social Security Act for any period beginning after December 31, 1996, may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

75.11(2) *Citizenship and alienage.*

a. To be eligible for Medicaid, a person must be one of the following:

(1) A citizen or national of the United States.

(2) A qualified alien residing in the United States before August 22, 1996.

(3) A qualified alien under the age of 21.

(4) A refugee admitted to the United States under Section 207 of the Immigration and Nationality Act (INA).

(5) An alien who has been granted asylum under Section 208 of the INA.

(6) An alien whose deportation is withheld under Section 243(h) or Section 241(b)(3) of the INA.

(7) A qualified alien veteran who has an honorable discharge that is not due to alienage.

(8) A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.

(9) A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in subparagraph (7) or (8), including a surviving spouse who has not remarried.

(10) A qualified alien who has resided in the United States for a period of at least five years.

(11) An Amerasian admitted as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V).

(12) A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7).

(13) A certified victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.

(14) An American Indian born in Canada to whom Section 289 of the INA applies or who is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e).

(15) An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to December 20, 2010, or to Section 602(b)(8) of Public Law 111-8 as amended to December 20, 2010.

b. As a condition of eligibility, each member shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the member's citizenship or alien status. When the member is incompetent or deceased, the form shall be signed by someone acting responsibly on the member's behalf. An adult shall sign the form for dependent children.

(1) As a condition of eligibility, all applicants for Medicaid shall attest to their citizenship or alien status by signing the application form which contains the same declaration.

(2) As a condition of continued eligibility, SSI-related Medicaid members not actually receiving SSI who have been continuous members since August 1, 1988, shall attest to their citizenship or alien status by signing the application form which contains a similar declaration at time of review.

(3) An attestation of citizenship or alien status completed on any one of the following forms shall meet the requirements of subrule 75.11(2) for children under the age of 19 who are otherwise eligible pursuant to 441—subrule 76.1(8):

1. Application for Food Assistance, Form 470-0306 or 470-0307 (Spanish);
2. Health and Financial Support Application, Form 470-0462 or 470-0462(S); or
3. Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS).

c. Except as provided in paragraph *"f,"* applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph *"b"* shall present satisfactory documentation of citizenship or nationality as defined in paragraph *"d," "e,"* or *"i."* A reference to a form in paragraph *"d"* or *"e"* includes any successor form. An applicant or member shall have a reasonable period to obtain and provide required documentation of citizenship or nationality.

(1) For the purposes of this requirement, the "reasonable period" begins on the date a written request for documentation or a notice pursuant to subparagraph 75.11(2)*"i"*(2) is issued to an applicant or member, whichever is later, and continues for 90 days.

(2) Medicaid shall be approved for new applicants and continue for members not previously required to provide documentation of citizenship or nationality until the end of the reasonable period to obtain and provide required documentation of citizenship or nationality. However, the receipt of Medicaid or HAWK-I benefits pending documentation of citizenship or nationality is limited to one reasonable period of up to 90 days under either program for each individual. An applicant or member who has already received benefits during any portion of a reasonable period shall not be granted coverage for a second reasonable period except as required to protect the confidentiality of an individual who received only limited Medicaid benefits provided pursuant to subrule 75.1(41) during the first period.

(3) Retroactive eligibility pursuant to 441—subrule 76.5(1) is available only after documentation of citizenship or nationality has been provided pursuant to paragraph *"d," "e,"* or *"i."* The retroactive months are outside the "reasonable period" during which Medicaid coverage may be provided without required documentation of citizenship or nationality.

d. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A United States passport.

(2) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(3) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(4) A valid state-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or

2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Documentation issued by a federally recognized Indian Tribe showing membership or enrollment in or affiliation with that Tribe.

(6) Another document that provides proof of United States citizenship or nationality and provides a reliable means of documentation of personal identity, as the Secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v).

e. Satisfactory documentation of citizenship or nationality may also be demonstrated by the combination of:

(1) Any identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act or any other documentation of personal identity that provides a reliable means of identification, as the secretary of the U.S. Department of Health and Human Services finds by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(D)(ii), and

(2) Any one of the following:

1. A certificate of birth in the United States.

2. Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

3. Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

4. Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

5. Another document that provides proof of United States citizenship or nationality, as the secretary of the U.S. Department of Health and Human Services may specify pursuant to 42 U.S.C. Section 1396b(x)(3)(C)(v).

f. A person for whom an attestation of United States citizenship has been made pursuant to paragraph *"b"* is not required to present documentation of citizenship or nationality for Medicaid eligibility if any of the following circumstances apply:

(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the federal Social Security Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the federal Social Security Act, Section 223 or 202, based on disability (as defined in Section 223(d)).

(3) The person is receiving supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act.

(4) The person is a child in foster care who is assisted by child welfare services funded under Part B of Title IV of the federal Social Security Act.

(5) The person is receiving foster care maintenance or adoption assistance payments funded under Part E of Title IV of the federal Social Security Act.

(6) The person has previously presented satisfactory documentary evidence of citizenship or nationality, as specified by the United States Secretary of Health and Human Services.

(7) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1396a(e)(4) as the newborn of a Medicaid-eligible mother.

(8) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1397ll(e) as the newborn of a mother eligible for assistance under a State Children's Health Insurance Program (SCHIP) pursuant to Title XXI of the Social Security Act.

g. If no other identity documentation allowed by subparagraph 75.11(2)*"e"*(1) is available, identity may be documented by affidavit as described in this paragraph. However, affidavits cannot be used to document both identity and citizenship.

(1) For children under the age of 16, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by the child's parent, guardian, or caretaker relative under penalty of perjury.

(2) For disabled persons who live in a residential care facility, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by a residential care facility director or administrator under penalty of perjury.

h. If no other documentation that provides proof of United States citizenship or nationality allowed by subparagraph 75.11(2)*"e"*(2) is available, United States citizenship or nationality may be documented using Form 470-4373 or 470-4373(S), Affidavit of Citizenship. However, affidavits cannot be used to document both identity and citizenship.

(1) Two affidavits of citizenship are required. The person who signs the affidavit must provide proof of citizenship and identity. A person who is not related to the applicant or member must sign at least one of the affidavits.

(2) When affidavits of citizenship are used, Form 470-4374 or 470-4374(S), Affidavit Concerning Documentation of Citizenship, or an equivalent affidavit explaining why other evidence of citizenship does not exist or cannot be obtained must also be submitted and must be signed by the applicant or member or by another knowledgeable person (guardian or representative).

i. In lieu of a document listed in paragraph *"d"* or *"e,"* satisfactory documentation of citizenship or nationality may also be presented pursuant to this paragraph.

(1) Provision of an individual's name, social security number, and date of birth to the department shall constitute satisfactory documentation of citizenship and identity if submission of the name, social security number, and date of birth to the Social Security Administration produces a response that substantiates the individual's citizenship.

(2) If submission of the name, social security number, and date of birth to the Social Security Administration does not produce a response that substantiates the individual's citizenship, the department shall issue a written notice to the applicant or member giving the applicant or member 90 days to correct any errors in the name, social security number, or date of birth submitted, to correct any errors in the Social Security Administration's records, or to provide other documentation of citizenship or nationality pursuant to paragraph *"d"* or *"e."*

75.11(3) *Deeming of sponsor's income and resources.*

a. When an alien admitted for lawful permanent residence is sponsored by a person who executed an affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the income

and resources of the alien shall be deemed to include the income and resources of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount deemed to the sponsored alien shall be the total gross countable income and resources of the sponsor and the sponsor's spouse for the FMAP-related or SSI-related coverage group applicable to the sponsored alien's household as described in 441—75.13(249A) less the following deductions:

(1) For FMAP-related coverage groups: The same income deductions, diversions, and disregards allowed for stepparent cases as described at 75.57(8)*"b"* and a $1,500 resource deduction.

(2) For SSI-related coverage groups: The deductions described at 20 CFR 416.1166a and 416.1204, as amended to April 1, 2010.

b. An indigent alien is exempt from the deeming of a sponsor's income and resources for 12 months after indigence is determined. An alien shall be considered indigent if the following are true:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income actually received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's income and resources for 12 months.

d. Deeming of the sponsor's income and resources does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title II of the Immigration and Nationality Act.

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined at subrule 75.11(1).

(3) The sponsored alien or the sponsor dies.

(4) The sponsored alien is a child under age 21.

(5) For SSI-related Medicaid, the sponsored alien becomes blind or disabled as defined under Title XVI of the Social Security Act after admission to the United States as a lawful permanent resident.

(6) For SSI-related Medicaid, three years after the date the sponsored alien was admitted to the United States as a lawful permanent resident.

75.11(4) *Eligibility for payment of emergency medical services.* Aliens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their alien status are eligible to receive Medicaid for care and services necessary for the treatment of an emergency medical condition as defined in subrule 75.11(1). To qualify for payment under this provision:

a. The alien must meet all other eligibility criteria, including state residence requirements provided at rules 441—75.10(249A) and 441—75.53(249A), with the exception of rule 441—75.7(249A) and subrules 75.11(2) and 75.11(3).

b. The medical provider who treated the emergency medical condition or the provider's designee must submit verification of the existence of the emergency medical condition on either:

(1) Form 470-4299, Verification of Emergency Health Care Services; or

(2) A signed statement that contains the same information as requested by Form 470-4299.

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

[**ARC 7932B**, IAB 7/1/09, effective 7/1/09; **ARC 8096B**, IAB 9/9/09, effective 10/14/09; **ARC 8642B**, IAB 4/7/10, effective 6/1/10; **ARC 8786B**, IAB 6/2/10, effective 6/1/10; **ARC 9439B**, IAB 4/6/11, effective 6/1/11]

441—75.12(249A) Inmates of public institutions. A person is not eligible for medical assistance for any care or services received while the person is an inmate of a public institution. For the purpose of this rule, the phrase "inmate of a public institution" is defined by 42 CFR Section 435.1009, as amended on November 10, 1994.

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

441—75.13(249A) Categorical relatedness.

75.13(1) *FMAP-related Medicaid eligibility.* Medicaid eligibility for persons who are under the age of 21, pregnant women, or specified relatives of dependent children who are not blind or disabled shall be determined using the income criteria in effect for the family medical assistance program (FMAP) as provided in subrule 75.1(14) unless otherwise specified. Income shall be considered prospectively.

75.13(2) *SSI-related Medicaid.* Except as otherwise provided in 441—Chapters 75 and 76, persons who are 65 years of age or older, blind, or disabled are eligible for Medicaid only if eligible for the Supplemental Security Income (SSI) program administered by the United States Social Security Administration.

a. SSI policy reference. The statutes, regulations, and policy governing eligibility for SSI are found in Title XVI of the Social Security Act (42 U.S.C. Sections 1381 to 1383f), in the federal regulations promulgated pursuant to Title XVI (20 CFR 416.101 to 416.2227), and in Part 5 of the Program Operations Manual System published by the United States Social Security Administration. The Program Operations Manual System is available at Social Security Administration offices in Ames, Burlington, Carroll, Cedar Rapids, Clinton, Council Bluffs, Creston, Davenport, Decorah, Des Moines, Dubuque, Fort Dodge, Iowa City, Marshalltown, Mason City, Oskaloosa, Ottumwa, Sioux City, Spencer, Storm Lake, and Waterloo, or through the Department of Human Services, Division of Financial, Health, and Work Supports, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

b. Income considered. For SSI-related Medicaid eligibility purposes, income shall be considered prospectively.

c. Trust contributions. Income that a person contributes to a trust as specified at 75.24(3)*"b"* shall not be considered for purposes of determining eligibility for SSI-related Medicaid.

d. Conditional eligibility. For purposes of determining eligibility for SSI-related Medicaid, the SSI conditional eligibility process, by which a client may receive SSI benefits while attempting to sell excess resources, found at 20 CFR 416.1240 to 416.1245, is not considered an eligibility methodology.

e. Valuation of life estates and remainder interests. In the absence of other evidence, the value of a life estate or remainder interest in property shall be determined using the following table by multiplying the fair market value of the entire underlying property (including all life estates and all remainder interests) by the life estate or remainder interest decimal corresponding to the age of the life estate holder or other person whose life controls the life estate.

If a Medicaid applicant or recipient disputes the value determined using the following table, the applicant or recipient may submit other evidence and the value of the life estate or remainder interest shall be determined based on the preponderance of all the evidence submitted to or obtained by the department, including the value given by the following table.

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.51441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43569	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

75.13(3) *Resource eligibility for SSI-related Medicaid for children.* Resources of all household members shall be disregarded when determining eligibility for children under any SSI-related coverage group except for those groups at subrules 75.1(3), 75.1(4), 75.1(6), 75.1(9), 75.1(10), 75.1(12), 75.1(13), 75.1(23), 75.1(25), 75.1(29), 75.1(33), 75.1(34), 75.1(36), 75.1(37), and 75.1(38).

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

441—75.14(249A) Establishing paternity and obtaining support.

75.14(1) As a condition of eligibility, adult Medicaid applicants and members in households with an absent parent shall cooperate in obtaining medical support for themselves and for any other person in the household for whom Medicaid is requested and for whom the applicant or member can legally assign rights for medical support, except when the applicant or member has good cause for refusal to cooperate as defined in subrule 75.14(8).

a. The adult applicant or member shall cooperate in the following:

(1) Identifying and locating the parent of the child for whom Medicaid is requested.

(2) Establishing the paternity of a child born out of wedlock for whom Medicaid is requested.

(3) Obtaining medical support and payments for medical care for the applicant or member and for a child for whom Medicaid is requested.

(4) Rescinded IAB 2/3/93, effective 4/1/93.

b. Cooperation is defined as including the following actions by the adult applicant or member upon request:

(1) Appearing at the income maintenance unit or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the applicant or member that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

c. Upon request, the adult applicant or member shall cooperate with the department in supplying information with respect to the absent parent, the receipt of medical support or payments for medical

care, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. Upon request, the adult applicant or member shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure medical support and payments for medical care or to establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. The child support recovery unit shall make the determination of whether or not the adult applicant or member has cooperated for the purposes of this rule.

75.14(2) Failure of an adult applicant or member to cooperate shall result in denial or cancellation of the noncooperating adult's Medicaid benefits. In family medical assistance program (FMAP)-related Medicaid cases, all deductions and disregards described at paragraphs 75.57(2)*"a," "b,"* and *"c"* shall be allowed when otherwise applicable.

75.14(3) Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(8) to 75.14(12) shall be used when making a determination of the existence of good cause.

75.14(4) Each Medicaid applicant or member shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the applicant's or member's own behalf or on behalf of any other family member for whom the applicant or member is applying. An assignment is effective the same date the eligibility information is entered into the automated benefit calculation system and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support shall not be assigned to the department.

75.14(5) Rescinded IAB 6/2/10, effective 8/1/10.

75.14(6) Pregnant women establishing eligibility under the mothers and children (MAC) coverage group as provided at subrule 75.1(28) shall be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.1(24) shall not be subject to the provisions in this rule until after the end of the month in which the 60-day postpartum period expires. Pregnant women establishing eligibility under any other coverage groups except those set forth in subrule 75.1(24) or 75.1(28) shall be subject to the provisions in this rule when establishing eligibility for born children. However, when a pregnant woman who is subject to these provisions fails to cooperate, the woman shall lose eligibility under her current coverage group and her eligibility for Medicaid shall be automatically redetermined under subrule 75.1(28).

75.14(7) Notwithstanding subrule 75.14(6), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.1(28) or 75.1(24) shall not be exempt from the provisions of 75.14(4) that require an adult applicant or member to assign any rights to medical support and payments for medical care.

75.14(8) Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The income maintenance unit shall determine that cooperation is against the child's best interest when the applicant's or member's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

(1) Physical or emotional harm to the child for whom support is to be sought; or

(2) Physical or emotional harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately.

(3) Physical harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately; or

(4) Emotional harm to the parent or specified relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

b. The income maintenance unit shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the income maintenance unit believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

(1) The child was conceived as the result of incest or forcible rape.

(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.

(3) The applicant or member is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the specified relative, the following shall be considered:

(1) The present emotional state of the individual subject to emotional harm.

(2) The emotional health history of the individual subject to emotional harm.

(3) Intensity and probable duration of the emotional impairment.

(4) The degree of cooperation required.

(5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

75.14(9) Claiming good cause. Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the department shall notify the applicant or member using Form 470-0169 or 470-0169(S), Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

(1) Advise the applicant or member of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or member that by law cooperation in establishing paternity and securing support is a condition of eligibility for the Medicaid program.

(3) Advise the applicant or member of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the applicant or member that good cause for refusal to cooperate may be claimed and that if the income maintenance unit determines, in accordance with these rules, that there is good cause, the applicant or member will be excused from the cooperation requirement.

(5) Advise the applicant or member that upon request, or following a claim of good cause, the income maintenance unit will provide further notice with additional details concerning good cause.

c. When the applicant or member makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or member shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

(1) Indicates that the applicant or member must provide corroborative evidence of good cause circumstance and must, when requested, furnish sufficient information to permit the county office to investigate the circumstances.

(2) Informs the applicant or member that, upon request, the income maintenance unit will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or member that on the basis of the corroborative evidence supplied and the agency's investigation when necessary, the income maintenance unit shall determine whether cooperation would be against the best interests of the child for whom support would be sought.

(4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or member that the child support recovery unit may review the income maintenance unit's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or member that the child support recovery unit may attempt to establish paternity and collect support in those cases where the income maintenance unit determines that this can be done without risk to the applicant or member if done without the applicant's or member's participation.

d. The applicant or member who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the income maintenance unit to determine that good cause does not exist. The applicant or member shall:

(1) Specify the circumstances that the applicant or member believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

75.14(10) Determination of good cause. The income maintenance unit shall determine whether good cause exists for each Medicaid applicant or member who claims to have good cause.

a. The income maintenance unit shall notify the applicant or member of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the income maintenance unit's findings and basis for determination.

(3) Be entered in the case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The income maintenance unit may exceed this time standard only when:

(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).

c. When the income maintenance unit determines that good cause does not exist:

(1) The applicant or member shall be so notified and be afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

d. The income maintenance unit shall make a good cause determination based on the corroborative evidence supplied by the applicant or member only after the income maintenance unit has examined the evidence and found that it actually verifies the good cause claim.

e. Before making a final determination of good cause for refusing to cooperate, the income maintenance unit shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or member's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or member has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The income maintenance unit shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

75.14(11) Proof of good cause. The applicant or member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or member requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence:

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or specified relative.

(4) Medical records which indicate emotional health history and present emotional health status of the specified relative or the children for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the specified relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or member is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or member with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or member, the income maintenance unit wishes to request additional corroborative evidence which is needed to permit a good cause determination, the income maintenance unit shall:

(1) Promptly notify the applicant or member that additional corroborative evidence is needed, and

(2) Specify the type of document which is needed.

c. When the applicant or member requests assistance in securing evidence, the income maintenance unit shall:

(1) Advise the applicant or member how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents which the applicant or member is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or member's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The income maintenance unit shall investigate the good cause claim when the office believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause shall be found when the claimant's statement and investigation which is conducted satisfies the county office that the applicant or member has good cause for refusing to cooperate.

(3) A determination that good cause exists shall be reviewed and approved or disapproved by the worker's immediate supervisor and the findings shall be recorded in the case record.

e. The income maintenance unit may further verify the good cause claim when the applicant's or member's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the income maintenance unit shall:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Before making the necessary contact, notify the applicant or member so the applicant or member may present additional corroborative evidence or information so that contact with the parent or putative

father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(12) Enforcement without specified relative's cooperation. When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or specified relative when the enforcement or collection activities do not involve their participation.

a. The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the income maintenance unit shall consider any recommendations from the child support recovery unit.

b. The determination shall be in writing, contain the income maintenance unit's findings and basis for the determination, and be entered into the case record.

c. When the income maintenance unit excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, the income maintenance unit shall notify the applicant or member to enable the individual to withdraw the application for assistance or have the case closed.

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

[**ARC 8785B**, IAB 6/2/10, effective 8/1/10]

441—75.15(249A) Disqualification for long-term care assistance due to substantial home equity. Notwithstanding any other provision of this chapter, if an individual's equity interest in the individual's home exceeds $500,000, the individual shall not be eligible for medical assistance with respect to nursing facility services or other long-term care services except as provided in 75.15(2). This provision is effective for all applications or requests for payment of long-term care services filed on or after January 1, 2006.

75.15(1) The limit on the equity interest in the individual's home for purposes of this rule shall be increased from year to year, beginning with 2011, based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

75.15(2) Disqualification based on equity interest in the individual's home shall not apply when one of the following persons is lawfully residing in the home:

a. The individual's spouse; or

b. The individual's child who is under age 21 or is blind or disabled as defined in Section 1614 of the federal Social Security Act.

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

441—75.16(249A) Client participation in payment for medical institution care. Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

75.16(1) *Income considered in determining client participation.* The department determines the amount of client participation based on the client's total monthly income, with the following exceptions:

a. FMAP-related clients. The income of a client and family whose eligibility is FMAP-related is not available for client participation when both of the following conditions exist:

(1) The client has a parent or child at home.

(2) The family's income is considered together in determining eligibility.

b. SSI-related clients who are employed. If a client receives SSI and is substantially gainfully employed, as determined by the Social Security Administration, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.

c. SSI-related clients returning home within three months. If the Social Security Administration continues a client's SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments shall be exempt from client participation.

d. Married couples.

(1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage shall be based on one-half of the couple's combined income when the partners are considered together for eligibility. Client participation for each partner who is considered individually for eligibility shall be determined individually from each person's income.

(3) Rescinded, IAB 7/11/90, effective 7/1/90.

e. State supplementary assistance recipients. The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client's entry to a medical institution.

f. Foster care recipients. The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.

g. Clients receiving a VA pension. The amount of $90 of veteran's pension income shall be exempt from client participation if the client is a veteran or a surviving spouse of a veteran who:

(1) Receives a reduced pension pursuant to 38 U.S.C. Section 5503(d)(2), or

(2) Resides at the Iowa Veterans Home and does not have a spouse or minor child.

75.16(2) *Allowable deductions from income.* In determining the amount of client participation, the department allows the following deductions from the client's income, taken in the order they appear:

a. Ongoing personal needs allowance. All clients shall retain $50 of their monthly income for a personal needs allowance. (See rules 441—81.23(249A), 441—82.19(249A), and 441—85.47(249A) regarding potential state-funded personal needs supplements.)

(1) If the client has a trust described in Section 1917(d)(4) of the Social Security Act (including medical assistance income trusts and special needs trusts), a reasonable amount paid or set aside for necessary expenses of the trust is added to the personal needs allowance. This amount shall not exceed $10 per month except with court approval.

(2) If the client has earned income, an additional $65 is added to the ongoing personal needs allowance from the earned income only.

(3) Rescinded IAB 7/4/07, effective 7/1/07.

b. Personal needs in the month of entry.

(1) Single person. A single person shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.

(2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.

(3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility shall each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance shall be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses shall be given to them during the month of entry up to the SSI benefit for a married couple.

(4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse shall be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.

c. Personal needs in the month of discharge. The client shall be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction shall be the SSI benefit for one person (or for a couple, if both members are discharged in the same month). This deduction does not apply when a spouse is at home.

d. Maintenance needs of spouse and other dependents.

(1) Persons covered. An ongoing allowance shall be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is

made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance shall also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents shall be considered in determining maintenance needs. The gross income of the spouse and dependent shall include all monthly earned and unearned income and assistance from the family investment program (FIP), supplemental security income (SSI), and state supplementary assistance (SSA). It shall also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income shall be considered as the SSI program considers income. In addition, the spouse and dependents shall be required to apply for every income benefit for which they are eligible except that they shall not be required to accept SSI, FIP or SSA in lieu of the maintenance needs allowance. Failure to apply for all benefits shall mean reduction of the maintenance needs allowance by the amount of the anticipated income from the source not applied for.

(3) Needs of spouse. The maintenance needs of the spouse shall be determined by subtracting the spouse's gross income from the maximum amount allowed as a minimum monthly maintenance needs allowance for the community spouse by Section 1924(d)(3)(C) of the Social Security Act (42 U.S.C. § 1396r-5(d)(3)(C)). (This amount is indexed for inflation annually according to the consumer price index.)

However, if either spouse has established through the appeal process that the community spouse needs income above the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary shall be substituted.

Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance shall not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents shall be established by subtracting each person's gross income from 133 percent of the monthly federal poverty level for a family of two and dividing the result by three. (Effective July 1, 1992, the percent shall be 150 percent.)

e. Maintenance needs of children (without spouse). When the client has children under 21 at home, an ongoing allowance shall be given to meet the children's maintenance needs.

The income of the children is considered in determining maintenance needs. The children's countable income shall be their gross income less the disregards allowed in the FIP program.

The children's maintenance needs shall be determined by subtracting the children's countable income from the FIP payment standard for that number of children. (However, if the children receive FIP, no deduction is allowed for their maintenance needs.)

f. Client's medical expenses. A deduction shall be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party and were not incurred for long-term care services during the imposition of a transfer of assets penalty period pursuant to rule 441—75.23(249A). This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

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

[**ARC 8444B**, IAB 1/13/10, effective 3/1/10]

441—75.17(249A) Verification of pregnancy. For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, the applicant's self-declaration of the pregnancy and the date of conception shall serve as verification of pregnancy, unless questionable.

75.17(1) *Multiple pregnancy.* If the pregnant woman claims to be carrying more than one fetus, a medical professional who has examined the woman must verify the number of fetuses in order for more than one to be considered in the household size.

75.17(2) *Cost of examination.* When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

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

441—75.18(249A) Continuous eligibility for pregnant women. A pregnant woman who applies for Medicaid prior to the end of her pregnancy and subsequently establishes initial Medicaid eligibility under the provisions of this chapter shall remain continuously eligible throughout the pregnancy and the 60-day postpartum period, as provided in subrule 75.1(24), regardless of any changes in family income.

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

441—75.19(249A) Continuous eligibility for children. A child under the age of 19 who is determined eligible for ongoing Medicaid shall retain that eligibility for up to 12 months regardless of changes in family circumstances except as described in this rule.

75.19(1) *Exceptions to coverage.* This rule does not apply to the following children:

a. Children whose eligibility was determined under the newborn coverage group described at subrule 75.1(20).

b. Children whose eligibility was determined under the medically needy coverage group described at subrule 75.1(35).

c. Children whose medical assistance is state-funded only.

d. Children who are eligible only in a retroactive month.

e. Children whose citizenship is not verified within the "reasonable period" described at paragraph 75.11(2)*"c."*

75.19(2) *Duration of coverage.* Coverage under this rule shall extend through the earliest of the following months:

a. The month of the household's annual eligibility review;

b. The month when the child reaches the age of 19; or

c. The month when the child moves out of Iowa.

75.19(3) *Assignment of review date.* Children entering an existing Medicaid household shall be assigned the same annual eligibility review date as that established for the household.

This rule is intended to implement Iowa Code Supplement section 249A.3 as amended by 2008 Iowa Acts, House File 2539.

[**ARC 8786B**, IAB 6/2/10, effective 6/1/10]

441—75.20(249A) Disability requirements for SSI-related Medicaid.

75.20(1) *Applicants receiving federal benefits.* An applicant receiving supplemental security income on the basis of disability, social security disability benefits under Title II of the Social Security Act, or railroad retirement benefits based on the Social Security law definition of disability by the Railroad Retirement Board, shall be deemed disabled without further determination of disability.

75.20(2) *Applicants not receiving federal benefits.* When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the Social Security Administration, the department shall determine eligibility for SSI-related Medicaid based on disability as follows:

a. A Social Security Administration (SSA) disability determination under either a social security disability (Title II) application or a supplemental security income application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

(1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.

(3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements, and:

1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or

2. The applicant no longer meets the nondisability requirements for SSI but may meet the department's nondisability requirements for Medicaid eligibility.

b. When there is no binding SSA decision and the department is required to establish eligibility for SSI-related Medicaid based on disability, initial determinations shall be made by disability determination services, a bureau of the Iowa department of education under the division of vocational rehabilitation services. The applicant or the applicant's authorized representative shall complete and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

(1) Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or

(2) Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

c. When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department shall stay a decision on disability pending the SSA decision on disability.

75.20(3) *Time frames for decisions.* Determination of eligibility based on disability shall be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action, or there is an administrative or other emergency beyond the department's or applicant's control.

75.20(4) *Reviews of disability.* In connection with any independent determination of disability, the department will determine whether reexamination of the member's disability will be required for periodic eligibility reviews. When a disability review is required, the member or the member's authorized representative shall complete and submit the same forms as required in paragraph 75.20(2)*"b."*

75.20(5) *Members whose disability was determined by the department.* When a Medicaid member has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the member shall continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid shall be canceled with timely notice. If there is an appeal within 65 days, the member shall continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

75.20(6) *Disability redeterminations for members who attain age 18.* If a member is eligible based on an independent determination of disability made under the standards applicable to persons under 18 years of age, the department shall redetermine the member's disability after the member attains the age of 18 years. The member's disability shall be redetermined:

a. Using the standards applicable to persons who are 18 years of age or older, and

b. Regardless of whether a review of the member's disability would otherwise be due.

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

[**ARC 9044B**, IAB 9/8/10, effective 11/1/10]

441—75.21(249A) Health insurance premium payment (HIPP) program. Under the health insurance premium payment program, the department shall pay for the cost of premiums, coinsurance and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care through Medicaid. Payment shall include only the cost to the Medicaid member or household.

75.21(1) *Condition of eligibility for group plans.* The Medicaid member or a person acting on the member's behalf shall cooperate in providing information necessary for the department to establish availability and the cost-effectiveness of a group health plan. When the department has determined that a group health plan is cost-effective, enrollment in the plan is a condition of Medicaid eligibility unless it can be established that insurance is being maintained on the Medicaid members through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

a. When a parent fails to provide information necessary to determine availability and cost-effectiveness of a group health plan, fails to enroll in a group health plan that has been determined

cost-effective, or disenrolls from a group health plan that has been determined cost-effective, Medicaid benefits of the parent shall be terminated unless good cause for failure to cooperate is established.

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

(1) There was a serious illness or death of the parent or a member of the parent's family.

(2) There was a family emergency or household disaster, such as a fire, flood, or tornado.

(3) The parent offers a good cause beyond the parent's control.

(4) There was a failure to receive the department's request for information or notification for a reason not attributable to the parent. Lack of a forwarding address is attributable to the parent.

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

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

75.21(2) *Individual health plans.* Participation in an individual health plan is not a condition of Medicaid eligibility. The department shall pay for the cost of premiums, coinsurance, and deductibles of individual health insurance plans for a Medicaid member if:

a. A household member is currently enrolled in the plan; and

b. The health plan is cost-effective as defined in subrule 75.21(3).

75.21(3) *Cost-effectiveness.* Cost-effectiveness for both group and individual health plans shall mean the expenditures in Medicaid payments for a set of services are likely to be greater than the cost of paying the premiums and cost-sharing obligations under the health plan for those services. When determining the cost-effectiveness of the health plan, the following data shall be considered:

a. The cost to the Medicaid member or household of the insurance premium, coinsurance, and deductibles. No cost paid by an employer or other plan sponsor shall be considered in the cost-effectiveness determination.

b. The scope of services covered under the health plan, including but not limited to exclusions for preexisting conditions.

c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for members covered under the health plan.

d. The specific health-related circumstances of the members covered under the health plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. When the information indicates any health conditions that could be expected to result in higher than average bills for any Medicaid member:

(1) If the member is currently covered by the health plan, the department shall obtain from the insurance company a summary of the member's paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the plan. The cost of providing the health insurance is compared to the actual claims to determine the cost-effectiveness of providing the coverage.

(2) If the member was not covered by the health plan in the previous 12 months, paid Medicaid claims may be used to project the cost-effectiveness of the plan.

e. Annual administrative expenditures of $50 per Medicaid member covered under the health plan.

f. Whether the estimated savings to Medicaid for members covered under the health insurance plan are at least $5 per month per household.

75.21(4) *Coverage of non-Medicaid-eligible family members.*

a. When a group health plan is determined to be cost-effective, the department shall pay for health insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the health plan in order to obtain coverage for the Medicaid-eligible family members. However:

(1) The needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness, and

(2) Payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

b. When an individual health plan is determined cost-effective, the department shall pay for the portion of the premium necessary to cover the Medicaid-eligible family members. If the portion of the premium to cover the Medicaid-eligible family members cannot be established, the department shall pay the entire premium. The family members who are not Medicaid-eligible shall not be considered when determining cost-effectiveness.

75.21(5) *Exceptions to payment.* Premiums shall not be paid for health insurance plans under any of the following circumstances:

a. The insurance plan is that of an absent parent.

b. The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., $50 per day for hospital services instead of 80 percent of the charge).

c. The insurance plan is a school plan offered on basis of attendance or enrollment at the school.

d. The premium is used to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.

e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).

f. The persons covered under the plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments shall be made if the case is not Medicaid-eligible on the date of decision.

g. The person is eligible only for a coverage group that does not provide full Medicaid services, such as the specified low-income Medicare beneficiary (SLMB) coverage group in accordance with subrule 75.1(34) or the IowaCare program in accordance with the provisions of 441—Chapter 92. Members under the medically needy coverage group who must meet a spenddown are not eligible for HIPP payment.

h. Insurance coverage is being provided through the Health Insurance Plan of Iowa (HIPIOWA), in accordance with Iowa Code chapter 514E.

i. Insurance is being maintained on the Medicaid-eligible persons in the household through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

j. The insurance is a Medicare supplemental policy and the Health Insurance Premium Payment Application, Form 470-2875, was received on or after March 1, 1996.

k. The person has health coverage through Medicare. If other Medicaid members in the household are covered by the health plan, cost-effectiveness is determined without including the Medicare-covered member.

l. The health plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).

m. The health plan pays secondary to another plan.

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

o. All Medicaid members covered by the health plan are eligible for Medicaid only under subrule 75.1(43). This coverage group requires the parent to apply for, enroll in, and pay for coverage available from the employer as a condition of Medicaid eligibility for the children.

75.21(6) *Duplicate policies.* When more than one cost-effective health plan is available, the department shall pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

75.21(7) *Discontinuation of premium payments.*

a. When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, the department shall complete a review in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If the department determines that the health plan is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility, the department shall discontinue premium payment after timely and adequate notice. The department shall request all information in writing and allow the household ten calendar days in which to provide it.

d. If the policyholder leaves the Medicaid household, premium payments shall be discontinued pending timely and adequate notice.

e. If the health plan is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

75.21(8) *Effective date of premium payment.* The effective date of premium payments for a cost-effective health plan shall be determined as follows:

a. Premium payments shall begin no earlier than the later of:

(1) The first day of the month in which the Employer's Statement of Earnings, Form 470-2844, the Health Insurance Premium Payment Application, Form 470-2875, or the automated HIPP referral, Form H301-1, is received by the HIPP unit; or

(2) The first day of the first month in which the health plan is determined to be cost-effective.

b. If the person is not enrolled in the health plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the health plan is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time before the current effective date of coverage.

d. In no case shall payments be made for premiums that were used as a deduction to income when determining client participation or the amount of the spenddown obligation.

e. The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

f. The effective date of coverage for individual health plans or for group health plans not obtained through an employer shall be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

75.21(9) *Method of premium payment.* Payments of premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to an employer in order to circumvent a payroll deduction.

b. When an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department shall issue reimbursement to the employee five working days before the employee's pay date.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for those withdrawals.

d. Payments for COBRA coverage shall be made directly to the insurance carrier or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment, or

(2) The department pays for only part of the total premium.

e. Reimbursements may also be paid by direct deposit to the member's own account in a financial institution or by means of electronic benefits transfer.

75.21(10) *Payment of claims.* Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

75.21(11) *Reviews of cost-effectiveness and eligibility.* Reviews of cost-effectiveness and eligibility shall be completed annually and may be conducted more frequently at the discretion of the department.

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

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

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

d. Redeterminations shall be completed whenever:

(1) A premium rate, deductible, or coinsurance changes,

(2) A person covered under the policy loses full Medicaid eligibility,

(3) Changes in employment or hours of employment affect the availability of health insurance,

(4) The insurance carrier changes,

(5) The policyholder leaves the Medicaid home, or

(6) There is a decrease in the services covered under the policy.

e. The policyholder shall report changes that may affect the availability or cost-effectiveness of the policy within ten calendar days from the date of the change. Changes may be reported by telephone, in writing, or in person.

f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(16)*"a,"* shall be considered if available and cost-effective.

g. When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health plan occurs, the department shall verify whether coverage may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other coverage continuation provisions.

(1) The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose.

(2) If cost-effective to do so, the department shall pay premiums to maintain insurance coverage for Medicaid members after the occurrence of the event which would otherwise result in termination of coverage.

75.21(12) *Time frames for determining cost-effectiveness.* The department shall determine cost-effectiveness of the health plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule 75.21(8)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(13) *Notices.*

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

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

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

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

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

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

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

75.21(14) *Rate refund.* The department shall be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(15) *Reinstatement of eligibility.*

a. When eligibility for the HIPP program is canceled because the persons covered under the health plan lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the member's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs, if all other eligibility factors are met.

75.21(16) *Amount of premium paid.*

a. For group health plans, the individual eligible to enroll in the plan shall provide verification of the cost of all possible health plan options (i.e., single, employee/children, family).

(1) The HIPP program shall pay only for the option that provides coverage to the Medicaid-eligible family members in the household and is determined to be cost-effective.

(2) The HIPP program shall not pay the portion of the premium cost which is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program shall pay the cost of covering the Medicaid members covered by the plan.

c. For both group and individual health plans, if another household member must be covered to obtain coverage for the Medicaid members, the HIPP program shall pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(3) and 75.21(4).

75.21(17) *Reporting changes.* Failure to report and verify changes may result in cancellation of Medicaid benefits.

a. The client shall verify changes in an employer-sponsored health plan by providing a pay stub reflecting the change or a statement from the employer.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. The client shall verify changes in individual policies, such as premiums or deductibles, with a statement from the insurance carrier.

d. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

e. Any underpayment that results from an unreported change shall be paid effective the first day of the month in which the change is reported.

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

[**ARC 7935B**, IAB 7/1/09, effective 9/1/09; **ARC 8503B**, IAB 2/10/10, effective 1/13/10]

441—75.22(249A) AIDS/HIV health insurance premium payment program. For the purposes of this rule, "AIDS" and "HIV" are defined in accordance with Iowa Code section 141A.1.

75.22(1) *Conditions of eligibility.* The department shall pay for the cost of continuing health insurance coverage to persons with AIDS or HIV-related illnesses when the following criteria are met:

a. The person with AIDS or HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions.

When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

d. A physician's statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician's statement shall also verify that the policyholder or the spouse of the policyholder is or will be unable to continue employment in the person's current position or that hours of employment will be significantly reduced due to AIDS or HIV-related illness. The Physician's Verification of Diagnosis, Form 470-2958, shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the federal poverty level for a family of the same size. The gross income of all family members shall be counted using the definition of gross income under the supplemental security income (SSI) program.

f. Liquid resources shall not exceed $10,000 per household. The following are examples of countable resources:

(1) Unobligated cash.

(2) Bank accounts.

(3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

g. The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

75.22(2) *Application process.*

a. Application. Persons applying for participation in this program shall complete the AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953. The applicant shall be required to provide documentation of income and assets. The application shall be available from and may be filed at any county departmental office or at the Division of Medical Services, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

An application shall be considered as filed on the date an AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953, containing the applicant's name, address and signature is received and date-stamped in any county departmental office or the division of medical services.

b. Time limit for decision. Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the control of the applicant or the department, a decision regarding the applicant's eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

c. Eligible on the day of decision. No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

d. Waiting list. After funds appropriated for this purpose are obligated, pending applications shall be denied by the division of medical services. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list, or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the day of the month of the applicant's birthday, lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

75.22(3) *Presumed eligibility* The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility shall be granted when:

a. The application is accompanied by a completed Physician's Verification of Diagnosis, Form 470-2958.

b. The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

c. It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

75.22(4) *Family coverage.* When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage for the policyholder or the policyholder's spouse with AIDS or an HIV-related illness shall be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

75.22(5) *Method of premium payment.* Premiums shall be paid in accordance with the provisions of subrule 75.21(9).

75.22(6) *Effective date of premium payment.* Premium payments shall be effective with the month of application or the effective date of eligibility, whichever is later.

75.22(7) *Reviews.* The circumstances of persons participating in the program shall be reviewed quarterly to ensure eligibility criteria continues to be met. The AIDS/HIV Health Insurance Premium Payment Program Review, Form 470-2877, shall be completed by the recipient or someone acting on the recipient's behalf for this purpose.

75.22(8) *Termination of assistance.* Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).

b. The insurance coverage is no longer available.

c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.

d. Funding appropriated for the program is exhausted.

e. The person with AIDS or an HIV-related illness dies.

f. The person fails to provide requested information necessary to establish continued eligibility for the program.

75.22(9) *Notices.*

a. An adequate notice as defined in 441—subrule 7.7(1) shall be provided under the following circumstances:

(1) To inform the applicant of the initial decision regarding eligibility to participate in the program.

(2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).

(3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.

(4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.

(5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in 441—subrule 7.7(1) shall be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

75.22(10) *Confidentiality.* The department shall protect the confidentiality of persons participating in the program in accordance with Iowa Code section 141A.9. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Obtain and Release Information, Form 470-0429, shall be signed by the recipient authorizing the department to make the contact.

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

441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993. In determining Medicaid eligibility for persons described in 441—Chapters 75 and 83, a transfer of assets

occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

75.23(1) *Ineligibility for services.* When an individual or spouse has transferred or disposed of assets for less than fair market value as defined in 75.23(11) on or after the look-back date specified in 75.23(2), the individual shall be ineligible for medical assistance as provided in this subrule.

a. Institutionalized individual. When an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the institutionalized individual is ineligible for medical assistance payment for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and community-based waiver services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home- and community-based waiver services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

b. Noninstitutionalized individual. When a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance payment for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving home health care services, home and community care for functionally disabled elderly individuals, personal care services, or other long-term care services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

c. Client participation after period of ineligibility. Expenses incurred for long-term care services during a transfer of assets penalty period may not be deducted as medical expenses in determining client participation pursuant to subrule 75.16(2).

75.23(2) *Look-back date.*

a. Transfer before February 8, 2006. For transfers made before February 8, 2006, the look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

b. Transfer on or after February 8, 2006. For transfers made on or after February 8, 2006, the look-back date is the date that is 60 months before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

75.23(3) *Period of ineligibility.* The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in subrule 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department shall determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. For the period from July 1, 2011, through June 30, 2012, this average statewide cost shall be $4,853.36 per month or $159.65 per day.

75.23(4) *Reduction of period of ineligibility.* The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

75.23(5) *Exceptions.* An individual shall not be ineligible for medical assistance, under this rule, to the extent that:

a. The assets transferred were a home and title to the home was transferred to either:

(1) A spouse of the individual.

(2) A child of the individual who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.

(4) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

b. The assets were transferred:

(1) To the individual's spouse or to another for the sole benefit of the individual's spouse.

(2) From the individual's spouse to another for the sole benefit of the individual's spouse.

(3) To a child of the individual who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c or to a trust established solely for the benefit of such a child.

(4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.

c. A satisfactory showing is made that one of the following is true:

(1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.

(2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

(3) All assets transferred for less than fair market value have been returned to the individual.

d. The denial of eligibility would work an undue hardship. Undue hardship shall exist only when all of the following conditions are met:

(1) Application of the transfer of asset penalty would deprive the individual of medical care such that the individual's health or life would be endangered or of food, clothing, shelter, or other necessities of life.

(2) The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.

(3) The person's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:

1. The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.

2. Household goods.
3. A vehicle required by the client for transportation.
4. Funds for burial of $4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for long-term care services.

75.23(6) *Assets held in common.* In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

75.23(7) *Transfer by spouse.* In the case of a transfer by a spouse of an individual which results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility shall be apportioned between the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period shall be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period shall be applied to the surviving spouse's period of ineligibility.

75.23(8) *Definitions.* In this rule the following definitions apply:

"Assets" shall include all income and resources of the individual and the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by:

1. The individual or the individual's spouse.
2. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

"Income" shall be defined by 42 U.S.C. Section 1382a.

"Institutionalized individual" shall mean an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is eligible for home- and community-based waiver services.

"Resources" shall be defined by 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

"Transfer or disposal of assets" means any transfer or assignment of any legal or equitable interest in any asset as defined above, including:

1. Giving away or selling an interest in an asset;
2. Placing an interest in an asset in a trust that is not available to the grantor (see 75.24(2)*"b"*(2));
3. Removing or eliminating an interest in a jointly owned asset in favor of other owners;
4. Disclaiming an inheritance of any property, interest, or right pursuant to Iowa Code section 633.704 on or after July 1, 2000 (see Iowa Code section 249A.3(11)*"c"*);
5. Failure to take a share of an estate as a surviving spouse (also known as "taking against a will") on or after July 1, 2000, to the extent that the value received by taking against the will would have exceeded the value of the inheritance received under the will (see Iowa Code section 249A.3(11)*"d"*); or
6. Transferring or disclaiming the right to income not yet received.

75.23(9) *Purchase of annuities.* Funds used to purchase an annuity for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of when the annuity was purchased or whether the conditions described in this subrule were met.

a. The entire amount used to purchase an annuity on or after February 8, 2006, with a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value

unless the annuity meets one of the conditions described in paragraph 75.23(9)*"b"* and also meets the condition described in paragraph 75.23(9)*"c."*

b. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9)*"a"* must meet one of the following conditions:

(1) The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(2) The annuity is purchased with proceeds from:

1. An account or trust described in Subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

2. A simplified employee pension (within the meaning of Section 408(k) of the United States Internal Revenue Code of 1986); or

3. A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(3) The annuity:

1. Is irrevocable and nonassignable;

2. Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration); and

3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

c. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9)*"a"* must have Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

d. The entire amount used to purchase an annuity on or after February 8, 2006, with the spouse of a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless Iowa is named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

75.23(10) *Purchase of promissory notes, loans, or mortgages.*

a. Funds used to purchase a promissory note, loan, or mortgage after February 8, 2006, shall be treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance for services described in 75.23(1), unless the note, loan, or mortgage meets all of the following conditions:

(1) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(2) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(3) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

b. Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The note, loan, or mortgage was purchased before February 8, 2006; or

(2) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in 75.23(9)*"a"* were met.

75.23(11) *Purchase of life estates.*

a. The entire amount used to purchase a life estate in another individual's home after February 8, 2006, shall be treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

b. Funds used to purchase a life estate in another individual's home for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The life estate was purchased before February 8, 2006; or

(2) The life estate was purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

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

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441—75.24(249A) Treatment of trusts established after August 10, 1993. For purposes of determining an individual's eligibility for, or the amount of, medical assistance benefits, trusts established after August 10, 1993, (except for trusts specified in 75.24(3)) shall be treated in accordance with 75.24(2).

75.24(1) *Establishment of trust.*

a. For the purposes of this rule, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if any of the following individuals established the trust other than by will: the individual, the individual's spouse, a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse), or a person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

b. The term "assets," with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by the individual or the individual's spouse, by a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual's spouse), or by any person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

c. In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule shall apply to the portion of the trust attributable to the individual.

d. This rule shall apply without regard to:

(1) The purposes for which a trust is established.

(2) Whether the trustees have or exercise any discretion under the trust.

(3) Any restrictions on when or whether distribution may be made for the trust.

(4) Any restriction on the use of distributions from the trust.

e. The term "trust" includes any legal instrument or device that is similar to a trust, including a conservatorship.

75.24(2) *Treatment of revocable and irrevocable trusts.*

a. In the case of a revocable trust:

(1) The principal of the trust shall be considered an available resource.

(2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.

(3) Any other payments from the trust shall be considered assets disposed of by the individual, subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

b. In the case of an irrevocable trust:

(1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual shall be

considered income to the individual. Payments for any other purpose shall be considered a transfer of assets by the individual subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

(2) Any portion of the trust from which, or any income on the principal from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual subject to the penalties specified at 75.23(3) and 441—Chapter 89. The value of the trust shall be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

75.24(3) *Exceptions.* This rule shall not apply to any of the following trusts:

a. A trust containing the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Social Security Act) and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

b. A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust), and the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual. For disposition of trust amounts pursuant to Iowa Code sections 633C.1 to 633C.5, the average statewide charges and Medicaid rates for the period from July 1, 2011, to June 30, 2012, shall be as follows:

(1) The average statewide charge to a private-pay resident of a nursing facility is $4,594 per month.

(2) The maximum statewide Medicaid rate for a resident of an intermediate care facility for the mentally retarded is $24,060 per month.

(3) The average statewide charge to a resident of a mental health institute is $16,475 per month.

(4) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is $5,312 per month.

(5) The average statewide charge to a home- and community-based waiver applicant or member shall be consistent with the level of care determination and correspond with the average charges and rates set forth in this paragraph.

c. A trust containing the assets of an individual who is disabled (as defined in 1614(a)(3) of the Social Security Act) that meets the following conditions:

(1) The trust is established and managed by a nonprofit association.

(2) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in 1614(a)(3) of the Social Security Act) by the parent, grandparent, or legal guardian of the individuals, by the individuals or by a court.

(4) To the extent that amounts remaining in the beneficiary's account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

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

[**ARC 7834B**, IAB 6/3/09, effective 7/8/09; **ARC 8898B**, IAB 6/30/10, effective 7/1/10; **ARC 9582B**, IAB 6/29/11, effective 7/1/11]

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

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

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

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

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

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

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

"Client" shall mean all of the following:

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

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

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

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

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

"Department" shall mean the Iowa department of human services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[**ARC 7935B**, IAB 7/1/09, effective 9/1/09]

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

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

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

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

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

441—75.28 to **75.49** Reserved.

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

441—75.50(249A) Definitions. The following definitions apply to this division in addition to the definitions in rule 441—75.25(249A).

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

"Application period" means the months beginning with the month in which the application is considered to be filed, through and including the month in which an eligibility determination is made.

"Assistance unit" includes any person whose income is considered when determining eligibility.

"Bona fide offer" means an actual or genuine offer which includes a specific wage or a training opportunity at a specified place when used to determine whether the parent has refused an offer of training or employment.

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

"Change in income" means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

"Change in work expenses" means a permanent change in the cost of dependent care or the beginning or ending of dependent care.

"Department" shall mean the Iowa department of human services.

"Dependent" means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

"Dependent child" or *"dependent children"* means a child or children who meet the nonfinancial eligibility requirements of the applicable FMAP-related coverage group.

"Income in-kind" is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

"Initial two months" means the first two consecutive months for which eligibility is granted.

"Medical institution," when used in this division, shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility's license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.
5. Hospital schools.

"Needy specified relative" means a nonparental specified relative, listed in 75.55(1), who meets all the eligibility requirements of the FMAP coverage group, listed in 75.1(14).

"Nonrecurring lump sum unearned income" means a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits such as social security, job insurance or workers' compensation.

"Parent" means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

"Prospective budgeting" means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

"Recipient" means a person for whom Medicaid is received as well as parents living in the home with the eligible children and other specified relatives as defined in subrule 75.55(1) who are receiving Medicaid for the children. Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

"Schedule of needs" means the total needs of a group as determined by the schedule of living costs, described at subrule 75.58(2).

"Stepparent" means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child's parent by ceremonial or common-law marriage.

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

"Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

441—75.51(249A) Reinstatement of eligibility. Rescinded IAB 2/10/10, effective 3/1/10.

441—75.52(249A) Continuing eligibility.

75.52(1) *Reviews.* Eligibility factors shall be reviewed at least annually for the FMAP-related programs. Reviews shall be conducted using information contained in and verification supplied with the review form specified in subrule 75.52(3).

75.52(2) *Additional reviews.* A redetermination of specific eligibility factors shall be made when:

a. The member reports a change in circumstances (for example, a change in income, as defined at rule 441—75.50(249A)), or

b. A change in the member's circumstances comes to the attention of a staff member.

75.52(3) *Forms.*

a. Information for the annual review shall be submitted on Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED), with the following exceptions:

(1) When the client has completed Form 470-0462 or 470-0466 (Spanish), Health and Financial Support Application, for another purpose, this form may be used as the review document for the annual review.

(2) Information for recertification of family medical assistance-related medically needy shall be submitted on Form 470-3118 or 470-3118(S), Medicaid Review.

b. The department shall supply the review form to the client as needed, or upon request, and shall pay the cost of postage to return the form.

(1) When the review form is issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the fifth calendar day of the following month.

(2) When the review form is not issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the seventh day after the date the form is mailed by the department.

(3) A copy of a review form received by fax or electronically shall have the same effect as an original form.

c. The review information for foster children or children in subsidized adoption or subsidized guardianship shall be submitted on Form 470-2914, Foster Care, Adoption, and Guardianship Medicaid Review.

75.52(4) *Client responsibilities.* For the purposes of this subrule, "clients" shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The client shall cooperate by giving complete and accurate information needed to establish eligibility.

b. The client shall complete the required review form when requested by the department in accordance with subrule 75.52(3). If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1)*"f"* and 75.57(2)*"l."*

c. The client shall report any change in the following circumstances at the annual review or upon the addition of an individual to the eligible group:

(1) Income from all sources, including any change in care expenses.
(2) Resources.
(3) Members of the household.
(4) School attendance.
(5) A stepparent recovering from an incapacity.
(6) Change of mailing or living address.
(7) Payment of child support.
(8) Receipt of a social security number.
(9) Payment for child support, alimony, or dependents as defined in paragraph 75.57(8)*"b."*
(10) Health insurance premiums or coverage.

d. All clients shall timely report any change in the following circumstances at any time:

(1) Members of the household.
(2) Change of mailing or living address.
(3) Sources of income.
(4) Health insurance premiums or coverage.

e. Clients described at subrule 75.1(35) shall also timely report any change in income from any source and any change in care expenses at any time.

f. A report shall be considered timely when made within ten days from the date:

(1) A person enters or leaves the household.
(2) The mailing or living address changes.
(3) A source of income changes.
(4) A health insurance premium or coverage change is effective.
(5) Of any change in income.
(6) Of any change in care expenses.

g. When a change is not reported as required in paragraphs 75.52(4)*"c"* through *"e,"* any excess Medicaid paid shall be subject to recovery.

h. When a change in any circumstance is reported, its effect on eligibility shall be evaluated and eligibility shall be redetermined, if appropriate, regardless of whether the report of the change was required in paragraphs 75.52(4)*"c"* through *"e."*

75.52(5) *Effective date.* After assistance has been approved, eligibility for continuing assistance shall be effective as of the first of each month. Any change affecting eligibility reported during a month shall be effective the first day of the next calendar month, subject to timely notice requirements at rule 441—7.6(217) for any adverse actions.

a. When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.11(249A).

b. Rescinded IAB 10/4/00, effective 10/1/00.

c. When an individual included in the eligible group becomes ineligible, that individual's Medicaid shall be canceled effective the first of the next month unless the action must be delayed due to timely notice requirements at rule 441—7.6(217).

[**ARC 8260B**, IAB 11/4/09, effective 1/1/10; **ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups. Notwithstanding the provisions of rule 441—75.10(249A), the following rules shall apply when determining eligibility for persons under FMAP or FMAP-related coverage groups.

75.53(1) *Definition of resident.* A resident of Iowa is one:

a. Who is living in Iowa voluntarily with the intention of making that person's home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

b. Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the specified relative is a resident.

75.53(2) *Retention of residence.* Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

75.53(3) *Suitability of home.* The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

75.53(4) *Absence from the home.*

a. An individual who is absent from the home shall not be included in the eligible group, except as described in paragraph *"b."*

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home. "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician's statement. Failure to return within one year from the date of entry into the medical institution will result in the individual's needs being removed from the eligible group.

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

(3) An individual is out of the home for reasons other than reasons in subparagraphs (1) and (2) and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual's needs being removed from the eligible group.

441—75.54(249A) Eligibility factors specific to child.

75.54(1) *Age.* Unless otherwise specified at rule 441—75.1(249A), Medicaid shall be available to a needy child under the age of 18 years without regard to school attendance.

a. A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month.

b. Medicaid shall also be available to a needy child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met.

(1) A child shall be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of

vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A child shall also be considered to be in regular attendance in months when the child is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a child's education is temporarily interrupted pending adjustment of an education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

75.54(2) *Residing with a relative.* The child shall be living in the home of one of the relatives specified in subrule 75.55(1). When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

75.54(3) *Deprivation of parental care and support.* Rescinded IAB 11/1/00, effective 1/1/01.

75.54(4) *Continuous eligibility for children.* Rescinded IAB 11/5/08, effective 11/1/08.

441—75.55(249A) Eligibility factors specific to specified relatives.

75.55(1) *Specified relationship.*

a. A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father or adoptive father.

Mother or adoptive mother.

Grandfather or grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather or adoptive grandfather.

Grandmother or grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother or adoptive grandmother.

Great-grandfather or great-great-grandfather.

Great-grandmother or great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother, brother-of-half-blood, stepbrother, brother-in-law or adoptive brother.

Sister, sister-of-half-blood, stepsister, sister-in-law or adoptive sister.

Uncle or aunt, of whole or half blood.

Uncle-in-law or aunt-in-law.

Great uncle or great-great-uncle.

Great aunt or great-great-aunt.

First cousins, nephews, or nieces.

b. A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

75.55(2) *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity as provided in rule 441—75.14(249A).

a. When necessary to establish eligibility, the department shall make the initial contact with the absent parent at the time of application. Subsequent contacts may be made by the child support recovery unit.

b. When contact with the family or other sources of information indicates that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible

group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the department shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.
[**ARC 8785B**, IAB 6/2/10, effective 8/1/10]

441—75.56(249A) Resources.

75.56(1) *Limitation.* Unless otherwise specified, a client may have the following resources and be eligible for the family medical assistance program (FMAP) or FMAP-related programs. Any resource not specifically exempted shall be counted toward the applicable resource limit when determining eligibility for adults. All resources shall be disregarded when determining eligibility for children.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the client. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at paragraph 75.56(1)*"n"* or *"o,"* the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. One motor vehicle per household. If the household includes more than one adult or working teenaged child whose resources must be considered as described in subrule 75.56(2), an equity not to exceed a value of $3,000 in one additional motor vehicle shall be disregarded for each additional adult or working teenaged child.

(1) The disregard for an additional motor vehicle shall be allowed when a working teenager is temporarily absent from work.

(2) The equity value of any additional motor vehicle in excess of $3,000 shall be counted toward the resource limit in paragraph 75.56(1)*"e."* When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

(3) Beginning July 1, 1994, and continuing in succeeding state fiscal years, the motor vehicle equity value to be disregarded shall be increased by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed $2,000 for applicant assistance units and $5,000 for member assistance units. EXCEPTION: Applicant assistance units that contain at least one person who was a Medicaid member in Iowa in the month before the month of application are subject to the $5,000 limit. Resources of the assistance unit shall be determined in accordance with persons considered, as described at subrule 75.56(2).

f. Money which is counted as income for the month and that part of lump-sum income defined at paragraph 75.57(9)*"c"*reserved for the current or future month's income.

g. Payments which are exempted for consideration as income and resources under subrule 75.57(6).

h. An equity not to exceed $1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of $1,500 shall be counted toward resource limits unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed $10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in calculating whether the eligible group's property is within the reserve defined in paragraph *"e."*

o. Nonhomestead property that produces income consistent with the property's fair market value.

75.56(2) *Persons considered.*

a. Resources of persons in the eligible group shall be considered in establishing property limits.

b. Resources of the parent who is living in the home with the eligible children but who is not eligible for Medicaid shall be considered in the same manner as if the parent were eligible for Medicaid.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income (SSI) members shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid member in another eligible group, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

e. The resources of a nonparental specified relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

75.56(3) *Homestead defined.* The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½ acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 75.56(5).

75.56(4) *Liquidation.* When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the member is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 75.57(1)*"d"* and 75.57(7)*"ag."* The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

75.56(5) *Net market value defined.* Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

75.56(6) *Availability.*

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant or member owns the property in part or in full and has control over it. That is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant or member has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Rescinded IAB 6/30/99, effective 9/1/99.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the property.

d. When the applicant or member owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

75.56(7) *Damage judgments and insurance settlements.*

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant or member the month following the month the payment was received. When the applicant or member signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

75.56(8) *Conservatorships.*

a. Conservatorships established prior to February 9, 1994. The department shall determine whether assets from a conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

(1) Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

(2) When the department worker questions whether the funds in a conservatorship are available, the worker shall refer the conservatorship to the central office. When assets in the conservatorship are not clearly available, central office staff may contact the conservator and request that the funds in the conservatorship be made available for current support and maintenance. When the conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(3) Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available.

(4) Payments received from the conservatorship for basic or special needs are considered income.

b. Conservatorships established on or after February 9, 1994. Conservatorships established on or after February 9, 1994, shall be treated according to the provisions of paragraphs 75.24(1)*"e"* and 75.24(2)*"b."*

75.56(9) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint, and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, inventory or supplies retained by the household shall not be considered a resource.

441—75.57(249A) Income. When determining initial and ongoing eligibility for the family medical assistance program (FMAP) and FMAP-related Medicaid coverage groups, all unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered.

1. Unless otherwise specified at rule 441—75.1(249A), the determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income received by the eligible group and available to meet the current month's needs is no more than 185 percent of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); (2) the countable net earned and unearned income is less than the schedule

of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2); and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the schedule of basic needs as identified at subrule 75.58(2) for the eligible group (Test 3).

2. The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); and (2) countable net unearned and earned income is less than the schedule of basic needs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 3).

3. Child support assigned to the department in accordance with 441—subrule 41.22(7) shall be considered unearned income for the purpose of determining continuing eligibility, except as specified at paragraphs 75.57(1)*"e,"* 75.57(6)*"u,"* and 75.57(7)*"o."* Expenses for care of children or disabled adults, deductions, and diversions shall be allowed when verification is provided.

75.57(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Financial assistance received for education or training. Rescinded IAB 2/11/98, effective 2/1/98.

c. Rescinded IAB 2/11/98, effective 2/1/98.

d. When the client sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in subrule 75.56(4). The interest portion of the payment is considered a resource the month following the month of receipt.

e. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment, for a member of the eligible group, made while the application is pending shall be treated as unearned income.

(2) Support payments shall be considered as unearned income in the month in which the IV-A agency (income maintenance) is notified of the payment by the IV-D agency (child support recovery unit).

The amount of income to consider shall be the actual amount paid or the monthly entitlement, whichever is less.

(3) Support payments reported by child support recovery during a past month for which eligibility is being determined shall be used to determine eligibility for the month. Support payments anticipated to be received in future months shall be used to determine eligibility for future months. When support payments terminate in the month of decision of an FMAP-related Medicaid application, both support payments already received and support payments anticipated to be received in the month of decision shall be used to determine eligibility for that month.

(4) When the reported support payment, combined with other income, creates ineligibility under the current coverage group, an automatic redetermination of eligibility shall be conducted in accordance with the provisions of rule 441—76.11(249A). Persons receiving Medicaid under the family medical assistance program in accordance with subrule 75.1(14) may be entitled to continued coverage under the provisions of subrule 75.1(21). Eligibility may be reestablished for any month in which the countable support payment combined with other income meets the eligibility test.

f. The client shall cooperate in supplying verification of all unearned income and of any change in income, as defined at rule 441—75.50(249A).

(1) When the information is available, the department shall verify job insurance benefits by using information supplied to the department by Iowa workforce development. When the department uses this

information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by Iowa workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

(2) When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. The client must report the discrepancy before the eligibility month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), applicable to the eligibility month, whichever is later.

75.57(2) *Earned income.* Earned income is defined as income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. With respect to self-employment, earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing the income. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

a. Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, considered in determining eligibility is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include work-related expenses other than child care. These expenses shall include, but are not limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Each person in the assistance unit is entitled to a deduction for care expenses subject to the following limitations.

(1) Persons in the eligible group and excluded parents shall be allowed care expenses for a child or incapacitated adult in the eligible group.

(2) Stepparents as described at paragraph 75.57(8)*"b"* and self-supporting parents on underage parent cases as described at paragraph 75.57(8)*"c"* shall be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

(3) Unless both parents are in the home and one parent is physically and mentally able to provide the care, child care or care for an incapacitated adult shall be considered a work expense in the amount paid for care of each child or incapacitated adult, not to exceed $175 per month, or $200 per month for a child under the age of two, or the going rate in the community, whichever is less.

(4) If both parents are in the home, adult or child care expenses shall not be allowed when one parent is unemployed and is physically and mentally able to provide the care.

(5) The deduction is allowable only when the care covers the actual hours of the individual's employment plus a reasonable period of time for commuting; or the period of time when the individual who would normally care for the child or incapacitated adult is employed at such hours that the individual is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.

(6) Any special needs of a physically or mentally handicapped child or adult shall be taken into consideration in determining the deduction allowed.

(7) If the amount claimed is questionable, the expense shall be verified by a receipt or a statement from the provider of care. The expense shall be allowed when paid to any person except a parent or legal guardian of the child, another member of the eligible group, or any person whose needs are met by diversion of income from any person in the eligible group.

c. Work incentive disregard. After deducting the allowable work-related expenses as defined at paragraphs 75.57(2)*"a"* and *"b"* and income diversions as defined at subrule 75.57(4), 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered is disregarded in determining eligibility for the family medical assistance program (FMAP) and those FMAP-related coverage groups subject to the three-step process for determining initial eligibility as described at rule 441—75.57(249A).

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility under the first two steps of the three-step process is determined without the application of the work incentive disregard as described at subparagraphs 75.57(9)*"a"*(2) and (3).

(3) A person who is not eligible for Medicaid because the person has refused to cooperate in applying for or accepting benefits from other sources, in accordance with the provisions of rule 441—75.2(249A), 441—75.3(249A), or 441—75.21(249A), is eligible for the work incentive disregard.

d. Rescinded IAB 6/30/99, effective 9/1/99.

e. A person is considered self-employed when the person:

(1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

(2) Establishes the person's own working hours, territory, and methods of work.

(3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

f. The net profit from self-employment income in a non-home-based operation shall be determined by deducting only the following expenses that are directly related to the production of the income:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.

(3) The cost of shelter in the form of rent, the interest on mortgage or contract payments; taxes; and utilities.

(4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.

(5) Insurance on the real or personal property involved.

(6) The cost of any repairs needed.

(7) The cost of any travel required.

(8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

g. When the client is renting out apartments in the client's home, the following shall be deducted from the gross rentals received to determine the profit:

(1) Shelter expense in excess of that set forth on the chart of basic needs components at subrule 75.58(2) for the eligible group.

(2) That portion of expense for utilities furnished to tenants which exceeds the amount set forth on the chart of basic needs components at subrule 75.58(2).

(3) Ten percent of gross rentals to cover the cost of upkeep.

h. In determining profit from furnishing board, room, operating a family life home, or providing nursing care, the following amounts shall be deducted from the payments received:

(1) $41 plus an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or $41 for a roomer, or an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder.

(2) Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.

i. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining profit from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member requests to have expenses in excess of the 40 percent considered, profit shall be determined in the same manner as specified at paragraph 75.57(2)*"j."*

j. In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the following expenses shall be deducted from the income received:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees.

(3) The cost of machinery and equipment in the form of rent; or the interest on mortgage or contract payment; and any insurance on such machinery equipment.

(4) Ten percent of the total gross income to cover the costs of upkeep when the work is performed in the home.

(5) Any other direct cost involved in the production of the income, except the purchase of capital equipment and payment on the principal of loans for capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

k. Rescinded IAB 6/30/99, effective 9/1/99.

l. The applicant or member shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—75.50(249A). A self-employed applicant or member shall keep any records necessary to establish eligibility.

75.57(3) *Shared living arrangements.* When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the applicant or member, exclusively for the applicant's or member's needs, are considered income.

75.57(4) *Diversion of income.*

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent living in the family group who meet the age and school attendance requirements specified in subrule 75.54(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent and a companion in the home only when the income and resources of the companion and the children are within family medical assistance program standards. The maximum income that shall be diverted to meet the needs of the ineligible children shall be the difference between the needs of the eligible group if the ineligible children were included and the needs of the eligible group with the ineligible children excluded, except as specified at paragraph 75.57(8)*"b."*

b. Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

75.57(5) *Income of unmarried specified relatives under the age of 19.*

a. Income of the unmarried specified relative under the age of 19 when that specified relative lives with a parent who receives coverage under family medical assistance-related programs or lives with a nonparental relative or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

b. Income of the unmarried specified relative under the age of 19 who lives in the same home as a self-supporting parent. The income of the unmarried specified relative under the age of 19 living in the same home as a self-supporting parent shall be treated in accordance with subparagraphs (1), (2), and (3) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative

had attained majority. The income of the specified relative's self-supporting parents shall be treated in accordance with paragraph 75.57(8)*"c."*

(3) When the unmarried specified relative is 18 years of age, the specified relative's income shall be treated in the same manner as though the specified relative had attained majority.

75.57(6) *Exempt as income and resources.* The following shall be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.

b. The value of the food assistance program benefit.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

k. Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

l. Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.

m. The income of a supplemental security income recipient.

n. Income of an ineligible child.

o. Income in-kind.

p. Family support subsidy program payments.

q. Grants obtained and used under conditions that preclude their use for current living costs.

r. All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 75.55(1), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.

s. Subsidized guardianship program payments.

t. Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or member by the representative payee.

u. The first $50 received by the eligible group which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed $50 per month per eligible group.

v. Bona fide loans. Evidence of a bona fide loan may include any of the following:

(1) The loan is obtained from an institution or person engaged in the business of making loans.

(2) There is a written agreement to repay the money within a specified time.

(3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.

w. Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).

x. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.

y. Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

z. Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."

aa. Payments received from the Radiation Exposure Compensation Act.

ab. Deposits into an individual development account (IDA) when determining eligibility. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. Deposits shall be deducted from nonexempt earned and unearned income beginning with the month following the month in which verification that deposits have begun is received. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions at paragraphs 75.57(2)*"a," "b,"* and *"c"* shall be applied to nonexempt earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

75.57(7) *Exempt as income.* The following are exempt as income.

a. Reimbursements from a third party.

b. Reimbursement from the employer for a job-related expense.

c. The following nonrecurring lump sum payments:

(1) Income tax refund.

(2) Retroactive supplemental security income benefits.

(3) Settlements for the payment of medical expenses.

(4) Refunds of security deposits on rental property or utilities.

(5) That part of a lump sum received and expended for funeral and burial expenses.

(6) That part of a lump sum both received and expended for the repair or replacement of resources.

d. Payments received by the family for providing foster care when the family is operating a licensed foster home.

e. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed $30 per person per calendar quarter.

When a monetary gift from any one source is in excess of $30, the total gift is countable as unearned income. When monetary gifts from several sources are each $30 or less, and the total of all gifts exceeds $30, only the amount in excess of $30 is countable as unearned income.

f. Federal or state earned income tax credit.

g. Supplementation from county funds, providing:

(1) The assistance does not duplicate any of the basic needs as recognized by the chart of basic needs components in accordance with subrule 75.58(2), or

(2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.

h. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.

i. A retroactive corrective family investment program (FIP) payment.

j. The training allowance issued by the division of vocational rehabilitation, department of education.

k. Payments from the PROMISE JOBS program.

l. The training allowance issued by the department for the blind.

m. Payments from passengers in a car pool.

n. Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.

o. Rescinded IAB 10/4/00, effective 10/1/00.

p. Rescinded IAB 10/4/00, effective 10/1/00.

q. Income of a nonparental relative as defined at subrule 75.55(1) except when the relative is included in the eligible group.

r. Rescinded IAB 10/4/00, effective 10/1/00.

s. Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.

t. Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.

u. Earnings of a person aged 19 or younger who is a full-time student as defined at subparagraphs 75.54(1)*"b"*(1) and (2). The exemption applies through the entire month of the person's twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

v. Income attributed to an unmarried, underage parent in accordance with paragraph 75.57(8)*"c"* effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.

w. Incentive payments received from participation in the adolescent pregnancy prevention programs.

x. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

y. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

z. Interest and dividend income.

aa. Rescinded IAB 10/4/00, effective 10/1/00.

ab. Honorarium income. All moneys paid to an eligible household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ac. Income that an individual contributes to a trust as specified at paragraph 75.24(3)*"b"* shall not be considered for purposes of determining eligibility for the family medical assistance program (FMAP) or FMAP-related Medicaid coverage groups.

ad. Benefits paid to the eligible household under the family investment program (FIP).

ae. Moneys received through the pilot self-sufficiency grants program or through the pilot diversion program.

af. Earnings from new employment of any person whose income is considered when determining eligibility during the first four calendar months of the new employment. The date the new employment or self-employment begins shall be verified before approval of the exemption. This four-month period shall be referred to as the work transition period (WTP).

(1) The exempt period starts the first day of the month in which the client receives the first pay from the new employment and continues through the next three benefit months, regardless if the job ends during the four-month period.

(2) To qualify for this disregard, the person shall not have earned more than $1,200 in the 12 calendar months prior to the month in which the new job begins, the income must be reported timely in

accordance with rule 441—76.10(249A), and the new job must have started after the date the application is filed. For purposes of this policy, the $1,200 earnings limit applies to the gross amount of income without any allowance for exemptions, disregards, work deductions, diversions, or the costs of doing business used in determining net profit from any income test in rule 441—75.57(249A).

(3) If another new job or self-employment enterprise starts while a WTP is in progress, the exemption shall also be applied to earnings from the new source that are received during the original 4-month period, provided that the earnings were less than $1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

(4) An individual is allowed the 4-month exemption period only once in a 12-month period. An additional 4-month exemption shall not be granted until the month after the previous 12-month period has expired.

(5) If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

(6) When a person living in the home whose income is not considered subsequently becomes an assistance unit member whose income is considered, the new job must start after the date of the change that causes the person's income to be considered in order for that person to qualify for the exemption.

(7) A person who begins new employment or self-employment that is intermittent in nature may qualify for the WTP. "Intermittent" includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families. However, a person is not considered as starting new employment or self-employment each time intermittent employment restarts or changes such as when the same temporary agency places the person in a new assignment or a child care provider acquires another child care client.

ag. Payments from property sold under an installment contract as specified in paragraphs 75.56(4)*"b"* and 75.57(1)*"d."*

ah. All census earnings received by temporary workers from the Bureau of the Census.

ai. Payments received through participation in the preparation for adult living program pursuant to 441—Chapter 187.

75.57(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. Treatment of income in excluded parent cases. A parent who is living in the home with the eligible children but who is not eligible for Medicaid is eligible for the 20 percent earned income deduction, child care expenses for children in the eligible group, the 58 percent work incentive disregard described at paragraphs 75.57(2)*"a," "b,"* and *"c,"* and diversions described at subrule 75.57(4). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group.

b. Treatment of income in stepparent cases. The income of a stepparent who is not included in the eligible group but who is living with the parent in the home of an eligible child shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) through (10) below.

(1) The stepparent's monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) The stepparent's monthly nonexempt earned income remaining after the 20 percent earned income deduction shall be allowed child care expenses for the stepparent's ineligible dependents in the home, subject to the restrictions described at subparagraphs 75.57(2)*"b"*(1) through (5).

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at subrule 75.57(10), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions at subparagraphs 75.57(8)*"b"*(1) through

(4) above shall be used to meet the needs of the stepparent and the stepparent's dependents living in the home, when the dependents' needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the schedule of needs for a family group of the same composition in accordance with subrule 75.58(2).

(6) The stepparent shall be allowed the 58 percent work incentive disregard from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions at subparagraphs 75.57(8)*"b"*(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 75.57(9)*"a"*(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) shall first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5) shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt, nonrecurring lump sum received by a stepparent shall be considered as income and counted in computing eligibility in the same manner as it would be treated for a parent. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent if that portion is not exempted according to paragraph 75.56(1)*"f."*

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent's dependents living in the home who are not eligible for FMAP-related Medicaid, the income of the parent may be diverted to meet the unmet needs of the children of the current marriage except as described at subrule 75.57(10).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any children of the parent living in the home who are not eligible for FMAP-related Medicaid shall be considered as one unit, and the stepparent and the stepparent's dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent's own self-supporting parents, the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions unless the provisions of rule 441—75.59(249A) apply. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 75.57(8)*"b"*(1) through (7). Child care expenses at subparagraph 75.57(8)*"b"*(2) shall be allowed for the self-supporting parent's ineligible children. Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with subparagraph 75.57(8)*"b"*(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 75.57(8)*"b"*(1) through (7) unless the provisions of rule 441—75.59(249A) apply. Child care expenses at subparagraph 75.57(8)*"b"*(2) shall be allowed for the ineligible dependents of the self-supporting spouse who is a stepparent of the minor parent. Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with subparagraph 75.57(8)*"b"*(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit. The self-supporting spouse and the spouse's ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

75.57(9) *Budgeting process.*

a. Initial and ongoing eligibility. Both initial and ongoing eligibility shall be based on a projection of income based on the best estimate of future income.

(1) Upon application, the department shall use all earned and unearned income received by the eligible group to project future income. Allowable work expenses shall be deducted from earned income, except in determining eligibility under the 185 percent test defined at rule 441—75.57(249A). The determination of initial eligibility is a three-step process as described at rule 441—75.57(249A).

(2) Test 1. When countable gross nonexempt earned and unearned income exceeds 185 percent of the schedule of living costs (Test 1), as identified at subrule 75.58(2) for the eligible group, eligibility does not exist under any coverage group for which these income tests apply. Countable gross income means nonexempt gross income, as defined at rule 441—75.57(249A), without application of any disregards, deductions, or diversions.

(3) Test 2. When the countable gross nonexempt earned and unearned income equals or is less than 185 percent of the schedule of living costs for the eligible group, initial eligibility under the schedule of living costs (Test 2) shall then be determined. Initial eligibility under the schedule of living costs is determined without application of the 58 percent work incentive disregard as specified at paragraph 75.57(2)*"c."* All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the schedule of living costs (Test 2) for the eligible group. When countable net earned and unearned income equals or exceeds the schedule of living costs for the eligible group, eligibility does not exist under any coverage group for which these income tests apply.

(4) Test 3. After application of Tests 1 and 2 for initial eligibility or of Test 1 for ongoing eligibility, the 58 percent work incentive disregard at paragraph 75.57(2)*"c"* shall be applied when there is eligibility for this disregard. When countable net earned and unearned income, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the schedule of basic needs (Test 3) for the eligible group, eligibility does not exist under any coverage group for which these tests apply. When the countable net income is less than the schedule of basic needs for the eligible group, the eligible group meets FMAP or CMAP income requirements.

(5) Rescinded IAB 10/4/00, effective 10/1/00.

(6) When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

(8) When a change in circumstances that is required to be timely reported by the client pursuant to paragraphs 75.52(4)*"d"* and *"e"* is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change occurred. When a change in circumstances that is required to be reported by the client at annual review or upon the addition of an individual to the eligible group pursuant to paragraph 75.52(4)*"c"* is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change was required to be reported. All other changes shall be acted upon when they are reported or otherwise become known to the department, allowing for a ten-day notice of adverse action, if required.

b. Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

(1) Income received by an individual employed under a contract shall be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months. EXCEPTION: Periodic or intermittent income from self-employment shall be treated as described at paragraph 75.57(9)*"i."*

(3) When the lump-sum income is earned income, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income is prorated when a recurring lump sum is received at any time.

c. Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 75.56(4) and 75.56(7) and at paragraphs 75.57(8)*"b"* and *"c,"* shall be treated in accordance with this rule. Nonrecurring lump-sum income includes an inheritance, an insurance settlement or tort recovery, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance, or workers' compensation.

(1) Nonrecurring lump-sum income shall be considered as income in the month of receipt and counted in computing eligibility, unless the income is exempt.

(2) When countable income exclusive of any family investment program grant but including countable lump-sum income exceeds the needs of the eligible group under their current coverage group, the countable lump-sum income shall be prorated. The number of full months for which a monthly amount of the lump sum shall be counted as income in the eligibility determination is derived by dividing the total of the lump-sum income and any other countable income received in or projected to be received in the month the lump sum was received by the schedule of living costs, as identified at subrule 75.58(2), for the eligible group. This period is referred to as the period of proration. Any income remaining after this calculation shall be applied as income to the first month following the period of proration and disregarded as income thereafter.

(3) The period of proration shall begin with the month when the nonrecurring lump sum was received, whether or not the receipt of the lump sum was timely reported. If receipt of the lump sum was reported timely and the calculation was completed timely, no recoupment shall be made. If receipt of the lump sum was not reported timely or the calculation was not completed timely, recoupment shall begin with the month of receipt of the nonrecurring lump sum.

(4) The period of proration shall be shortened when:

1. The schedule of living costs as defined at subrule 75.58(2) increases; or

2. A portion of the lump sum is no longer available to the eligible group due to loss or theft or because the person controlling the lump sum no longer resides with the eligible group and the lump sum is no longer available to the eligible group; or

3. There is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82, and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over $25 per incident; cost of replacement of exempt resources as defined in subrule 75.56(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified.

(5) When countable income, including the lump-sum income, is less than the needs of the eligible group in accordance with the provisions of their current coverage group, the lump sum shall be counted as income for the month of receipt.

(6) For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of proration.

(7) During the period of proration, individuals not in the eligible group when the lump-sum income was received may be eligible as a separate eligible group. Income of this eligible group plus income of the parent or other legally responsible person in the home, excluding the lump-sum income already considered, shall be considered as available in determining eligibility.

d. The third digit to the right of the decimal point in any calculation of income, hours of employment and work expenses for care, as defined at paragraph 75.57(2)*"b,"* shall be dropped.

e. In any month for which an individual is determined eligible to be added to a currently active family medical assistance (FMAP) or FMAP-related Medicaid case, the individual's needs, income, and resources shall be included. An individual who is a member of the eligible group and who is determined

to be ineligible for Medicaid shall be canceled prospectively effective the first of the following month if the timely notice of adverse action requirements as provided at 441—subrule 76.4(1) can be met.

f. Rescinded IAB 10/4/00, effective 10/1/00.

g. Rescinded IAB 2/11/98, effective 2/1/98.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual's annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3) through (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3) through (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department shall recalculate the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

75.57(10) *Restriction on diversion of income.* Rescinded IAB 7/11/01, effective 9/1/01.

75.57(11) *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 8556B**, IAB 3/10/10, effective 2/10/10; **ARC 9043B**, IAB 9/8/10, effective 11/1/10]

441—75.58(249A) Need standards.

75.58(1) *Definition of eligible group.* The eligible group consists of all eligible persons specified below and living together, except when one or more of these persons have elected to receive supplemental security income under Title XVI of the Social Security Act or are voluntarily excluded in accordance with the provisions of rule 441—75.59(249A). There shall be at least one child, which may be an unborn child, in the eligible group except when the only eligible child is receiving supplemental security income.

a. The following persons shall be included (except as otherwise provided in these rules) without regard to the person's employment status, income or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as caretaker when the parent is in the home but is unable to act as caretaker.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required

to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity.

3. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

4. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity for the family medical assistance program (FMAP) and FMAP-related program purposes.

5. A stepparent who is considered incapacitated and is receiving Medicaid shall be referred to the department of education, division of vocational rehabilitation services, for evaluation and services. Acceptance of these services is optional.

(4) The stepparent who is not incapacitated when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent is required in the home to care for the dependent children. These services must be required to the extent that if the stepparent were not available, it would be necessary to allow for care as a deduction from earned income of the parent.

75.58(2) *Schedule of needs.* The schedule of living costs represents 100 percent of the basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the schedule of needs defined at rule 441—75.50(249A). The 185 percent schedule is included for the determination of eligibility in accordance with rule 441—75.57(249A). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in the eligible group. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the eligible group. The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below:

SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
Test 1 185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Test 2 Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Test 3 Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communications	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

(1) Shelter: Rental, taxes, upkeep, insurance, amortization.

(2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.

(3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.

(4) Food: Including school lunches.

(5) Clothing: Including layette, laundry, dry cleaning.

(6) Personal care and supplies: Including regular school supplies.

(7) Medicine chest items.

(8) Communications: Telephone, newspapers, magazines.

(9) Transportation: Including bus fares.

b. Special situations in determining eligible group:

(1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving Medicaid for the relative's own children.

(2) When the unmarried specified relative under the age of 19 is living in the same home with a parent or parents who receive Medicaid, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parents. When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent who receives Medicaid but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent who does not receive Medicaid, the needs of the specified relative, when eligible, shall be included in the eligible group with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined at subrule 75.55(1), only the needs of the eligible children shall be included in the eligible group. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group has elected to receive supplemental security income benefits, the person, income and resources shall not be considered in determining eligibility for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of Medicaid, the eligibility shall be computed on the basis of their comprising one eligible group.

(5) When a child is ineligible for Medicaid, the income and resources of that child are not used in determining eligibility of the eligible group and the ineligible child is not a part of the household size. However, the income and resources of a parent who is ineligible for Medicaid are used in determining eligibility of the eligible group and the ineligible parent is counted when determining household size.

441—75.59(249A) Persons who may be voluntarily excluded from the eligible group when determining eligibility for the family medical assistance program (FMAP) and FMAP-related coverage groups.

75.59(1) *Exclusions from the eligible group.* In determining eligibility under the family medical assistance program (FMAP) or any FMAP-related Medicaid coverage group in this chapter, the following persons may be excluded from the eligible group when determining Medicaid eligibility of other household members.

a. Siblings (of whole or half blood, or adoptive) of eligible children.

b. Self-supporting parents of minor unmarried parents.

c. Stepparents of eligible children.

d. Children living with a specified relative, as listed at subrule 75.55(1).

75.59(2) *Needs, income, and resource exclusions.* The needs, income, and resources of persons who are voluntarily excluded shall also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent shall not be counted in the household size when determining eligibility for the minor unmarried parent's child. However, the income and resources of the minor unmarried parent shall be used in determining eligibility for the unmarried minor parent's child. If a stepparent is voluntarily excluded, the natural or adoptive parent shall not be counted in the household size when determining eligibility for the natural or adoptive parent's children. However, the income and resources of the natural or adoptive parent shall be used in determining eligibility for the natural or adoptive parent's children.

75.59(3) *Medicaid entitlement.* Persons whose needs are voluntarily excluded from the eligibility determination shall not be entitled to Medicaid under this or any other coverage group.

75.59(4) *Situations where parent's needs are excluded.* In situations where the parent's needs are excluded but the parent's income and resources are considered in the eligibility determination (e.g., minor unmarried parent living with self-supporting parents), the excluded parent shall be allowed the earned income deduction, child care expenses and the work incentive disregard as provided at paragraphs 75.57(2)*"a," "b,"* and *"c."*

75.59(5) *Situations where child's needs, income, and resources are excluded.* In situations where the child's needs, income, and resources are excluded from the eligibility determination pursuant to subrule 75.59(1), and the child's income is not sufficient to meet the child's needs, the parent shall be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted shall be the difference between the schedule of basic needs of the eligible group with the child included and the schedule of basic needs with the child excluded, in accordance with the provisions of subrule 75.58(2), minus any countable income of the child.

441—75.60(249A) Pending SSI approval. When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the eligible group pending approval of supplemental security income.

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

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◊ Two or more ARCs

1 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

CHAPTER 78
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]
[Prior to 2/11/87, Human Services[498]]

441—78.1(249A) Physicians' services. Payment will be approved for all medically necessary services and supplies provided by the physician including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment shall be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid.

b. Routine physical examinations. Rescinded IAB 8/1/07, effective 8/1/07.

c. Treatment of certain foot conditions as specified in 78.5(2)*"a," "b,"* and *"c."*

d. Acupuncture treatments.

e. Rescinded 9/6/78.

f. Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program shall be utilized in determining when a given procedure is unproven or experimental in nature.

g. Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by the Iowa Foundation for Medical Care or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admittance to the hospital. Approval shall be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

78.1(2) Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

a. Drugs are covered as provided by rule 441—78.2(249A).

b. Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. Rescinded IAB 1/30/08, effective 4/1/08.

e. All physicians who administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. Vaccines available through the Vaccines for Children program shall be obtained from the department of public health for Medicaid members. Physicians shall, however, receive reimbursement for the administration of these vaccines to Medicaid members.

f. Nonprescription drugs. Rescinded IAB 1/30/08, effective 4/1/08.

78.1(3) Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug is not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury. When injecting an amphetamine or legend vitamin, prior approval must be obtained as specified in 78.1(2)*"a"*(3).

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment will not be approved for vaccines which are available through the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health.

g. Payment will not be approved for injections of "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

78.1(4) For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

(1) Correction of a congenital anomaly; or

(2) Restoration of body form following an accidental injury; or

(3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

(1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program. This list is for example purposes only and is not considered all inclusive.

(1) Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

78.1(5) The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 78.10(249A).

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 78.15(249A).

78.1(7) No payment shall be made for the services of a private duty nurse.

78.1(8) Payment for mileage shall be the same as that in effect in part B of Medicare.

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

b. When only one patient is seen in a single visit the allowance shall be based on a follow-up home visit. When more than one patient is seen in a single visit, payment shall be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

c. Payment will be approved for mileage in connection with nursing home visits when:

(1) It is necessary for the physician to travel outside the home community, and

(2) There are not physicians in the community in which the nursing home is located.

d. Payment will be approved for tasks related to a resident receiving nursing facility care which are performed by a physician's employee who is a nurse practitioner, clinical nurse specialist, or physician assistant as specified in 441—paragraph 81.13(13)*"e."* On-site supervision of the physician is not required for these services.

78.1(10) Payment will be approved in independent laboratory when it has been certified as eligible to participate in Medicare.

78.1(11) Rescinded, effective 8/1/87.

78.1(12) Payment will be made on the same basis as in Medicare for services associated with treatment of chronic renal disease including physician's services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis. Payment will be made for deductibles and coinsurance for those persons eligible for Medicare.

78.1(13) Payment will be made to the physician for services rendered by auxiliary personnel employed by the physician and working under the direct personal supervision of the physician, when such services are performed incident to the physician's professional service.

a. Auxiliary personnel are nurses, physician's assistants, psychologists, social workers, audiologists, occupational therapists and physical therapists.

b. An auxiliary person is considered to be an employee of the physician if the physician:

(1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.

(2) Sets work standards.

(3) Establishes job description.

(4) Withholds taxes from the wages of the auxiliary personnel.

c. Direct personal supervision in the office setting means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

Direct personal supervision outside the office setting, such as the member's home, hospital, emergency room, or nursing facility, means the physician must be present in the same room as the auxiliary person.

Advanced registered nurse practitioners certified under board of nursing rules 655—Chapter 7 performing services within their scope of practice are exempt from the direct personal supervision requirement for the purpose of reimbursement to the employing physicians. In these exempted circumstances, the employing physicians must still provide general supervision and be available to provide immediate needed assistance by telephone. Advanced registered nurse practitioners who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

A physician assistant licensed under board of physician assistants' professional licensure rules in 645—Chapter 325 is exempt from the direct personal supervision requirement but the physician must still provide general supervision and be available to provide immediate needed assistance by telephone.

Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

78.1(14) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a physician for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.1(15) The certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification.

78.1(16) No payment will be made for sterilization of an individual under the age of 21 or who is mentally incompetent or institutionalized. Payment will be made for sterilization performed on an individual who is aged 21 or older at the time the informed consent is obtained and who is mentally competent and not institutionalized when all the conditions in this subrule are met.

a. The following definitions are pertinent to this subrule:

(1) Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing and which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment of an operation on the genital urinary tract. Mental illness or retardation is not considered an illness or injury.

(2) Hysterectomy means a medical procedure or operation to remove the uterus.

(3) Mentally incompetent individual means a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(4) Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

b. The sterilization shall be performed as the result of a voluntary request for the services made by the person on whom the sterilization is performed. The person's consent for sterilization shall be documented on:

(1) Form 470-0835 or 470-0835(S), Consent Form, or

(2) An official sterilization consent form from another state's Medicaid program that contains all information found on the Iowa form and complies with all applicable federal regulations.

c. The person shall be advised prior to the receipt of consent that no benefits provided under the medical assistance program or other programs administered by the department may be withdrawn or withheld by reason of a decision not to be sterilized.

d. The person shall be informed that the consent can be withheld or withdrawn any time prior to the sterilization without prejudicing future care and without loss of other project or program benefits.

e. The person shall be given a complete explanation of the sterilization. The explanation shall include:

(1) A description of available alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.

(2) A thorough description of the specific sterilization procedure to be performed and benefits expected.

(3) A description of the attendant discomforts and risks including the type and possible effects of any anesthetic to be used.

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

g. The information in paragraphs *"b"* through *"f"* shall be effectively presented to a blind, deaf, or otherwise handicapped individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual's choice present when consent is obtained.

h. The consent form described in paragraph 78.1(16)*"b"* shall be attached to the claim for payment and shall be signed by:

(1) The person to be sterilized,

(2) The interpreter, when one was necessary,

(3) The physician, and

(4) The person who provided the required information.

i. Informed consent shall not be obtained while the individual to be sterilized is:

(1) In labor or childbirth, or

(2) Seeking to obtain or obtaining an abortion, or

(3) Under the influence of alcohol or other substance that affects the individual's state of awareness.

j. Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization and only when one or more of the following conditions is met:

(1) The individual or representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing, or

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy and has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

78.1(17) Abortions. Payment for an abortion or related service is made when Form 470-0836 is completed for the applicable circumstances and is attached to each claim for services. Payment for an abortion is made under one of the following circumstances:

a. The physician certifies that the pregnant woman's life would be endangered if the fetus were carried to term.

b. The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition.

c. The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of the rape.

d. The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of incest.

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross-reference 78.28(3))

78.1(19) Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review

applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the published criteria established by the IFMC and the department. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

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

78.1(20) Transplants.

a. Payment will be made only for the following organ and tissue transplant services:

(1) Kidney, cornea, skin, and bone transplants.

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

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

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

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

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

(5) Heart transplants. Artificial hearts and ventricular assist devices, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplants, are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants and heart-lung transplants described above require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1)*"f."*) Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

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

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

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.
2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.
- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.
- Consistent failure of insulin-based management to prevent acute complications.

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

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

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

b. Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

c. All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.

d. Payment will not be made for any transplant not specifically listed in paragraph *"a."*

78.1(21) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term "physician" does not include a psychiatrist. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.1(22) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement shall be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

78.1(23) EPSDT care coordination. Rescinded IAB 12/3/08, effective 2/1/09.

78.1(24) Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the Current Dental Terminology, Third Edition (CDT-3), for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

a. Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

b. Separate payment shall be available only for application of topical fluoride varnish, which shall be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening shall not be available, as this service is already part of and paid under the EPSDT screening examination.

c. Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician's supervision that this application is not a substitute for comprehensive dental care.

d. Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

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

[**ARC 8714B**, IAB 5/5/10, effective 5/1/10]

441—78.2(249A) Prescribed outpatient drugs. Payment will be made for "covered outpatient drugs" as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) subject to the conditions and limitations specified in this rule.

78.2(1) *Qualified prescriber.* All drugs are covered only if prescribed by a legally qualified practitioner (physician, dentist, podiatrist, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner).

78.2(2) *Prescription required.* As a condition of payment for all drugs, including "nonprescription" or "over-the-counter" drugs that may otherwise be dispensed without a prescription, a prescription shall

be transmitted as specified in Iowa Code sections 124.308 and 155A.27, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions shall be available for audit by the department.

78.2(3) *Qualified source.* All drugs are covered only if marketed by manufacturers that have signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990).

78.2(4) *Prescription drugs.* Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A as amended by 2010 Iowa Acts, Senate File 2088, section 347.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required. However, prior authorization shall not be required for such a drug for a member whose regimen on the drug was established before January 1, 2011, as verified by documented pharmacy claims.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed Form 470-4914, Fax Confidentiality Certificate, and

2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

b. Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act.

(2) Drugs used for anorexia, weight gain, or weight loss.

(3) Drugs used for cosmetic purposes or hair growth.

(4) Rescinded IAB 11/2/11, effective 11/1/11.

(5) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee.

(6) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (drugs identified through the Drug Efficacy Study Implementation (DESI) review)).

(7) "Covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any "Part D eligible individual" as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including a member who is not enrolled in a Medicare Part D plan.

(8) Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility, as defined in subparagraph (1).

(9) Drugs used for the treatment of sexual or erectile dysfunction, except when used to treat a condition other than sexual or erectile dysfunction for which the drug has been approved by the U.S. Food and Drug Administration.

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

78.2(5) *Nonprescription drugs.* The following drugs that may otherwise be dispensed without a prescription are covered subject to the prior authorization requirements stated below and as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

Acetaminophen tablets 325 mg, 500 mg
Acetaminophen elixir 160 mg/5 ml
Acetaminophen solution 100 mg/ml
Acetaminophen suppositories 120 mg
Artificial tears ophthalmic solution
Artificial tears ophthalmic ointment
Aspirin tablets 325 mg, 650 mg, 81 mg (chewable)
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
Aspirin tablets, buffered 325 mg
Bacitracin ointment 500 units/gm
Benzoyl peroxide 5%, gel, lotion
Benzoyl peroxide 10%, gel, lotion
Calcium carbonate chewable tablets 500 mg, 750 mg, 1000 mg, 1250 mg
Calcium carbonate suspension 1250 mg/5 ml
Calcium carbonate tablets 600 mg
Calcium carbonate-vitamin D tablets 500 mg-200 units
Calcium carbonate-vitamin D tablets 600 mg-200 units
Calcium citrate tablets 950 mg (200 mg elemental calcium)
Calcium gluconate tablets 650 mg
Calcium lactate tablets 650 mg
Cetirizine hydrochloride liquid 1 mg/ml
Cetirizine hydrochloride tablets 5 mg
Cetirizine hydrochloride tablets 10 mg
Chlorpheniramine maleate tablets 4 mg
Clotrimazole vaginal cream 1%
Diphenhydramine hydrochloride capsules 25 mg
Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
Epinephrine racemic solution 2.25%
Ferrous sulfate tablets 325 mg
Ferrous sulfate elixir 220 mg/5 ml
Ferrous sulfate drops 75 mg/0.6 ml
Ferrous gluconate tablets 325 mg
Ferrous fumarate tablets 325 mg
Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
Ibuprofen suspension 100 mg/5 ml
Ibuprofen tablets 200 mg
Insulin
Lactic acid (ammonium lactate) lotion 12%
Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine syrup 5 mg/5 ml
Loratadine tablets 10 mg
Magnesium hydroxide suspension 400 mg/5 ml
Magnesium oxide capsule 140 mg (85 mg elemental magnesium)
Magnesium oxide tablets 400 mg
Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
Miconazole nitrate cream 2% topical and vaginal
Miconazole nitrate vaginal suppositories, 100 mg
Multiple vitamin and mineral products with prior authorization

Neomycin-bacitracin-polymyxin ointment
Niacin (nicotinic acid) tablets 50 mg, 100 mg, 250 mg, 500 mg
Nicotine gum 2 mg, 4 mg
Nicotine lozenge 2 mg, 4 mg
Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
Pediatric oral electrolyte solutions
Permethrin lotion 1%
Polyethylene glycol 3350 powder
Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
Pseudoephedrine hydrochloride liquid 30 mg/5 ml
Pyrethrins-piperonyl butoxide liquid 0.33-4%
Pyrethrins-piperonyl butoxide shampoo 0.3-3%
Pyrethrins-piperonyl butoxide shampoo 0.33-4%
Salicylic acid liquid 17%
Senna tablets 187 mg
Sennosides-docusate sodium tablets 8.6 mg-50 mg
Sennosides syrup 8.8 mg/5 ml
Sennosides tablets 8.6 mg
Sodium bicarbonate tablets 325 mg
Sodium bicarbonate tablets 650 mg
Sodium chloride hypertonic ophthalmic ointment 5%
Sodium chloride hypertonic ophthalmic solution 5%
Tolnaftate 1% cream, solution, powder

Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

78.2(6) *Quantity prescribed and dispensed.*

a. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe a quantity of prescription medication sufficient for up to a 31-day supply. Oral contraceptives may be prescribed in 90-day quantities.

b. Oral solid forms of covered nonprescription items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription or the currently available consumer package size except when dispensed via a unit-dose system.

78.2(7) *Lowest cost item.* The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

78.2(8) *Consultation.* In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990), a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation shall be found in rules of the Iowa board of pharmacy.

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

[**ARC 8097B**, IAB 9/9/09, effective 11/1/09; **ARC 9175B**, IAB 11/3/10, effective 1/1/11; **ARC 9699B**, IAB 9/7/11, effective 9/1/11; **ARC 9834B**, IAB 11/2/11, effective 11/1/11; **ARC 9882B**, IAB 11/30/11, effective 1/4/12]

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Foundation for Medical Care (IFMC). All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Readmissions to the same facility due to premature discharge shall not be paid a new DRG. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross-reference 78.28(5)) The criteria are available from IFMC, 6000 Westown Parkway,

Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

78.3(1) Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

78.3(2) No payment will be approved for private duty nursing.

78.3(3) Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

78.3(4) Services provided for intestinal or gastric bypass surgery for treatment of obesity requires prior approval, which must be obtained by the attending physician before surgery is performed.

78.3(5) Payment will be approved for drugs provided inpatients subject to the same provisions specified in 78.2(1) and 78.2(4)*"b"*(1) to (10) except for 78.2(4)*"b"*(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

a. Payment will be approved for drugs and supplies provided outpatients subject to the same provisions specified in 78.2(1) through 78.2(4) except for 78.2(4)*"b"*(7). The basis of payment for drugs provided outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

b. Hospitals that wish to administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health for Medicaid members.

78.3(6) Payment for nursing care provided by a hospital shall be made to those hospitals which have been certified by the department of inspections and appeals as meeting the standards for a nursing facility.

78.3(7) Payment for inpatient hospital tests for purposes of diagnosis and treatment shall be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient's condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient's diagnosis or treatment.

78.3(8) Rescinded IAB 2/6/91, effective 4/1/91.

78.3(9) Payment will be made for sterilizations in accordance with 78.1(16).

78.3(10) Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

a. Recipient selection and education.

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified.

The team should consist of:

A surgeon director.

A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

Anesthesiology.
Cardiology.
Dialysis.
Gastroenterology.
Hepatology.
Immunology.
Infectious diseases.
Nephrology.
Neurology.
Pathology.
Pediatrics.
Psychiatry.
Pulmonary medicine.
Radiology.
Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include the following:

Persons with expertise in the following areas available at the transplant center:

Anesthesiology.
Blood bank services.
Cardiology.
Cardiovascular surgery.
Dialysis.
Dietary services.
Gastroenterology.

Infection control.

Laboratory services (pathology, microbiology, immunology, tissue typing, and monitoring of immunosuppressive drugs).

Legal counsel familiar with transplantation laws and regulations.

Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.

Respiratory therapy.

Pharmaceutical services.

Physical therapy.

Psychiatry.

Psycho-social.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI). As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. Experience and survival rates.

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year.

For approval of an extrarenal organ transplant program it is highly desirable that the institution: 1. has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or 2. has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level.

To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

d. Organ procurement. The transplant center will participate in a nationwide organ procurement and typing network.

Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria.

The transplant center must be a member of the National Organ Procurement and Transplant Network.

e. Maintenance of data, research, review and evaluation.

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

These data should be maintained in the computer at the transplant center monthly.

The transplant center will submit the above data to the United Network of Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research.

Ongoing research regarding the transplanted organs is required.

The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program.

The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient.

The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program.

The transplant center will provide information to members of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process.

The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

f. Application procedure. A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to the Iowa Medicaid enterprise provider services unit. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to the Iowa Medicaid enterprise provider services unit.

g. Review and approval of facilities. An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes which would affect its approved status. Specifically, a facility must report any significant decrease in its experience level or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

78.3(11) Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

78.3(12) Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16)*"a"* and *"r"* to determine if a medical emergency exists.

Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual's health unless immediate medical treatment is given.

The determination of whether a medical emergency exists will be based on the patient's medical condition including presenting symptoms and medical history prior to treatment or evaluation.

78.3(13) Payment for patients in acute hospital beds who are determined by IFMC to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective *(a)* as of the date of notice by IFMC that the lower level of care is required or *(b)* for the days IFMC determines in an outlier review that the lower level of care was required.

78.3(14) Payment for patients in acute hospital beds who are determined by IFMC to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective *(a)* as of the date of notice by IFMC that the lower level of care is required or *(b)* for the days IFMC determines in an outlier review that the lower level of care was required.

78.3(15) Payment for inpatient hospital charges associated with surgical procedures on the "Outpatient/Same Day Surgery List" produced by the Iowa Foundation for Medical Care shall be made only when attending physician has secured approval from the hospital's utilization review department prior to admittance to the hospital. Approval shall be granted when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete or modify entries on the "Outpatient/Same Day Surgery List."

78.3(16) Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3) and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3), with the rate component limits being revised July 1, 2001, and every second year thereafter.

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

78.3(18) Preprocedure review by the IFMC is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 78.28(5))

78.3(19) Rescinded IAB 10/8/97, effective 12/1/97.

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

441—78.4(249A) Dentists. Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Payment will also be made for the following dental procedures subject to the exclusions for services to adults 21 years of age and older set forth in subrule 78.4(14):

78.4(1) *Preventive services.* Payment shall be made for the following preventive services:

a. Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six-month period except for persons who, because of physical or mental disability, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

b. Topical application of fluoride is payable once in a six-month period except for people who need more frequent applications because of physical or mental disability. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants are payable for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental disability that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

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

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

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

c. A complete mouth radiograph survey consisting of a minimum of 14 periapical films and bite-wing films is a payable service once in a five-year period, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases. Complete mouth radiograph surveys are not payable under the age of six. A panographic-type radiography with bitewings is considered the same as a complete mouth radiograph survey.

d. Supplemental bitewing films are payable only once in a 12-month period.

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.

i. Temporomandibular joint radiograph.

j. Cephalometric film.

k. Diagnostic casts are payable only for orthodontic cases or when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

78.4(3) *Restorative services.* Payment shall be made for the following restorative services:

a. Treatment of dental caries is payable in those areas which require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials are reimbursable only once for the same restoration in a two-year period.

c. Rescinded IAB 5/1/02, effective 7/1/02.

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

e. Cast post and core, steel post and composite or amalgam in addition to a crown is payable when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

f. Payment as indicated will be made for the following restorative procedures:

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

(2) One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid.

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Rescinded IAB 5/1/02, effective 7/1/02.

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

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, local anesthesia and inhaled anesthesia are included in the restorative fee and may not be billed separately.

(7) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(8) More than four surfaces on an amalgam restoration will be reimbursed as a "four-surface" amalgam.

(9) An amalgam restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

78.4(4) *Periodontal services.* Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is payable once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing is payable when prior approval has been received. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (Cross-reference 78.28(2)*"a"*(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.28(2)*"a"*(2))

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

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

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

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

(2) Gingivoplasty will be paid per tooth.

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

78.4(5) *Endodontic services.* Payment shall be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when extensive posttreatment restorative procedures are not necessary and when missing teeth do not jeopardize the integrity or function of the dental arches.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment is payable when prior approval has been received. Payment for an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue will be approved when nonsurgical treatment has been attempted and a reasonable time has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross-reference 78.28(2)*"d"*)

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment shall be granted when the conventional treatment has been completed, a reasonable time has elapsed, and failure has been demonstrated with a radiograph and narrative history.

78.4(6) *Oral surgery—medically necessary.* Payment shall be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy, as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician's reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

a. Extractions, both surgical and nonsurgical.

b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.

c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.

d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.

e. Root recovery (surgical removal of residual root).

f. Oral antral fistula closure (or antral root recovery).

g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.

h. Surgical exposure of impacted or unerupted tooth to aid eruption.

i. General anesthesia, intravenous sedation, and non-intravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants its use.

j. Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

k. Payment may be made for postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

78.4(7) *Prosthetic services.* Payment may be made for the following prosthetic services:

a. An immediate denture and a first-time complete denture including six months' postdelivery care. An immediate denture and a first-time complete denture are payable when the denture is provided to establish masticatory function. An immediate denture or a first-time complete denture is payable only once following the removal of teeth it replaces. A complete denture is payable only once in a five-year period except when the denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of complete dentures due to resorption in less than a five-year period is not payable.

b. A removable partial denture replacing anterior teeth, including six months' postdelivery care. A removable partial denture replacing anterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a

removable partial denture replacing anterior teeth due to resorption in less than a five-year period is not payable.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. A removable partial denture replacing posterior teeth shall be approved when the member has fewer than eight posterior teeth in occlusion or the member has a full denture in one arch, and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.28(2)*"c"*(1))

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

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

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

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

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

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

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

k. Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

l. Dental implants and related services when prior authorization has been received. Prior authorization shall be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

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

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

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

malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, openbite, and crossbite.

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

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

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

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

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

78.4(10) *Treatment in a nursing facility.* Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

78.4(11) *Office visit.* Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or exams are not billed for that visit.

78.4(12) *Office calls after hours.* Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

78.4(13) *Drugs.* Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist's office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

78.4(14) *Services to members 21 years of age or older.* Orthodontic procedures are not covered for members 21 years of age or older.

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

[**ARC 9702B**, IAB 9/7/11, effective 9/1/11; **ARC 9883B**, IAB 11/30/11, effective 1/4/12]

441—78.5(249A) Podiatrists. Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

a. Durable plantar foot orthotic.

b. Plaster impressions for foot orthotic.

c. Molded digital orthotic.

d. Shoe padding when appliances are not practical.

e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.

f. Rams horn (hypertrophic) nails.

g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

a. Treatment of flatfoot. The term "flatfoot" is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2)*"c."* Payment shall be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist's office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

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

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) *Payable professional services are:*

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation.

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

(1) When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.
2. Verification of lenses after fabrication.
3. Adjustment and alignment of completed lens order.

(2) New lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.
2. Up to four times per year for children one through three years of age.
3. Once every 12 months for children four through seven years of age.
4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Protective lenses are allowed for:

1. Children through seven years of age.
2. Members with vision in only one eye.
3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Rescinded IAB 4/3/02, effective 6/1/02.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.
2. Sizing and measurements.
3. Fitting and adjustment.
4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.
2. One frame every 12 months is allowed for children four through six years of age.
3. When there is a prescribed lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.
2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk.

g. Rescinded IAB 4/3/02, effective 6/1/02.

h. Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

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

78.6(2) *Ophthalmic materials.* Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

a. Corrected curve lenses, unless clinically contraindicated, manufactured by reputable American manufacturers.

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

c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

78.6(3) *Reimbursement.* The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice.

a. Materials payable by fee schedule are:

(1) Lenses, single vision and multifocal.

(2) Frames.

(3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

(1) Contact lenses.

(2) Schroeder shield.

(3) Ptosis crutch.

(4) Protective lenses and safety frames.

(5) Subnormal visual aids.

78.6(4) *Prior authorization.* Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

(Cross-reference 78.28(3))

78.6(5) *Noncovered services.* Noncovered services include, but are not limited to, the following services:

a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.

b. Glasses for protective purposes including glasses for eye safety, sunglasses, or glasses with photogray lenses. An exception to this is in 78.6(3)*"b"*(4).

c. A second pair of glasses or spare glasses.

d. Cosmetic surgery and experimental medical and surgical procedures.

e. Contact lenses if vision is correctable with noncontact lenses except as found at paragraph 78.6(1)*"i."*

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

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

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

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross-reference 78.28(3))

78.7(1) to **78.7(3)** Rescinded IAB 4/3/02, effective 6/1/02.

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

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of "pain" is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient's condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

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

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

b. The neuromusculoskeletal conditions listed in the table in paragraph *"a"* generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

(1) The maximum therapeutic benefit has been achieved for a given condition.

(2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient's condition.

(3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) *Documenting X-ray.* An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or

3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph *"c"* of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient's name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient's clinical record.

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph *"a"* of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph *"a"* of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor's office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

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

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member's residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10)*"a"* may be provided in settings other than the member's residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member's community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or

counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, evidenced by the physician's signature and date on a plan of treatment.

78.9(1) *Treatment plan.* A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 62 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

a. Place of service.
b. Type of service to be rendered and the treatment modalities being used.
c. Frequency of the services.
d. Assistance devices to be used.
e. Date home health services were initiated.
f. Progress of member in response to treatment.
g. Medical supplies to be furnished.
h. Member's medical condition as reflected by the following information, if applicable:
(1) Dates of prior hospitalization.
(2) Dates of prior surgery.
(3) Date last seen by a physician.
(4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
(5) Prognosis.
(6) Functional limitations.
(7) Vital signs reading.
(8) Date of last episode of instability.
(9) Date of last episode of acute recurrence of illness or symptoms.
(10) Medications.
i. Discipline of the person providing the service.
j. Certification period (no more than 62 days).
k. Estimated date of discharge from the hospital or home health agency services, if applicable.
l. Physician's signature and date. The plan of care must be signed and dated by the physician before the claim for service is submitted for reimbursement.

78.9(2) *Supervisory visits.* Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician and included in the plan of

care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"b."*

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"c."*

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"d."*

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services

furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) *Medical social services.*

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

(1) Are reasonable and necessary to the treatment of a member's illness or injury.

(2) Contribute meaningfully to the treatment of the member's condition.

(3) Are under the direction of a physician.

(4) Are provided by or under the supervision of a qualified medical or psychiatric social worker.

(5) Address social problems that are impeding the member's recovery.

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

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

(1) The potential risk factors,

(2) The medical factor or symptom which verifies the child is at risk,

(3) The reason the member is unable to obtain care outside of the home,

(4) The medically related task of the home health agency,

(5) The member's diagnosis,

(6) Specific services and goals, and

(7) The medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.

(4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.

(5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.

(6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.

(7) Second pregnancy in 12 months.

(8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.

(4) Preexisting mental or physical disabilities such as deaf, blind, hemaplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or mental retardation.

(5) Drug or alcohol abuse.

(6) Symptoms of postpartum psychosis.

(7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.

(8) Demonstrated disturbance in maternal and infant bonding.

(9) Discharge or release from hospital against medical advice before 36 hours postpartum.

(10) Insufficient antepartum care by history.

(11) Multiple births.

(12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

(1) Birth weight of five pounds or under or over ten pounds.

(2) History of severe respiratory distress.

(3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.

(4) Disabling birth injuries.

(5) Extended hospitalization and separation from other family members.

(6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to mental retardation.

(7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.

(8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.

(9) Discharge or release against medical advice before 36 hours of age.

(10) Nutrition or feeding problems.

e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:

(1) Child or sibling victim of child abuse or neglect.

(2) Mental retardation or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.

(3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.

(4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.

(5) Malignancies such as leukemia or carcinoma.

(6) Severe injuries necessitating treatment or rehabilitation.

(7) Disruption in family or peer relationships.

(8) Suspected developmental delay.

(9) Nutritional deficiencies.

78.9(10) *Private duty nursing or personal care services for persons aged 20 and under.* Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.
5. Transportation services.
6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.28(9))

78.9(11) *Vaccines.* Home health agencies which wish to administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health for Medicaid members. Home health agencies may provide Vaccines for Children clinics and be reimbursed for vaccine administration to provide Vaccines for Children program vaccines to Medicaid children in other than the home setting.

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

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 9315B**, IAB 12/29/10, effective 2/2/11]

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) *General payment requirements.* Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the diagnosis, prognosis, and length of time the item is to be required.

For items requiring prior approval, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior approval is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior approval requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

(1) Physical fitness equipment, e.g., an exercycle, weights.

(2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.

(3) Self-help devices, e.g., safety grab bars, raised toilet seats.

(4) Training equipment, e.g., speech teaching machines, braille training texts.

(5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.

(6) Equipment which basically serves comfort or convenience functions, or is primarily for the convenience of a person caring for the patient, e.g., elevators, stairway elevators and posture chairs.

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

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise, and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators will be maintained on a rental basis for the duration of use.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

78.10(2) *Durable medical equipment.* DME is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

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

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

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

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

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

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

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

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

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

Alternating pressure pump.

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

Bedpan.

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

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary only for members with significant hypoxemia as defined by Medicare and shown by supporting medical documentation. The physician's, physician assistant's, or advanced registered nurse practitioner's prescription shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained at one year of age and at two years of age and documented in the provider record.

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

1. A diagnosis of the disease requiring home use of oxygen;
2. The oxygen flow rate and concentration;
3. The type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and

5. The initial reading on the time meter clock on each concentrator, where applicable.

Oxygen prescribed "PRN" or "as necessary" is not allowed.

(2) If the patient's condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician (doctor of medicine or osteopathy), physician assistant, or advanced registered nurse practitioner of the medical necessity for portable oxygen for specific activities.

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

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

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

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

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

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

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

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

(3) Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a patient with a diagnosis of a lung disorder if all of the following conditions are met:

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

2. The patient resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

3. Treatment by flutter device failed or is contraindicated.

4. Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

5. All other less costly alternatives have been tried.

(4) Automated medication dispenser. Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

1. The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

2. The member is on two or more medications prescribed to be administered more than one time a day.

3. The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

4. Less costly alternatives, such as medisets or telephone reminders, have failed.

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

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

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

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

78.10(3) *Prosthetic devices.* Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the patient's condition may improve sometime in the future.

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

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

(1) Artificial eyes.

(2) Artificial limbs.

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

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

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

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

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

(8) Ostomy appliances.

(9) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

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

(11) Tracheotomy tubes.

(12) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross-reference 78.28(4))

c. Prior approval is required for the following prosthetic devices:

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

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

A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity

for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

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

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

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

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

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

(3) Oral nutritional products. Payment for oral nutritional products shall be approved as medically necessary only when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for the mentally retarded. A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for oral supplementation pursuant to these standards. The documentation shall include:

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

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

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

d. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is photographic evidence supporting moderate to severe nonsynostotic positional plagiocephaly and either:

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

(2) The member is between 6 and 18 months of age and there is documentation of either of the following conditions:

1. Cephalic index at least two standard deviations above the mean for the member's gender and age; or

2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) *Medical supplies.* Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the

preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member's caregiver for each refill.

a. Only the following types of medical supplies and supplies necessary for the effective use of a payable item can be purchased through the medical assistance program:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

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

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

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

Dialysis supplies.

Diapers (for members aged four and above).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

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

Disposable underpads.

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Respirator supplies.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for the mentally retarded when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

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

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

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

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

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

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

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

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 8993B**, IAB 8/11/10, effective 10/1/10; **ARC 9256B**, IAB 12/1/10, effective 1/1/11]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved

only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

a. The individual is admitted as a hospital inpatient or in an emergency situation.

b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

One patient - normal allowance

Two patients - 3/4 normal allowance per patient

Three patients - 2/3 normal allowance per patient

Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5)*"j."*

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

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

441—78.12(249A) Behavioral health intervention. Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of an Axis I psychological disorder, subject to the limitations in this rule.

78.12(1) *Definitions.*

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

"Behavioral health intervention" means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;

2. Improving a member's health and well-being related to the member's Axis I disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and

3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

"Licensed practitioner of the healing arts" or *"LPHA,"* as used in this rule, means a practitioner such as a physician (M.D. or D.O.), an advanced registered nurse practitioner (ARNP), a psychologist,

a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who:

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

78.12(2) *Covered services.*

a. Service setting.

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

b. Crisis intervention. Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

c. Behavior intervention. Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

d. *Family training.* Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and

2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and

2. Be based on a curriculum with a training manual.

e. *Skill training and development.* Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;

2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and

3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,

2. Conflict resolution skills,

3. Daily living skills,

4. Employment-related skills,

5. Interpersonal relationship skills,

6. Problem-solving skills, and

7. Social skills.

78.12(3) *Excluded services.*

a. Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

b. Respite, day care, education, and recreation services are not covered under behavioral health intervention.

78.12(4) *Coverage requirements.* Medicaid covers behavioral health intervention only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder.

b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member's need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,

2. Behavioral support in the community,

3. Specific skills impaired due to the member's mental illness, and

4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

c. For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

78.12(5) *Approval of plan.* The behavioral health intervention provider shall contact the Iowa Plan provider for authorization of the services.

a. Initial plan. The initial services implementation plan must meet all of the following criteria:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(6);

(2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;

(3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

(4) The provider meets the requirements of rule 441—77.12(249A); and

(5) The plan does not exceed six months' duration.

b. Subsequent plans. The Iowa Plan contractor may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)*"a"* if the services are recommended by a licensed practitioner of the healing arts who has:

(1) Reexamined the member;

(2) Reviewed the original diagnosis and treatment plan; and

(3) Evaluated the member's progress, including a formal assessment as required by 78.12(4)*"c"*(3).

78.12(6) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, "medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by an Axis I disorder;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10; **ARC 9487B**, IAB 5/4/11, effective 7/1/11]

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

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

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

78.13(3) *Access to free transportation.* Transportation shall be provided only if the member does not have access to transportation that is available at no cost to the member, such as transportation provided by volunteers, relatives, friends, social service agencies, nursing facilities, residential care centers, or any other source. EXCEPTION: If a prescribed drug is needed immediately, transportation will be provided to obtain the drug even if free delivery is available.

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

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

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

(1) A previous relationship between the member and the requested provider,

(2) Prior experience of the member with closer providers, or

(3) Special expertise or experience of the requested provider.

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

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

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

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

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

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

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

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

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

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

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

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) *Physician examination.* The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

a. Has been advised that it may be in the member's best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) *Audiological testings.* A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) *Hearing aid evaluation.* A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) *Hearing aid selection.* A physician or audiologist may recommend a specific brand or model appropriate to the member's condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member's condition.

78.14(5) *Travel.* When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member's place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) *Purchase of hearing aid.* The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

a. A child needs the aid for speech development,

b. The aid is needed for educational or vocational purposes,

c. The aid is for a blind member,

d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or

e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) *Payment for hearing aids.*

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1)*"a."*

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross-reference 78.28(4)*"a"*)

(2) Payment for a hearing aid costing more than $650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross-reference 78.28(4)*"b"*):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output

shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

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

[**ARC 8008B**, IAB 7/29/09, effective 8/1/09]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) *Definitions.*

"Custom-molded shoe" means a shoe that:

1. Has been constructed over a cast or model of the recipient's foot;
2. Is made of leather or another suitable material of equal quality;
3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
4. Has some form of closure.

"Depth shoe" means a shoe that:

1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

"Insert" means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient's foot or is made over a model of the foot.

78.15(2) *Prescription.* The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient's diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) *Diagnosis.* The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

(1) The reasons the recipient cannot be fitted with a depth shoe.
(2) Pain.
(3) Tissue breakdown or a high probability of tissue breakdown.
(4) Any limitation on walking.

78.15(4) *Frequency.* Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

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

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1)*"b"* with the following exceptions:

(1) Services by staff psychiatrists, or

(2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or

(3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)*"b"*(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)*"b"*(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6)*"b."*

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs *"c"* to *"h"* below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio.

Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours

in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the "National Register of Health Service Providers in Psychology" or the "Iowa Register of Health Service Providers for Psychology." Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient's clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient's needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist

of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

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

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as screening center services. Screening centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Screening centers shall receive reimbursement for the administration of vaccines to Medicaid members.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

(1) Six screenings in the first year of life.

(2) Four screenings between the ages of 1 and 2.

(3) One screening a year at ages 3, 4, 5, and 6.

(4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Rescinded IAB 12/3/08, effective 2/1/09.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

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

441—78.19(249A) Rehabilitation agencies.

78.19(1) *Coverage of services.*

a. General provisions regarding coverage of services.

(1) Services are provided in the recipient's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided a recipient residing in a nursing facility or residential care facility are payable when a statement is submitted signed by the facility that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a recipient residing in an intermediate care facility for the mentally retarded since these facilities are responsible for providing or paying for services required by recipients.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1)*"b"*(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1)*"b"*(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1)*"b"*(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the

same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)

2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)

3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)*"b"*(7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1)*"b"*(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)*"b"*(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number "5" under 78.19(1)*"b"*(16) will not apply to trial therapy.

78.19(2) *General guidelines for plans of treatment.*

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to 78.19(1)*"b"*(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.
(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).
(11) A brief summary of the initial evaluation or baseline.
(12) The patient's prognosis.
(13) The services to be rendered.
(14) The frequency of the services and discipline of the person providing the service.
(15) The anticipated duration of the services and the estimated date of discharge (if applicable).
(16) Assistive devices to be used.
(17) Functional limitations.
(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.
(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).
(20) Quantitative, measurable, short-term and long-term functional goals.
(21) The period of time of a session.
(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:
(1) To whom the services were provided (patient, family member, etc.).
(2) Prior teaching, training, or counseling provided.
(3) The medical necessity of the rendered services.
(4) The identification of specific services and goals.
(5) The date of the start of the services.
(6) The frequency of the services.
(7) Progress in response to the services.
(8) The estimated length of time the services are needed.

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

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

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

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) *Vaccines.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as rural health center services. Rural health clinics that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children

program and obtain the vaccines from the department of public health. However, the administration of vaccines is a covered service.

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

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as family planning clinic services. Family planning clinics that wish to administer those vaccines for Medicaid members who receive services at the clinic shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Family planning clinics shall receive reimbursement for the administration of vaccines to Medicaid members.

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

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) *Sterilization.* Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) *Vaccines.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as clinic services. Clinics that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Clinics shall receive reimbursement for the administration of vaccines to Medicaid members.

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

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as maternal health center services. Maternal health centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Maternal health centers shall receive reimbursement for the administration of vaccines to Medicaid members.

78.25(1) *Provider qualifications.*

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Rescinded IAB 12/3/08, effective 2/1/09.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) *Services covered for all pregnant women.* Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)*"b."*

78.25(3) *Enhanced services covered for women with high-risk pregnancies*. Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Rescinded IAB 12/3/08, effective 2/1/09.

b. Education, which shall include as appropriate education about the following:

(1) High-risk medical conditions.

(2) High-risk sexual behavior.

(3) Smoking cessation.

(4) Alcohol usage education.

(5) Drug usage education.

(6) Environmental and occupational hazards.

c. Nutrition assessment and counseling, which shall include:

(1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.

(2) Ongoing nutritional assessment.

(3) Development of an individualized nutritional care plan.

(4) Referral to food assistance programs if indicated.

(5) Nutritional intervention.

d. Psychosocial assessment and counseling, which shall include:

(1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.

(2) A profile of the client's family composition, patterns of functioning and support systems.

(3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.

e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:

(1) Assessment of mother's health status.

(2) Physical and emotional changes postpartum.

(3) Family planning.

(4) Parenting skills.

(5) Assessment of infant health.
(6) Infant care.
(7) Grief support for unhealthy outcome.
(8) Parenting of a preterm infant.
(9) Identification of and referral to community resources as needed.

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

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's Web site.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;

b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and

c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239, or in local hospital utilization review offices. (Cross-reference 78.28(6))

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

[**ARC 8205B**, IAB 10/7/09, effective 11/11/09]

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

78.27(1) *Definitions.*

"Adult" means a person who is 18 years of age or older.

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Case management" means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

"Comprehensive service plan" means an individualized, goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

"Department" means the Iowa department of human services.

"Emergency" means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

"HCBS" means home- and community-based services.

"Interdisciplinary team" means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member's need for services.

"ISIS" means the department's individualized services information system.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

78.27(2) *Member eligibility.* To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. Risk factors. The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member's life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

b. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

c. Income. The countable income used in determining the member's Medicaid eligibility does not exceed 150 percent of the federal poverty level.

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

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

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

e. Plan for service. The department has approved the member's plan for home- and community-based habilitation services. A service plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before department approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member's needs.

(2) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

78.27(3) *Application for services.* The case manager shall apply for services on behalf of a member by entering a program request for habilitation services in ISIS. The department shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the service plan have been completed.

78.27(4) *Comprehensive service plan.* Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager shall establish an interdisciplinary team for the member. The team shall include the case manager and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved.

(2) With the interdisciplinary team, the case manager shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial service plan and annual updates to the service plan must be approved by the Iowa Medicaid enterprise in the individualized services information system before services are implemented. Services provided before the approval date are not payable. The written case plan must be completed, signed and dated by the case manager or service worker within 30 calendar days after plan approval.

(10) Any changes to the service plan must be approved by the Iowa Medicaid enterprise in the individualized services information system before the implementation of services. Services provided before the approval date are not payable.

b. Service goals and activities. The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;
2. The funding source for the service; and
3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;
2. The number of hours per day of on-site staff supervision needed by the member; and
3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan shall include documentation of:

(1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;

(2) The need for the restriction; and

(3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. Emergency plan. The comprehensive service plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

(1) The member's interdisciplinary team shall identify in the comprehensive service plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

(2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

(3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval. Services shall be entered into ISIS based on the comprehensive service plan. A service plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2)*"e."*

78.27(5) *Requirements for services.* Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member's needs as identified in the member's comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) *Case management.* Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Exclusion. Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) *Home-based habilitation.* "Home-based habilitation" means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

(1) Adaptive skill development;

(2) Assistance with activities of daily living;

(3) Community inclusion;

(4) Transportation;

(5) Adult educational supports;

(6) Social and leisure skill development;

(7) Personal care; and

(8) Protective oversight and supervision.

b. Exclusions. Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) *Day habilitation.* "Day habilitation" means assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member's maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member's:

(1) Intellectual functioning;

(2) Physical and emotional health and development;

(3) Language and communication development;

(4) Cognitive functioning;

(5) Socialization and community integration;

(6) Functional skill development;

(7) Behavior management;

(8) Responsibility and self-direction;

(9) Daily living activities;

(10) Self-advocacy skills; or

(11) Mobility.

b. Setting. Day habilitation shall take place in a nonresidential setting separate from the member's residence. Services shall not be provided in the member's home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member's home if the services are provided in an area apart from the member's sleeping accommodations.

c. Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

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

(1) Vocational or prevocational services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in day habilitation services.

78.27(9) *Prevocational habilitation.* "Prevocational habilitation" means services that prepare a member for paid or unpaid employment.

a. Scope. Prevocational habilitation services include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Services are not oriented to a specific job task, but instead are aimed at a generalized result. Services shall be reflected in the member's

comprehensive service plan and shall be directed to habilitative objectives rather than to explicit employment objectives.

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

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

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available for the service under these programs shall be maintained in the file of each member receiving prevocational habilitation services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in prevocational services.

78.27(10) *Supported employment habilitation.* "Supported employment habilitation" means services associated with maintaining competitive paid employment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available under these programs shall be maintained in the file of each member receiving supported employment services.

(2) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing or maintaining members in day activity programs, work activity programs, or sheltered workshop programs.

(6) Supports for volunteer work or unpaid internships.

(7) Tuition for education or vocational training.

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

78.27(11) *Adverse service actions.*

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

(1) Rescinded IAB 12/29/10, effective 1/1/11.

(2) The member is not eligible for or in need of home- and community-based habilitation services.

(3) The service is not identified in the member's comprehensive service plan.

(4) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(5) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(6) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 consecutive days, the department will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

78.27(12) *County reimbursement.* The county board of supervisors of the member's county of legal settlement shall reimburse the department for all of the nonfederal share of the cost of home- and community-based habilitation services provided to an adult member with a chronic mental illness as defined in 441—Chapter 90. The department shall notify the county's central point of coordination administrator through ISIS of the approval of the member's service plan.

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 9311B**, IAB 12/29/10, effective 1/1/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11]

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

78.28(1) Services, procedures, and medications prescribed by a physician (M.D. or D.O.) which are subject to prior approval or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code Supplement section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Automated medication dispenser. (Cross-reference 78.10(2)*"b"*) Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

(2) The member is on two or more medications prescribed to be administered more than one time a day.

(3) The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

(4) Less costly alternatives, such as medisets or telephone reminders, have failed.

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

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

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

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

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

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

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

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

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

(1) Information requested on the prior authorization form includes a medical history, diagnosis, and prognosis completed by a physician. In addition, a speech or language pathologist needs to describe

current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status.

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

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

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

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

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

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

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

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

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross-reference 78.10(2)*"c"*)

i. Prior authorization is required for oral nutritional products. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for oral nutritional products when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition.

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

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

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

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

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

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

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

(2) The patient resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

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

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

a. The following periodontal services:

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

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

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

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

b. Surgical endodontic treatment which includes an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue will be approved when nonsurgical treatment has been attempted and a reasonable time has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross-reference 78.4(5)*"c"*)

c. The following prosthetic services:

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

(2) A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth will be approved for members whose medical condition precludes the use of a removable partial denture. High noble or noble metals will be approved only when the member is allergic to all other restorative

materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7)*"d"*)

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

(4) Dental implants and related services will be authorized when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

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

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

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

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

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

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

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

78.28(3) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross-references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(4) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross-reference 78.14(7)*"d"*(1))

b. A hearing aid costing more than $650. The department shall approve payment for either of the following purposes (Cross-reference 78.14(7)*"d"*(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(5) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross-reference 441—78.1(249A))

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

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

78.28(6) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

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

78.28(7) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(8) Rescinded IAB 1/3/96, effective 3/1/96.

78.28(9) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization

shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.9(10))

78.28(10) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross-reference 78.10(3)*"b"*)

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

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9702B**, IAB 9/7/11, effective 9/1/11; **ARC 9883B**, IAB 11/30/11, effective 1/4/12]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) *Limitations.*

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) *Exclusions.* Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) *Payment.*

a. Payment shall be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

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

[**ARC 9649B**, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) *Vaccines.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as birth center services. Birth centers that wish to

administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Birth centers shall receive reimbursement for the administration of vaccines to Medicaid members.

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

441—78.31(249A) Hospital outpatient services.

78.31(1) *Covered hospital outpatient services.* Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs *"g"* to *"m"* are subject to a random sample retrospective review for medical necessity by the Iowa Foundation for Medical Care. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs *"a"* to *"f"* shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs *"g"* to *"m"* shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

a. Emergency service.
b. Outpatient surgery.
c. Laboratory, X-ray and other diagnostic services.
d. General or family medicine.
e. Follow-up or after-care specialty clinics.
f. Physical medicine and rehabilitation.
g. Alcoholism and substance abuse.
h. Eating disorders.
i. Cardiac rehabilitation.
j. Mental health.
k. Pain management.
l. Diabetic education.
m. Pulmonary rehabilitation.
n. Nutritional counseling for persons aged 20 and under.

78.31(2) *Requirements for all outpatient services.*

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs *"d"* and *"f"* and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. Hospital outpatient programs that wish to administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health for Medicaid members. Hospital outpatient programs receive payment via the APC reimbursement for the administration of vaccines to Medicaid members.

78.31(3) *Application for certification.* Hospital outpatient programs listed in subrule 78.31(1), paragraphs *"g"* to *"m,"* must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff's relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) *Requirements for specific types of service.*

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

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

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

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

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

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa, bulimia, or bulimarexia. Compulsive overeaters are not acceptable for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia as established by the DSM III R (Diagnostic and Statistical Manual, Third Edition, Revised).

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary

self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

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

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

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

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

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

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

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

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

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

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

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

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

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

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

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

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

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

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

c. Cardiac rehabilitation.

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

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

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

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

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

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

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

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

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.

Physician's orders.

Laboratory reports.

Electrocardiogram reports.

History and physical examination.

Angiogram report, if applicable.

Operative report, if applicable.

Preadmission interview.

Exercise prescription.

Rehabilitation plan, including participant's goals.

Documentation for exercise sessions and progress notes.

Nurse's progress reports.

Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, disrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs

are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

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

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

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

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

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

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

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

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

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

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

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11]

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to clients eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.34(1) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and include:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the client, and dishes.

c. Rescinded IAB 9/30/92, effective 12/1/92.

d. Meal preparation planning and preparing balanced meals.

78.34(2) *Home health services.* Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

a. Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

(8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service include health-related care, social services, and other related support services.

78.34(4) *Nursing care services.* Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would

provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in rule 441—83.1(249A).

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with

understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is one hour.

78.34(9) *Home and vehicle modification.* Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

(1) Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service.

(2) The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's

assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS ill and handicapped waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.34(13)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3).

(6) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13)*"b"*(2) or the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)*"d."* The savings plan shall meet the requirements in paragraph 78.34(13)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.36(249A) Hospice services.

78.36(1) *General characteristics.* A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

(1) Nursing care.

(2) Medical social services.

(3) Physician services.

(4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.

(5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.

(6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

(7) Homemaker and home health aide services.

(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.

(9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate

direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.

2. The individual or the individual's representative revokes the election.

3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.

4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

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

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to consumers eligible for the HCBS elderly waiver services as established in 441—Chapter 83. The consumer shall have a billable waiver service each calendar quarter. Services must be billed in whole units.

78.37(1) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service include health-related care, social services, and other related support services.

78.37(2) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.

2. A remote, portable activator.

3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client is incapacitated or occupied providing direct care to the client. A unit of service is one hour. Components of the service include:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, and washing and mending clothes.

c. Accompaniment to medical or psychiatric services.

d. Meal preparation: planning and preparing balanced meals.

e. Bathing and dressing for self-directing recipients.

78.37(5) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.21(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

78.37(7) *Chore services.* Chore services include the following services: window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows; minor repairs to walls, floors, stairs, railings and handles; heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal; and yard work such as mowing lawns, raking leaves and shoveling walks. A unit of service is one-half hour.

78.37(8) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.37(9) *Home and vehicle modification.* Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for recipients to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation, and to reduce social isolation. A unit of service is per mile, per trip, or rate established by area agency on aging.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is one hour.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service provided by an individual or an agency, other than an assisted living program, is 1 hour or one 8- to 24-hour day. When provided by an assisted living program, a unit of service is one calendar month. If services are provided by an assisted living program for less than one full calendar month, the monthly reimbursement rate shall be prorated based on the number of days service is provided. Except for services provided by an assisted living program, each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care on behalf of the member or on behalf of the provider.

g. The member, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a guardian if the guardian has given advanced direction for the service provision.

78.37(16) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.37(16)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment

factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.37(16)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.37(16)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and assistive devices are not subject to the average cost in subparagraph 78.37(16)*"b"*(2) or the utilization adjustment factor in subparagraph 78.37(16)*"b"*(3). Anticipated costs for home and vehicle modification and assistive devices shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and assistive devices may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual

budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.37(16)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or assistive device. When authorized, the budget may include an amount allocated for a home or vehicle modification or an assistive device. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or device.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.37(16)*"d."* The savings plan shall meet the requirements in paragraph 78.37(16)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds

from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.37(17) *Case management services.* Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to clients eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.38(1) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and are:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the client, and dishes.

c. Accompaniment to medical or psychiatric services or for children aged 18 and under to school.

d. Meal preparation: planning and preparing balanced meals.

78.38(4) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.41(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

78.38(6) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.38(7) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full

day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service include health-related care, social services, and other related support services.

78.38(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.38(9) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.38(9)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.38(9)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.38(9)*"b"*(3).

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.38(9)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.38(9)*"d."* The savings plan shall meet the requirements in paragraph 78.38(9)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter)]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) *Vaccines.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Federally qualified health centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, vaccine administration is a covered service.

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

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) *Direct payment.* Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) *Location of service.* Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered

nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) *Vaccine administration.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Advanced registered nurse practitioners who wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Advanced registered nurse practitioners shall receive reimbursement for the administration of vaccines to Medicaid members.

78.40(5) *Prenatal risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

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

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. All services include the applicable and necessary instruction, supervision, assistance and support as required by the member in achieving the member's life goals. The services, amount and supports provided under the HCBS intellectual disability waiver shall be delivered in the least restrictive environment and in conformity with the member's service plan. Reimbursement shall not be available under the waiver for any services that the member can obtain through the Medicaid state plan. All services shall be billed in whole units.

78.41(1) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities.

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph 78.41(1)*"f"*(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 5,110 hourly units are available per state fiscal year except a leap year when 5,124 hourly units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

78.41(2) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is one hour.

d. Payment for respite services shall not exceed $7,050 per the member's waiver year.

e. The service shall be identified in the member's individual comprehensive plan.

f. Respite services shall not be simultaneously reimbursed with other residential or respite services or with supported community living, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

g. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

h. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.60(249A).

i. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

j. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.41(3) *Personal emergency response or portable locator system.*

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) *Home and vehicle modification.* Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs *"a"* and *"b"* that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in 441—subrule 83.67(1) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.

2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.

3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in 441—subrule 83.67(1). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.

2. Job analysis for a specific job.

3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.

4. Identifying and arranging reasonable accommodations with the employer.

5. Providing disability awareness and training to the employer when it is deemed necessary.

6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

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

1. Job opening identification with the consumer.

2. Assistance with applying for a job, including completion of applications or interviews.

3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.

2. Job coaching.

3. On-the-job or work-related crisis intervention.

4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.

5. Consumer-directed attendant care services as defined in subrule 78.41(8).

6. Assistance with time management.

7. Assistance with appropriate grooming.

8. Employment-related supportive contacts.

9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.

10. On-site vocational assessment after employment.

11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

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

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.

(6) All services shall be identified in the consumer's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;
3. Tuition for education or vocational training; or
4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.41(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private

insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is one hour.

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)*"d."*

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS intellectual disability waiver supported community living service.

78.41(12) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis. A unit of service is a full day (4 to 8 hours) or a half-day (1 to 4 hours) or an extended day (8 to 12 hours).

78.41(13) *Prevocational services.* Prevocational services are services that are aimed at preparing a member for paid or unpaid employment, but that are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but at more generalized habilitative goals, and are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) that are otherwise available to the member through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4 to 8 hours), a half day (1 to 4 hours), or an hour.

78.41(14) *Day habilitation services.*

a. Scope. Day habilitation services are services that assist or support the consumer in developing or maintaining life skills and community integration. Services must enable or enhance the consumer's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the consumer's home. The unit of service is an hour. The units of services payable are limited to a maximum of 10 hours per month.

c. Unit of service. Except as provided in paragraph *"b,"* the unit of service may be an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

d. Exclusions.

(1) Services shall not be provided in the consumer's home, except as provided in paragraph *"b."* For this purpose, services provided in a residential care facility where the consumer lives are not considered to be provided in the consumer's home.

(2) Services shall not include vocational or prevocational services and shall not involve paid work.

(3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(4) Services shall not be provided simultaneously with other Medicaid-funded services.

78.41(15) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disabilities waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.41(15)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.41(15)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.41(15)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.41(15)*"b"*(2) or the utilization adjustment factor in subparagraph 78.41(15)*"b"*(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Costs for home and vehicle modification and supported employment services to obtain a job may be paid to the financial management services provider in a one-time payment. Before becoming part of the individual budget, all home and vehicle modifications and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.41(15)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.41(15)*"d."* The savings plan shall meet the requirements in paragraph 78.41(15)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12]

441—78.42(249A) Pharmacies administering influenza vaccine to children. Payment will be made to a pharmacy for the administration of influenza vaccine available through the vaccines for children program administered by the department of public health if the pharmacy is enrolled in the vaccines for children program. No payment will be made for the vaccine.

[**ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to consumers eligible for the HCBS brain injury services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan. The services, amount and supports provided under the HCBS brain injury waiver shall be delivered in the least restrictive environment and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid.

All services shall be billed in whole units.

78.43(1) *Case management services.* Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are at the ICF/MR level of care whose county has voluntarily chosen to participate in the HCBS brain injury waiver are eligible for targeted case management and, therefore, are not eligible for case management as a waiver service.

78.43(2) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work or day programs.

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph 78.43(2)*"e"*(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 8,395 hourly units are available per state fiscal year except a leap year, when 8,418 hourly units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS brain injury waiver supported community living services, Medicaid nursing, or Medicaid home health aide services.

f. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.81(249A).

g. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

h. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.43(4) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs *"a"* and *"b"* that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in rule 441—83.87(249A) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet the consumer's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.
2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.
3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in rule 441—83.87(249A). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

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

1. Job opening identification with the consumer.
2. Assistance with applying for a job, including completion of applications or interviews.

3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Consumer-directed attendant care services as defined in subrule 78.43(13).
6. Assistance with time management.
7. Assistance with appropriate grooming.
8. Employment-related supportive contacts.
9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
10. On-site vocational assessment after employment.
11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

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

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.

(6) All services shall be identified in the consumer's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;
3. Tuition for education or vocational training; or
4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other

Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.43(5) *Home and vehicle modification.* Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The case

manager or service worker may encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

(1) Provide for health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to $6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a full day (4 to 8 hours) or a half day (1 to 4 hours) or an extended day (8 to 12 hours). Components of the service include health-related care, social services, and other related support services.

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are services which are aimed at preparing a member for paid or unpaid employment, but which are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but at more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) which are otherwise available to the member through a state or local education agency, or

(2) Vocational rehabilitation services which are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4 to 8 hours), a half day (1 to 4 hours), or an hour.

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

a. A complete assessment of both appropriate and maladaptive behaviors.

b. Development of a structured behavioral intervention plan which should be identified in the ITP.

c. Implementation of the behavioral intervention plan.

d. Ongoing training and supervision to caregivers and behavioral aides.

e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is one hour.

78.43(15) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Specialized medical equipment.
7. Supported community living.
8. Supported employment.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.43(15)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.43(15)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.43(15)*"b"*(3).

(6) Anticipated costs for home and vehicle modification, specialized medical equipment, and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.43(15)*"b"*(2) or the utilization adjustment factor in subparagraph 78.43(15)*"b"*(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications, specialized medical equipment, and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker. Costs for these services may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.43(15)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.43(15)*"d."* The savings plan shall meet the requirements in paragraph 78.43(15)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) *Applicability.* ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.

b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal DSM-IV-TR Axis I diagnosis consistent with a severe and persistent mental illness. Members with a primary diagnosis of substance disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

(2) The expected frequency and duration of each service,

(3) The location where the services will be provided,

(4) A crisis plan, and

(5) The schedule for updates of the treatment plan.

78.45(2) *Services.* The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. Evaluation and medication management.

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. Integrated therapy and counseling for mental health and substance abuse. This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. Community support. Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. Medication monitoring. Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

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

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to consumers eligible for the HCBS physical disability waiver established in 441—Chapter 83 when identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan and those delineated in Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. The service shall be delivered in the least restrictive environment consistent with the consumer's needs and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid or from any other funding source.

All services shall be billed in whole units as specified in the following subrules.

78.46(1) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. The services must be cost-effective and necessary to prevent institutionalization.

a. Providers must demonstrate proficiency in delivery of the services in the member's plan of care. Proficiency must be demonstrated through documentation of prior training or experience or a certificate of formal training.

(1) All training or experience will be detailed on Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, which must be reviewed and approved by the service worker for appropriateness of training or experience prior to the provision of services. Form 470-3372 becomes an attachment to and part of the case plan.

(2) The member shall give direction and training for activities which are not medical in nature to maintain independence. Licensed registered nurses and therapists must provide on-the-job training and supervision to the provider for skilled activities listed below and described on Form 470-3372. The training and experience must be sufficient to protect the health, welfare and safety of the member.

b. Nonskilled service activities covered are:

(1) Help with dressing.

(2) Help with bath, shampoo, hygiene, and grooming.

(3) Help with access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance which includes emptying the catheter bag, collecting a specimen and cleaning the external area around the catheter. Certification of training which includes demonstration of competence for catheter assistance is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Help with medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. Certification of training in a medication aide course is available through the area community colleges.

(8) Minor wound care which does not require skilled nursing care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistance in use of assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

c. Skilled service activities covered are the following performed under the supervision of a licensed nurse or licensed therapist working under the direction of a licensed physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall not be included in the reimbursement for consumer-directed attendant care services.

(1) Tube feedings of members unable to eat solid foods.

(2) Assistance with intravenous therapy which is administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions such as brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nurse-delegated activities under the supervision of the registered nurse.

(11) Monitoring medication reactions requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood altering or psychotropic drugs or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

d. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

e. The member, guardian, or attorney in fact under a durable power of attorney for health care shall:

(1) Select the person or agency that will provide the components of the attendant care services.

(2) Determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care on behalf of the member or on behalf of the provider.

g. The member, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a guardian if the guardian has given advanced direction for the service provision.

78.46(2) *Home and vehicle modification.* Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

(1) Provide for the health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to $6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through Medicaid as medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging.

78.46(6) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.46(6)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.46(6)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.46(6)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and specialized medical equipment are not subject to the average cost in subparagraph 78.46(6)*"b"*(2) or the utilization adjustment factor in subparagraph 78.46(6)*"b"*(3). Anticipated costs for home and vehicle modification and specialized medical equipment shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and specialized medical equipment may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.46(6)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and

approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.46(6)*"d."* The savings plan shall meet the requirements in paragraph 78.46(6)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.
(2) Select employees from a worker registry.
(3) Verify employee qualifications.
(4) Specify additional employee qualifications.
(5) Determine employee duties.
(6) Determine employee wages and benefits.
(7) Schedule employees.
(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) *Medicaid recipient eligibility.* Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) *Provider eligibility.* Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) *Services.* Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. Initial assessment. The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;
2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
3. Assessment for the presence of untreated illness; and
4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Rehabilitation services for adults with chronic mental illness. Rescinded IAB 8/1/07, effective 9/5/07.

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) *Covered services.* Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) *Case management services.* Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. "Case management" means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child's planned discharge if the child's stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child's planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child's service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

(1) Taking the child's history;

(2) Identifying the needs of the child;

(3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;

(4) Completing documentation of the information gathered and the assessment results; and

(5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

(1) Include the child's strengths and preferences;

(2) Consider the child's physical and social environment;

(3) Specify goals of providing services to the child; and

(4) Specify actions to address the child's medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.
2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.
3. Making referrals to providers for needed services.
4. Scheduling appointments for the child.
5. Facilitating the timely delivery of services.
6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.
2. Whether the services in the plan of care are adequate to meet the needs of the child.
3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

(1) The name of the child;
(2) The dates of case management services;
(3) The agency chosen by the family to provide the case management services;
(4) The nature, content, and units of case management services received;
(5) Whether the goals specified in the care plan have been achieved;
(6) Whether the family has declined services in the care plan;
(7) Time lines for providing services and reassessment; and
(8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

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

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) *Covered services.* Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as local education agency services. Agencies that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, the administration of vaccines is a covered service.

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) *Coordination services.* Rescinded IAB 12/3/08, effective 2/1/09.

78.50(3) *Delivery of services.* Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

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

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to consumers eligible for the HCBS children's mental health waiver as established in 441—Chapter 83. All services shall be provided in accordance with the general standards in subrule 78.52(1), as well as standards provided specific to each waiver service in subrules 78.52(2) through 78.52(5).

78.52(1) *General service standards.* All children's mental health waiver services shall be provided in accordance with the following standards:

a. Services must be based on the consumer's needs as identified in the consumer's service plan developed pursuant to 441—83.127(249A).

(1) Services must be delivered in the least restrictive environment consistent with the consumer's needs.

(2) Services must include the applicable and necessary instruction, supervision, assistance and support as required by the consumer to achieve the consumer's goals.

b. Payment for services shall be made only upon departmental approval of the services. Waiver services provided before approval of the consumer's eligibility for the waiver shall not be paid.

c. Services or service components must not be duplicative.

(1) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through the Iowa Medicaid program outside of the waiver.

(2) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through natural supports or community resources.

(3) Services may not be simultaneously reimbursed for the same period as nonwaiver Medicaid services or other Medicaid waiver services.

(4) Costs for waiver services are not reimbursable while the consumer is in a medical institution.

78.52(2) *Environmental modifications and adaptive devices.*

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.52(3) *Family and community support services.* Family and community support services shall support the consumer and the consumer's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the consumer's and the family's social and emotional strength.

a. Dependent on the needs of the consumer and the consumer's family members individually or collectively, family and community support services may be provided to the consumer, to the consumer's family members, or to the consumer and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the consumer's interdisciplinary team pursuant to 441—83.127(249A).

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

(1) Developing and maintaining a crisis support network for the consumer and for the consumer's family.

(2) Modeling and coaching effective coping strategies for the consumer's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the consumer and the family.

(4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.

(5) Modeling and coaching the strategies and interventions identified in the consumer's crisis intervention plan as defined in 441—24.1(225C) for life situations with the consumer's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the consumer's positive self-image.

(8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed $1500 per consumer per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must identify the transportation or therapeutic resource as a support need.

(2) The annual amount available for transportation and therapeutic resources must be listed in the consumer's service plan.

(3) The consumer's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the consumer or the consumer's family or legal guardian.

(4) The consumer's Medicaid targeted case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

(6) Family and community support services providers shall maintain records to:

1. Ensure that the transportation and therapeutic resources provided to not exceed the maximum amount authorized; and

2. Support the annual reporting requirements in 441—subparagraph 79.1(15)*"a"*(1).

e. The following components are specifically excluded from family and community support services:

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

(5) Academic services.

(6) General supervision and consumer care.

f. A unit of family and community support services is one hour.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the consumer and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the consumer to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is one hour. Any period less than one hour shall be prorated.

78.52(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The "usual caregiver" means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

a. Respite care shall not be provided to members during the hours in which the usual caregiver is employed, except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.

b. The usual caregiver cannot be absent from the home for more than 14 consecutive days during respite provision.

c. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team. The team shall determine the type of respite care to be provided according to these definitions:

(1) Basic individual respite is provided on a ratio of one staff to one member. The member does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(2) Specialized respite is provided on a ratio of one or more nursing staff to one member. The member has specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(3) Group respite is provided on a ratio of one staff to two or more members receiving respite. These members do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

d. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.

e. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

f. A unit of service is one hour.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

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1 Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

3 Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

4 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

5 At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

6 Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

7 July 1, 2009, effective date of amendments to 78.27(2)*"d"* delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

8 May 11, 2011, effective date of 78.34(5)*"d,"* 78.38(5)*"h,"* 78.41(2)*"g,"* 78.43(3)*"d,"* and 78.52(5)*"a"* delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

79.1(1) *Types of reimbursement.*

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Fee for service with cost settlement. Providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider

during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:

1. The indirect administrative costs shall be limited to 20 percent of other costs.
2. Mileage shall be reimbursed at a rate no greater than the state employee rate.
3. The rates a provider may charge are subject to limits established at 79.1(2).
4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1)*"e"*(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 2.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5)*"aa"* and 79.1(16)*"h."*

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

Provider category	Basis of reimbursement	Upper limit
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 11/30/09 less 5%. Air ambulance: Fee schedule in effect 11/30/09 less 5%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 11/30/09 less 5%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	$50.57 per day for each day on which a team meeting is held. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Behavioral health intervention	Fee schedule as determined by the Iowa Plan for Behavioral Health	Fee schedule in effect 7/1/11.
Behavioral health services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Birth centers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Chiropractors	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 11/30/09 less 2.5%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 11/30/09 less 5%.
Family planning clinics	Fee schedule	Fee schedule in effect 1/31/10.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.

Provider category	Basis of reimbursement	Upper limit
		3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	Fee schedule	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers effective 7/1/11: Provider's rate in effect 11/30/09. If no 11/30/09 rate: Veterans Administration contract rate or $22.12 per half-day, $44.03 per full day, or $66.03 per extended day if no Veterans Administration contract. For intellectual disability waiver: County contract rate or, effective 7/1/11 in the absence of a contract rate, provider's rate in effect 11/30/09. If no 11/30/09 rate, $29.47 per half-day, $58.83 per full day, or $75.00 per extended day.
2. Emergency response system:		
Personal response system	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: Initial one-time fee: $49.53. Ongoing monthly fee: $38.52.
Portable locator system	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: One equipment purchase: $307.69. Initial one-time fee: $49.53. Ongoing monthly fee: $38.52.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09. For intellectual disability waiver effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $19.81 per hour.

Provider category	Basis of reimbursement	Upper limit
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $82.92 per visit. For intellectual disability waiver effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $82.92 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate, not to exceed $296.94 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate, not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed $296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $33.75 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $18.01 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed $296.94 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $33.75 per hour not to exceed $296.94 per day.

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $18.01 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed $296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed the facility's daily Medicaid rate.
Camps	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed $296.94 per day.
Adult day care	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with mental retardation	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $7.71 per half hour.

Provider category	Basis of reimbursement	Upper limit
8. Home-delivered meals	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $7.71 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver: $1,010 lifetime maximum. For intellectual disability waiver: $5,050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: $6,060 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	Effective 7/1/11: County contract rate or, in the absence of a contract rate, provider's rate in effect 11/30/09. If no 11/30/09 rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	Effective 7/1/11 for non-county contract: Provider's rate in effect 11/30/09. If no 11/30/09 rate: $8.25 per unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/11: $110.05 per unit.
14. Senior companion	Fee schedule	Effective 7/1/11 for non-county contract: Provider's rate in effect 11/30/09. If no 11/30/09 rate: $6.59 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $20.20 per hour not to exceed $116.72 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $1,117 per calendar month. When prorated per day for a partial month, $36.71 per day.
Individual	Fee agreed upon by member and provider	Effective July 1, 2010, $13.47 per hour not to exceed $78.56 per day.
16. Counseling		
Individual:	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $10.79 per unit.

Provider category	Basis of reimbursement	Upper limit
Group:	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $43.14 per hour.
17. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	For brain injury waiver: Retrospective cost-settled rate. For elderly waiver: Quarterly revision of reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted under the appropriations made for the medical assistance program for the fiscal year.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: $34.98 per hour, $78.88 per day not to exceed the maximum daily ICF/MR rate.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: $34.98 per hour. Maximum of 26 hours per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: $34.98 per hour for all activities other than personal care and services in an enclave setting. $19.81 per hour for personal care. $6.19 per hour for services in an enclave setting. $2,883.71 per month for total service. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	$6,060 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $10.79 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $43.14 per hour.

Provider category	Basis of reimbursement	Upper limit
23. Prevocational services	Fee schedule	For the brain injury waiver effective 7/1/11: $48.22 per day, $24.11 per half-day, or $13.21 per hour. For the intellectual disability waiver effective 7/1/11: County contract rate or, in absence of a contract rate, $48.22 per day, $24.11 per half-day, or $13.21 per hour.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
Child development home or center	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour.
Supported community living provider	Retrospectively limited prospective rate	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $34.98 per hour, not to exceed the maximum ICF/MR rate per day.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: The maximum ICF/MR rate per day.
26. Day habilitation	Fee schedule	Effective 7/1/11: County contract rate or, in the absence of a contract rate, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.21 per hour, $32.15 per half-day, or $64.29 per day.
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	$6,060 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $34.98 per hour.
29. In-home family therapy	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $93.63 per hour.
30. Financial management services	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $65.65 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $15.15 per hour.

Provider category	Basis of reimbursement	Upper limit
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget.
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	$46.70 per hour or $105.97 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	$13.21 per hour, $32.15 per half-day, or $64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	$9.91 per hour, $24.11 per half-day, or $48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of $34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	$6.19 per hour for services in an enclave setting; $19.81 per hour for personal care; and $34.98 per hour for all other services. Total not to exceed $2,883.71 per month. Maximum of 40 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost settlement	Medicaid rate in effect 11/30/09 less 5%.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)*"d"*)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.

Provider category	Basis of reimbursement	Upper limit
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 11/30/09 less 5%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)*"c"*	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 11/30/09 less 5%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate.
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 11/30/09 less 5%.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"1" and (2)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of 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.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"* (1) and (2) is 110% of the patient-day-weighted median.

Provider category	Basis of reimbursement	Upper limit
	The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"*(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 11/30/09 less 5%.
Physical therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.

Provider category	Basis of reimbursement	Upper limit
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 11/30/09 less 5%.
Anesthesia services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Podiatrists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Prescribed drugs	See 79.1(8)	$6.20 dispensing fee effective 8/1/11. (See 79.1(8)*"a," "b,"* and *"e."*)
Psychiatric medical institutions for children		
1. Inpatient	Retrospective cost-related	Effective 8/1/11: Actual and allowable cost not to exceed a maximum for non-state-owned providers of 103% of patient-day-weighted average costs of non-state-owned providers located within Iowa.
2. Outpatient day treatment	Fee schedule	Effective 8/1/11: Fee schedule in effect 11/30/09.
Psychologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule less 5%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
Screening centers	Fee schedule	Reimbursement rate for center in effect 11/30/09 less 5%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.

79.1(3) *Ambulatory surgical centers.*

a. Payment is made for facility services on a fee schedule determined by the department and published on the department's Web site. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)*"c"*). This payment is made directly to the physician or dentist.

79.1(4) *Durable medical equipment, prosthetic devices, medical supply dealers.* Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality.

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" shall mean a Medicaid patient 17 years or younger.

"Adult" shall mean a Medicaid patient 18 years or older.

"Average daily rate" shall mean the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base year cost report" means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5)*"x."* Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base amount" shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Blended capital costs" shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" shall mean an add-on to the blended base amount, which shall compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children's Hospitals and Related Institutions.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5)*"f,"* so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Disproportionate share percentage" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate

exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5)*"y"*(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

"GME/DSH fund implementation year" means 2009.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

"Indirect medical education rate" shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Inlier" shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

"Long stay outlier" shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)*"f."*

"Low-income utilization rate" shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients

under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

"Medicaid inpatient utilization rate" shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" shall mean a designated level II or level III neonatal unit.

"Net discharges" shall mean total discharges minus transfers and short stay outliers.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rate table listing" shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

"Rebasing" shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Rebasing implementation year" means 2008 and every three years thereafter.

"Recalibration" shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*"f."*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)*"r."* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)*"r."* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization.

The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.
4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical

rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $16,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)*"r,"* and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)*"r,"* which are paid per diem, as specified in paragraph 79.1(5)*"i."*

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)*"r"* and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's base-year cost report pursuant to paragraph 79.1(5)*"a."* No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)*"j."*

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing

implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate-setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)*"y"*(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph *"y."*

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph 79.1(5)*"y."* Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5)*"y."*

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph *"f."*

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)*"b"*(1), a neonatal intensive care unit under subparagraph 79.1(5)*"b"*(2), a psychiatric unit under paragraph 79.1(5)*"i,"* or a physical rehabilitation hospital or unit under paragraph 79.1(5)*"i"* shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if the unit's program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals

certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit's certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)*"i"* if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5)*"i"* if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital's fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state's fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is $26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. Non-state-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between $51 million and the actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report

would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

(1) Advertising.
(2) Promotional items.
(3) Feasibility studies.
(4) Administrative travel and entertainment.
(5) Dues, subscriptions, or membership costs.
(6) Contributions made to other organizations.
(7) Home office costs.
(8) Public relations items.
(9) Any patient convenience items.
(10) Management fees for administrative services.
(11) Luxury employee benefits (i.e., country club dues).
(12) Motor vehicles for other than patient care.
(13) Reorganization costs.

y. Graduate medical education and disproportionate share fund. Payment shall be made to hospitals qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is $8,210,006. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is $14,415,396. If a hospital fails to qualify for indirect

medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is $6,890,959. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5)*"u"* or 79.1(5)*"v"* cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age, is a voting member of the National Association of Children's Hospitals and Related Institutions, and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audits and rate-setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus

2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. $9,900,000.

(2) One-twelfth of the $9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the $9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)*"a"* to *"z"* are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)*"a"* to *"z."* Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)*"k."*

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code	Explanation
Y	The condition was present or developing at the time of the order for inpatient admission.
N	The condition was not present or developing at the time of the order for inpatient admission.
U	Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
W	Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

79.1(6) *Independent laboratories.* The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician's Current Procedural Terminology (CPT) published by the American

Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) *Physicians.*

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)*"e"* for the guidelines for immunization replacement.

b. Payment reduction for services rendered in facility settings. The fee schedule amount paid to physicians based on paragraph 79.1(7)*"a"* shall be reduced by an adjustment factor as determined by the department. For the purpose of this provision, a "facility" place of service (POS) is defined as any of the following:

(1) Hospital inpatient unit (POS 21).
(2) Hospital outpatient unit (POS 22).
(3) Hospital emergency room (POS 23).
(4) Ambulatory surgical center (POS 24).
(5) Skilled nursing facility (POS 31).
(6) Inpatient psychiatric facility (POS 51).
(7) Community mental health center (POS 53).
(8) Comprehensive inpatient rehabilitation (POS 61).

79.1(8) *Drugs.* The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to October 7, 2008. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.

a. Reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph *"g"*; or

2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph *"g."*

(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph *"g."*

(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2, plus the professional dispensing fee specified in paragraph *"g."*

(4) The submitted charge, representing the provider's usual and customary charge for the drug.

b. Reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph *"g"*; or

2. For covered specialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph *"g."*

(2) The submitted charge, representing the provider's usual and customary charge for the drug.

c. No payment shall be made for sales tax.

d. All hospitals that wish to administer vaccines which are available through the vaccines for children program to Medicaid members shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the

administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.

e. The basis of payment for nonprescription drugs shall be the same as specified in paragraph *"a"* except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.

f. An additional reimbursement amount of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

g. For services rendered on or after August 1, 2011, the professional dispensing fee is $6.20 or the pharmacy's usual and customary fee, whichever is lower.

h. For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

i. Pharmacies and providers that are enrolled in the Iowa Medicaid program shall make available drug acquisition cost information, product availability information, and other information deemed necessary by the department to assist the department in monitoring and revising reimbursement rates subject to 79.1(8)*"a"*(3) and 79.1(8)*"c"* and for the efficient operation of the pharmacy benefit.

(1) Pharmacies and providers shall produce and submit the requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

(2) Pharmacies and providers shall submit information to the department or its designee within 30 days following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy or provider.

j. Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

79.1(9) *HCBS consumer choices financial management.*

a. Monthly allocation. A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer's individual budget amount as determined under 441—paragraph 78.34(13)*"b,"*78.37(16)*"b,"*78.38(9)*"b,"*78.41(15)*"b,"*78.43(15)*"b,"* or 78.46(6)*"b."*

b. Cost settlement. The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

c. Start-up grants. A qualifying financial management service provider may be reimbursed up to $10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) *Copayment by member.* A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than $25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is $25.01 to $50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is $50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

b. The member shall pay $1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay $2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay $3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay $1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

n. The member shall pay a $3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13)*"k."* This $3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

79.1(14) *Reimbursement for hospice services.*

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency; HCBS respite when provided by nonfacility providers, camps, home care agencies, or providers of residential-based supported community living; and HCBS group respite provided by home health agencies.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate-Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed $1,570 per consumer per year for supported community living services.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed $1,500 per child per year for family and community support services.

c. Prospective rates for new providers other than respite.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph *"e."*

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph *"d."*

d. Prospective rates for established providers other than respite.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph *"f."*

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph *"f."*

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) Providers who do not reimburse revenues exceeding 102.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 102.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) *Outpatient reimbursement for hospitals.*

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or *"APC"* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or *"APC relative weight"* means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2009, means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph *"g"* and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

"Discount factor" means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

"GME/DSH fund implementation year" means 2009.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

"Healthcare common procedures coding system" or *"HCPCS"* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that

incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

"Hospital-based clinic" means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

"International classifications of diseases—fourth edition, ninth revision (ICD-9)" is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person's injury or illness.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

"Modifier" means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

"Multiple significant procedure discounting" means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

"Observation services" means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

"Outpatient hospital services" means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

"Outpatient prospective payment system" or *"OPPS"* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

"Outpatient visit" shall mean those hospital-based outpatient services which are billed on a single claim form.

"Packaged service" means a service that is secondary to other services but is considered an integral part of another service.

"Pass-through" means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rebasing" shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

"Significant procedure" shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

"Status indicator" or *"SI"* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)*"c."*

(2) Except as provided in paragraph 79.1(16)*"h,"* outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)*"j."*

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)*"e."*
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital.	For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	Items, codes, and services: ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.

G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "S," "T," "V," or "X." ● In all other circumstances, payment is made through a separate APC payment.

Q2	T-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "T." ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)*"r."* If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.

Y	Nonimplantable durable medical equipment	For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital's base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n."*

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n,"* for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus $2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)*"a"* shall be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)*"j."*

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16)*"v"*(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16)*"v."*

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;

2. Recompute Medicaid payments due based on the recalculated Medicaid rates;

3. Recoup any previous overpayments; and

4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—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 treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room and on whether the member is participating in the MediPASS program.

1. For members not participating in the MediPASS program who were referred to the emergency room by appropriate medical personnel and for members participating in the MediPASS program who were referred to the emergency room by their MediPASS primary care physician, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members not participating in the MediPASS program who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

3. For members participating in the MediPASS program who were not referred to the emergency room by their MediPASS primary care physician, no payment will be made for treatment provided in the emergency room.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993.

Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Rescinded IAB 6/30/10, effective 7/1/10.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is $2,776,336. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.
2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.
3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. $9,900,000.

(2) One-twelfth of the $9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the $9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall

request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification and equipment.* Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

Service	Payment amount	Number of payments
Initial assessment	$75	One per patient
New problem assessment	$40	Two per patient per 12 months
Problem follow-up assessment	$40	Four per patient per 12 months
Preventative follow-up assessment	$25	One per patient per 6 months

79.1(19) *Reimbursement for translation and interpretation services.* Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) *Dentists.* The dental fee schedule is based on the definitions of dental and surgical procedures given in the Current Dental Terminology, Third Edition (CDT-3).

79.1(21) *Rehabilitation agencies.* Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) *Medicare crossover claims for inpatient and outpatient hospital services.* Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered inpatient or outpatient hospital services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

"Medicaid reimbursement" means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Reimbursement of crossover claims. Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim shall be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim shall be the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse hospitals for the portion of crossover claims not covered by Medicaid reimbursement pursuant to paragraph *"b"* and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph *"b."* The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year.

d. Application of savings. Savings in Medicaid reimbursements attributable to the limits on inpatient and outpatient crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1). The unit

of service may be a quarter-hour, a half-hour, an hour, a half-day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) *Reimbursement for home- and community-based habilitation services.* Reimbursement for case management, job development, and employer development is based on a fee schedule developed using the methodology described in paragraph 79.1(1)*"d."* Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment is based on a retrospective cost-related rate calculated using the methodology in this subrule. All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is one hour. EXCEPTIONS:

1. A unit of service is one day when a member receives direct supervision for 14 or more hours per day, averaged over a calendar month. The member's comprehensive service plan must identify and reflect the need for this amount of supervision. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

2. When cost-effective, a daily rate may be developed for members needing fewer than 14 hours of direct supervision per day. The provider must obtain approval from the Iowa Medicaid enterprise for a daily rate for fewer than 14 hours of service per day.

(3) A unit of day habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(4) A unit of prevocational habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(5) A unit of supported employment habilitation for activities to obtain a job is:

1. One job placement for job development and employer development.
2. One hour for enhanced job search.

(6) A unit of supported employment habilitation supports to maintain employment is one hour.

b. Submission of cost reports. The department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed $1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report that meets the requirement of paragraph 79.1(24)*"b,"* the department shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. Reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the

amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(25) *Reimbursement for community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).*

a. Reimbursement methodology. Effective for services rendered on or after October 1, 2006, community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles. Rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report.

(1) Until a provider that was enrolled int he Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

b. Reporting requirements. All providers shall submit cost reports using Form 470-4419, Financial and Statistical Report. A hospital-based provider shall also submit the Medicare cost report, CMS Form 2552-96.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

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

[**ARC 7835B**, IAB 6/3/09, effective 7/8/09; **ARC 7937B**, IAB 7/1/09, effective 7/1/09; **ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **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]

441—79.2(249A) Sanctions against provider of care. The department reserves the right to impose sanctions against any practitioner or provider of care who has violated the requirements for participation in the medical assistance program.

79.2(1) *Definitions.*

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Iowa Medicaid enterprise" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

"Person" means any natural person, company, firm, association, corporation, or other legal entity.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance to a recipient pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

"Suspension of payments" means the withholding of all payments due a provider until the resolution of the matter in dispute between the provider and the department.

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

79.2(2) *Grounds for sanctioning providers.* Sanctions may be imposed by the department against a provider for any one or more of the following reasons:

a. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

d. Failure to disclose or make available to the department or its authorized agent, records of services provided to medical assistance recipients and records of payments made for those services.

e. Failure to provide and maintain the quality of services to medical assistance recipients within accepted medical community standards as adjudged by professional peers.

f. Engaging in a course of conduct or performing an act which is in violation of state or federal regulations of the medical assistance program, or continuing that conduct following notification that it should cease.

g. Failure to comply with the terms of the provider certification on each medical assistance check endorsement.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing the recipient to receive services or merchandise not required or requested by the recipient.

i. Rebating or accepting a fee or portion of a fee or a charge for medical assistance patient referral.

j. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto.

k. Submission of a false or fraudulent application for provider status under the medical assistance program.

l. Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.

m. Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent practice resulting in death or injury to patients.

n. Failure to meet standards required by state or federal law for participation, for example, licensure.

o. Exclusion from Medicare because of fraudulent or abusive practices.

p. Documented practice of charging recipients for covered services over and above that paid for by the department, except as authorized by law.

q. Failure to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

r. Formal reprimand or censure by an association of the provider's peers for unethical practices.

s. Suspension or termination from participation in another governmental medical program such as workers' compensation, crippled children's services, rehabilitation services or Medicare.

t. Indictment for fraudulent billing practices, or negligent practice resulting in death or injury to the provider's patients.

79.2(3) *Sanctions.* The following sanctions may be imposed on providers based on the grounds specified in 79.2(2).

a. A term of probation for participation in the medical assistance program.

b. Termination from participation in the medical assistance program.

c. Suspension from participation in the medical assistance program. This includes when the department is notified by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective on the date established by the Centers for Medicare and Medicaid Services and at least for the period of time of the Medicare suspension.

d. Suspension or withholding of payments to provider.

e. Referral to peer review.

f. Prior authorization of services.

g. One hundred percent review of the provider's claims prior to payment.

h. Referral to the state licensing board for investigation.

i. Referral to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.

j. Providers with a total Medicaid credit balance of more than $500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance shall be charged interest at 10 percent per year on each overpayment. The interest shall begin to accrue retroactively to the first full month that the provider had a credit balance over $500.

Nursing facilities shall make repayment or reach agreement with the division of medical services. All other providers shall make repayment or reach agreement with the Iowa Medicaid enterprise. Overpayments and interest charged may be withheld from future payments to the provider.

79.2(4) *Imposition and extent of sanction.*

a. The decision on the sanction to be imposed shall be the commissioner's or designated representative's except in the case of a provider terminated from the Medicare program.

b. The following factors shall be considered in determining the sanction or sanctions to be imposed:

(1) Seriousness of the offense.
(2) Extent of violations.
(3) History of prior violations.
(4) Prior imposition of sanctions.
(5) Prior provision of provider education.
(6) Provider willingness to obey program rules.
(7) Whether a lesser sanction will be sufficient to remedy the problem.
(8) Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. The sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated where the conduct was accomplished in the course of official duty or was effectuated with the knowledge or approval of that person.

b. Suspension or termination from participation shall preclude the provider from submitting claims for payment, whether personally or through claims submitted by any clinic, group, corporation, or other association, for any services or supplies except for those services provided before the suspension or termination.

c. No clinic, group, corporation, or other association which is the provider of services shall submit claims for payment for any services or supplies provided by a person within the organization who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

d. When the provisions of paragraph 79.2(5)*"c"* are violated by a provider of services which is a clinic, group, corporation, or other association, the department may suspend or terminate the organization, or any other individual person within the organization who is responsible for the violation.

79.2(6) *Notice of sanction.* When a provider has been sanctioned, the department shall notify as appropriate the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

79.2(7) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or has been practicing in a manner inconsistent with the program requirements, or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted. Notification shall set forth:

a. The nature of the discrepancies or violations,
b. The known dollar value of the discrepancies or violations,
c. The method of computing the dollar value,
d. Notification of further actions to be taken or sanctions to be imposed by the department, and
e. Notification of any actions required of the provider. The provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken.

79.2(8) *Suspension or withholding of payments pending a final determination.* Where the department has notified a provider of a violation pursuant to 79.2(7) or an overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payment pending a final determination. Where the department intends to withhold or suspend payments it shall notify the provider in writing.

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

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request may result in claim denial or recoupment.

79.3(1) *Financial (fiscal) records.*

a. A provider of service shall maintain records as necessary to:

(1) Support the determination of the provider's reimbursement rate under the medical assistance program; and

(2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) *Medical (clinical) records.* A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. Definition. "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

(1) The provision of each service and each activity billed to the program; and

(2) First and last name of the member receiving the service.

b. Purpose. The medical record shall provide evidence that the service provided is:

(1) Medically necessary;

(2) Consistent with the diagnosis of the member's condition; and

(3) Consistent with professionally recognized standards of care.

c. Components.

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2)*"d."* The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.

13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)*"c"* or *"d,"* 441—paragraph 77.33(6)*"d,"* 441—paragraph 77.34(5)*"d,"* 441—paragraph 77.37(15)*"d,"* 441—paragraph 77.39(13)*"e,"* 441—paragraph 77.39(14)*"d,"* or 441—paragraph 77.46(5)*"i,"* or 441—subparagraph 78.9(10)*"a"*(1).
5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Any supplies dispensed as part of the service.
7. The first and last name and professional credentials, if any, of the person providing the service.
8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.
9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2)*"b."*)

(1) Physician (MD and DO) services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(2) Pharmacy services:
1. Prescriptions.
2. Nursing facility physician order.
3. Telephone order.
4. Pharmacy notes.
5. Prior authorization documentation.

(3) Dentist services:
1. Treatment notes.
2. Anesthesia notes and records.
3. Prescriptions.

(4) Podiatrist services:
1. Service or office notes or narratives.
2. Certifying physician statement.
3. Prescription or order form.

(5) Certified registered nurse anesthetist services:
1. Service notes or narratives.
2. Preanesthesia physical examination report.

3. Operative report.
4. Anesthesia record.
5. Prescriptions.

(6) Other advanced registered nurse practitioner services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(7) Optometrist and optician services:

1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
3. Prior authorization documentation.

(8) Psychologist services:

1. Service or office psychotherapy notes or narratives.
2. Psychological examination report and notes.

(9) Clinic services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Prescriptions.
5. Medication administration records.

(10) Services provided by rural health clinics or federally qualified health centers:

1. Service or office notes or narratives.
2. Form 470-2942, Prenatal Risk Assessment.
3. Procedure, laboratory, or test orders and results.
4. Immunization records.

(11) Services provided by community mental health centers:

1. Service referral documentation.
2. Initial evaluation.
3. Individual treatment plan.
4. Service or office notes or narratives.
5. Narratives related to the peer review process and peer review activities related to a member's treatment.
6. Written plan for accessing emergency services.

(12) Screening center services:

1. Service or office notes or narratives.
2. Immunization records.
3. Laboratory reports.
4. Results of health, vision, or hearing screenings.

(13) Family planning services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Immunization records.
5. Consent forms.
6. Prescriptions.
7. Medication administration records.

(14) Maternal health center services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Form 470-2942, Prenatal Risk Assessment.

(15) Birthing center services:

1. Service or office notes or narratives.
2. Form 470-2942, Prenatal Risk Assessment.

(16) Ambulatory surgical center services:

1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
2. Physician orders.
3. Consent forms.
4. Anesthesia records.
5. Pathology reports.
6. Laboratory and X-ray reports.

(17) Hospital services:

1. Physician orders.
2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
3. Progress or status notes.
4. Diagnostic procedures, including laboratory and X-ray reports.
5. Pathology reports.
6. Anesthesia records.
7. Medication administration records.

(18) State mental hospital services:

1. Service referral documentation.
2. Resident assessment and initial evaluation.
3. Individual comprehensive treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.

(19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:

1. Physician orders.
2. Progress or status notes.
3. Service notes or narratives.
4. Procedure, laboratory, or test orders and results.
5. Nurses' notes.
6. Physical therapy, occupational therapy, and speech therapy notes.
7. Medication administration records.
8. Form 470-0042, Case Activity Report.

(20) Services provided by intermediate care facilities for persons with mental retardation:

1. Physician orders.
2. Progress or status notes.
3. Preliminary evaluation.
4. Comprehensive functional assessment.
5. Individual program plan.
6. Form 470-0374, Resident Care Agreement.
7. Program documentation.
8. Medication administration records.
9. Nurses' notes.
10. Form 470-0042, Case Activity Report.

(21) Services provided by psychiatric medical institutions for children:

1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.

(22) Hospice services:
1. Physician certifications for hospice care.
2. Form 470-2618, Election of Medicaid Hospice Benefit.
3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
4. Plan of care.
5. Physician orders.
6. Progress or status notes.
7. Service notes or narratives.
8. Medication administration records.
9. Prescriptions.

(23) Services provided by rehabilitation agencies:
1. Physician orders.
2. Initial certification, recertifications, and treatment plans.
3. Narratives from treatment sessions.
4. Treatment and daily progress or status notes and forms.

(24) Home- and community-based habilitation services:
1. Notice of decision for service authorization.
2. Service plan (initial and subsequent).
3. Service notes or narratives.

(25) Behavioral health intervention:
1. Order for services.
2. Comprehensive treatment or service plan (initial and subsequent).
3. Service notes or narratives.

(26) Services provided by area education agencies and local education agencies:
1. Service notes or narratives.
2. Individualized education program (IEP).
3. Individual health plan (IHP).
4. Behavioral intervention plan.

(27) Home health agency services:
1. Plan of care or plan of treatment.
2. Certifications and recertifications.
3. Service notes or narratives.
4. Physician orders or medical orders.

(28) Services provided by independent laboratories:
1. Laboratory reports.
2. Physician order for each laboratory test.

(29) Ambulance services:
1. Documentation on the claim or run report supporting medical necessity of the transport.
2. Documentation supporting mileage billed.

(30) Services of lead investigation agencies:
1. Service notes or narratives.
2. Child's lead level logs (including laboratory results).
3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
4. Health education notes, including follow-up notes.

(31) Medical supplies:
1. Prescriptions.
2. Certificate of medical necessity.
3. Prior authorization documentation.
4. Medical equipment invoice or receipt.

(32) Orthopedic shoe dealer services:
1. Service notes or narratives.

2. Prescriptions.
3. Certifying physician's statement.

(33) Case management services, including HCBS case management services:

1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
2. Notice of decision for service authorization.
3. Service notes or narratives.
4. Social history.
5. Comprehensive service plan.
6. Reassessment of member needs.
7. Incident reports in accordance with 441—subrule 24.4(5).

(34) Early access service coordinator services:

1. Individualized family service plan (IFSP).
2. Service notes or narratives.

(35) Home- and community-based waiver services, other than case management:

1. Notice of decision for service authorization.
2. Service plan.
3. Service logs, notes, or narratives.
4. Mileage and transportation logs.
5. Log of meal delivery.
6. Invoices or receipts.
7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.

(36) Physical therapist services:

1. Physician order for physical therapy.
2. Initial physical therapy certification, recertifications, and treatment plans.
3. Treatment notes and forms.
4. Progress or status notes.

(37) Chiropractor services:

1. Service or office notes or narratives.
2. X-ray results.

(38) Hearing aid dealer and audiologist services:

1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
2. Documentation of hearing aid evaluation and selection (Form 470-0828).
3. Waiver of informed consent.
4. Prior authorization documentation.
5. Service or office notes or narratives.

(39) Behavioral health services:

1. Assessment.
2. Individual treatment plan.
3. Service or office notes or narratives.

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]

441—79.4(249A) Reviews and audits.

79.4(1) *Definitions.*

"Authorized representative," within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

"Claim" means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

"Clinical record" means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

"Confidence level" means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

"Customary and prevailing fee" means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

"Extrapolation" means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

"Fiscal record" means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

"Overpayment" means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

"Procedure code" means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

"Random sample" means a statistically valid random sample for which the probability of selection for every item in the universe is known.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

"Universe" means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records of the provider to determine whether:

(1) The department has correctly paid claims for goods or services.

(2) The provider has furnished the services to Medicaid members.

(3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise surveillance and utilization review services unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)*"d"* to document the basis for services or activities provided, in the following format:

Iowa Department of Human Services
Iowa Medicaid Enterprise Surveillance and Utilization Review Services
Documentation Checklist

Date of Request: _____
Reviewer Name & Phone Number: _____
Provider Name: _____
Provider Number: _____
Provider Type: _____

Please sign this form and return it with the information requested.
Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.
Please send copies. Do not send original records.
If you have any questions about this request or checklist, please contact the reviewer listed above.

	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[Note: number of specific documents required varies by provider type]
	Any additional documentation that demonstrates the medical necessity of the service provided or otherwise required for Medicaid payment. List additional documentation below if needed.

The person signing this form is certifying that all documentation that supports the Medicaid billed rates, units, and services is enclosed.

Signature	Title	Telephone Number

470-4479 (4/08)

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph *"b."*

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:

1. Establish good cause for the delay in submitting the records; and

2. Be received by the department before the date the records are due to be submitted.

(2) Under exceptional circumstances, a provider may request one additional 15-calendar-day extension. The provider or the provider's designee shall submit a written request that:

1. Establishes exceptional circumstances for the delay in submitting records; and

2. Is received by the department before the expiration of the initial 15-day extension period.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

79.4(4) *Preliminary report of audit or review findings.* If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) *Disagreement with audit or review findings.* If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph *"a"* of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph *"c"* of this subrule.

c. Disagreement with sampling results. When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:

(1) Be arranged and paid for by the provider.

(2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.

(3) Be conducted by a certified public accountant if the issues relate to fiscal records.

(4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.

(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) *Finding and order for repayment.* Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) *Appeal by provider of care.* A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment.

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

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

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

441—79.7(249A) Medical assistance advisory council.

79.7(1) *Officers.* Officers shall be a chairperson and a vice-chairperson.

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) *Membership.* The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2and 3.

79.7(3) *Expenses, staff support, and technical assistance.* Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

79.7(4) *Meetings.* The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting. Each notice shall include an agenda for the meeting.

79.7(5) *Procedures.*

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.

d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) *Duties.*

a. Executive committee. Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

(1) Recommendations on the reimbursement for medical services rendered by providers of services.

(2) Identification of unmet medical needs and maintenance needs which affect health.

(3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

(4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

(5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. Council. The medical assistance advisory council shall:

(1) Advise the professional groups and business entities represented and act as liaison between them and the department.

(2) Report at least annually to the professional groups and business entities represented.

(3) Perform other functions as may be provided by state or federal law or regulation.

(4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) *Responsibilities.*

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

(1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and

(2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members on the council and executive committee.

[**ARC 8263B**, IAB 11/4/09, effective 12/9/09]

441—79.8(249A) Requests for prior authorization. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) *Making the request.*

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

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

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

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

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.12(249A) Advance directives. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

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

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

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

441—79.14(249A) Provider enrollment.

79.14(1) Application request. A provider of medical or remedial services that wishes to enroll as an Iowa Medicaid provider shall begin the enrollment process by contacting the provider services unit at the Iowa Medicaid enterprise to request an application form.

a. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

b. An intermediate care facility for persons with mental retardation shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the Iowa Medicaid enterprise provider services unit at P.O. Box 36450, Des Moines, Iowa 50315.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

c. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

d. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

79.14(3) Notification. Providers shall be notified of the decision on their application by the Iowa Medicaid enterprise provider services unit within 30 calendar days.

79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.

79.14(5) Effective date of approval. Applications shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application forms by the Iowa Medicaid enterprise provider services unit.

79.14(6) Providers approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(7) No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.

79.14(8) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(9) Amendments to application forms shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(10) Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(11) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 60 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, and telephone number.

a. When a provider fails to provide current information within the 60-day period, the department may terminate the provider's Medicaid enrollment upon 30 days' notice. The termination may be appealed under 441—Chapter 7.

b. When the department incurs an informational tax-reporting fine because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine shall be the responsibility of the individual provider to the extent that the fine relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine may be appealed under 441—Chapter 7.

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

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11]

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least $5 million during a federal fiscal

year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) *Policy requirements.* Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1)*"a"*;

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) *Reporting requirements.*

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

(1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

79.15(3) *Enforcement.* Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11]

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) *State elections.* In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as published in the Federal Register, Vol. 75, No. 144, on July 28, 2010. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term "hospital-based eligible professional (EP)" as set forth in 42 CFR Section 495.4 as amended to July 28, 2010, the department elects the calendar year preceding the payment year as the period used to calculate whether or not an eligible professional is "hospital-based" for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to July 28, 2010, eligible providers may elect to use either:

(1) The methodology found in 42 CFR Section 495.306(c) as amended to July 28, 2010, or

(2) The methodology found in 42 CFR Section 495.306(d) as amended to July 28, 2010.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to July 28, 2010, the "12-month period selected by the state" shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to July 28, 2010, the "12-month period selected by the state" shall mean the hospital fiscal year.

79.16(2) *Eligible providers.* To be deemed an "eligible provider" for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,
2. A dentist,
3. A certified nurse midwife,
4. A nurse practitioner, or
5. A physician assistant practicing in a federally qualified health center or a rural health clinic when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, defined as a health care facility where the average length of stay is 25 days or fewer, which has a CMS certification number with the last four digits in the series 0001-0879 or 1300-1399.

(3) A children's hospital, defined as a separately certified children's hospital, either freestanding or a hospital-within-hospital, that predominately treats individuals under 21 years of age and has a CMS certification number with the last four digits in the series 3300-3399.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional's patient volume covered by Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a "pediatrician" is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.
2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) *Application and agreement.* Any eligible provider who wants to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the National Level Repository, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the EHR incentive payment program section of the Iowa Medicaid portal access (IMPA) Web site at https://secureapp.dhs.state.ia.us/impa/. The applicant shall use the Web site to:

(1) Attest to the applicant's qualifications to receive the incentive payment, and

(2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, the eligible provider must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) *Payment.* The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the National Level Repository.

a. The primary communication channel from the department to the provider will be the IMPA Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

(1) Eligibility,

(2) Purchase of certified electronic health record technology, and

(3) Meaningful use of electronic health record technology.

79.16(5) *Administrative appeal.* Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

a. Provider eligibility determination.

b. Incentive payments.

c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

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1 Effective date of 79.1(2) and 79.1(5)*"t"* delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

3 Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.

4 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

5 At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

6 Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.

7 July 1, 2009, effective date of amendments to 79.1(1)*"d,"* 79.1(2), and 79.1(24)*"a"*(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

CHAPTER 80
PROCEDURE AND METHOD OF PAYMENT
[Prior to 7/1/83, Social Services[770] Ch 80]

441—80.1(249A) The fiscal agent function in medical assistance. Rescinded IAB 5/25/05, effective 7/1/05.

441—80.2(249A) Submission of claims. Providers of medical and remedial care participating in the program shall submit claims for services rendered to the Iowa Medicaid enterprise on at least a monthly basis. All nursing facilities and providers of home- and community-based services shall submit claims for services after end of the calendar month in which the services are provided. Following audit of the claim, the Iowa Medicaid enterprise will make payment to the provider of care.

80.2(1) Electronic submission. Providers are encouraged to submit claims electronically whenever possible.

a. Ambulance service providers may bill electronically only when the procedures performed are identified by codes based on the ones that Medicare recognizes as emergency and support medical necessity without a review by the Iowa Medicaid enterprise.

b. When filing electronic claims, pharmacies shall use the format prescribed by the National Council for Prescription Drug Programs.

c. Claims submitted electronically after implementation of the Health Insurance Portability and Accountability Act of 1996 shall be filed on the Accredited Standards Committee (ASC) X12N 837 transaction, Health Care Claim. The department shall send all providers written notice when the Act is implemented.

(1) Providers listed as filing claims on Form CMS-1500 or on the Claim for Targeted Medical Care shall file claims on the professional version of the Health Care Claim.

(2) Providers listed as filing claims on Form CMS-1450 or on the Iowa Medicaid Long-Term Care Claim shall file the institutional version of the Health Care Claim.

(3) Dentists shall file the dental version of the Health Care Claim.

(4) Pharmacists providing drugs and injections shall use the format prescribed by the National Council for Prescription Drug Programs.

d. If a claim submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3969, Claim Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3969 the attachment control number submitted on the ASC X12N 837 electronic transaction.

80.2(2) Claim forms. Claims for payment for services provided recipients shall be submitted on Form CMS-1500, Health Insurance Claim Form, except as noted below.

a. The following providers shall submit claims on Form UB-92, CMS-1450:

(1) Home health agencies providing services other than home- and community-based services.

(2) Hospitals providing inpatient care or outpatient services, including inpatient psychiatric hospitals.

(3) Psychiatric medical institutions for children.

(4) Rehabilitation agencies.

(5) Hospice providers.

(6) Medicare-certified nursing facilities.

(7) Nursing facilities for the mentally ill.

(8) Special population nursing facilities as defined in rule 441—81.6(249A).

(9) Out-of-state nursing facilities.

b. All other nursing facilities and intermediate care facilities for the mentally retarded shall file claims on Form 470-0039, Iowa Medicaid Long-Term Care Claim.

c. Pharmacies shall submit claims on the Universal Pharmacy Claim Form when filing paper claims.

d. Dentists shall submit claims on the dental claim form approved by the American Dental Association.

e. Rescinded IAB 8/1/07, effective 9/5/07.

f. Providers of home- and community-based waiver services, including home health agencies, shall submit claims on Form 470-2486, Claim for Targeted Medical Care. In the event of the death of the member, the case manager or service worker shall sign and date the claim form if the services were delivered.

g. Case management providers shall submit claims on Form 470-2486, Claim for Targeted Medical Care, for services provided pursuant to 441—Chapter 90 and on FACS-generated claims for services provided pursuant to 441—Chapter 186.

h. Providers billing claims for Medicare beneficiaries that do not cross over electronically to the Iowa Medicaid enterprise shall submit:

(1) Form 470-4707, Medicare Crossover Invoice (Institutional), along with the Explanation of Medicare Benefits (EOMB) for institutional services.

(2) Form 470-4708, Medicare Crossover Invoice (Professional), along with the Explanation of Medicare Benefits (EOMB) for professional services.

80.2(3) Providers shall purchase or copy their supplies of forms CMS-1450 and CMS-1500 for use in billing.

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

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9724B**, IAB 9/7/11, effective 9/1/11; **ARC 9889B**, IAB 11/30/11, effective 1/4/12]

441—80.3(249A) Payment from other sources.

80.3(1) *Payments deducted.* The amount of any payment made directly to the provider of care by the recipient, relatives, or any source shall be deducted from the established cost standard for the service provided to establish the amount of payment to be made by Iowa Medicaid.

80.3(2) *Third-party liability.* When a third-party liability for medical expenses exists, this resource shall be utilized before the Medicaid program makes payment unless:

a. The department pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third party. This "pay and chase" provision applies to claims for:

(1) Prenatal care,

(2) Preventive pediatric services, and

(3) All services provided to a person for whom there is court-ordered medical support.

b. Otherwise authorized by the department.

80.3(3) *Recovery from third parties legally responsible to pay for health care.* Parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall:

a. Respond to any inquiry by the state regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of the item or service.

b. Agree not to deny any claim submitted by the state solely because of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim, if both of the following conditions are met:

(1) The claim is submitted to the entity by the state within the three-year period beginning on the date on which the item or service was furnished.

(2) Any action by the state to enforce its rights with respect to the claim is commenced within six years of the date that the claim was submitted by the state.

c. Reimburse the Medicaid program within 90 days of the request for repayment.

This rule is intended to implement Iowa Code chapter 249A.

[**ARC 7547B**, IAB 2/11/09, effective 3/18/09]

441—80.4(249A) Time limit for submission of claims and claim adjustments.

80.4(1) *Submission of claims.* Payment will not be made on any claim where the amount of time that has elapsed between the date the service was rendered and the date the initial claim is received by the Iowa Medicaid enterprise exceeds 365 days. The department shall consider claims submitted beyond the 365-day limit for payment only if retroactive eligibility on newly approved cases is made that exceeds 365 days or if attempts to collect from a third-party payer delay the submission of a claim.

80.4(2) *Claim adjustments.* A provider's 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 order to have the adjustment considered.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

441—80.5(249A) Authorization process.

80.5(1) *Identification cards.* The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to members for use in securing medical and health services available under the program except as provided in 441—76.6(249A).

a. The department shall issue the Medical Assistance Eligibility Card:

(1) When the member's eligibility is initially determined.

(2) Annually thereafter.

(3) Upon the member's request for replacement of a lost, stolen, or damaged card.

b. The Medical Assistance Eligibility Card is valid only for months in which the member has established eligibility, as indicated on the department's eligibility verification system (ELVS). Payment will be made for services provided to an ineligible person when ELVS indicates that the person was eligible for the period in which the service was provided.

80.5(2) *Third-party liability.* Rescinded IAB 2/11/09, effective 3/18/09.

[**ARC 7547B**, IAB 2/11/09, effective 3/18/09]

441—80.6(249A) Payment to provider—exception. Payments for medical services may be made only to the provider of the services except as provided below:

80.6(1) *Medical assistance corrective payments.* Payment may be made to the client or county relief agency in accordance with rule 441—75.8(249A).

80.6(2) *Assignment.* Payment may be made in accordance with an assignment to a county for medical services received while the recipient was receiving interim assistance or while an appeal of a denial of medical assistance was pending.

80.6(3) *Business agent of provider.* Payment may be made to a business agent that furnishes statements and receives payments in the name of the provider if the agent's compensation is:

a. Related to the cost of processing the billing.

b. Not related on a percentage or other basis to the amount that is billed or collected.

c. Not dependent upon the collection of the payment.

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

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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.

"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.

"Department's accounting firm" means the firm on contract with the department to calculate nursing facility rates and provide other accounting services as requested.

"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.

"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 Part 483, as amended to September 23, 1992, 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 mental retardation as defined in 42 CFR 483.102 as amended to October 1, 2010.

"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.

"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).

"PASRR" means the preadmission screening and annual review of persons with mental illness, mental retardation or a related condition who live in or seek entry to a Medicaid-certified nursing facility, as required by 42 CFR Part 483, Subpart C, as amended to October 1, 2010.

"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.

"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 21 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.

"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]

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 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. Adverse decisions by the IME medical services unit 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 IME medical services unit 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 mental retardation, 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, mental retardation, or related conditions 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 mental retardation or a related condition.

(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 whether the person seeking admission:

(1) 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 October 1, 2010; or

(2) Needs specialized services for mental retardation or a related condition as defined in paragraph 81.13(14)*"c,"* using the procedures set forth in 42 CFR 483.136 as amended to October 1, 2010.

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 the nursing facility is an appropriate placement.

d. Nursing facility payment under the Iowa Medicaid program will be made for persons with mental illness, mental retardation, or a related condition only if it is determined by the division of mental health and disability services that the person's treatment needs will be or are being met.

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]

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 subrules 81.13(2)*"a"* and 81.13(6)*"c."*)

81.5(1) *Notice.* When a public assistance recipient requests transfer or discharge, or another person requests this for the recipient, the administrator shall promptly notify the local office of the department. This shall be done in sufficient time to permit a social service worker 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.

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 department's accounting firm. All Medicare-certified hospital-based nursing facilities shall submit a copy of their Medicare cost report to the department's accounting firm. Costs for patient care services shall be reported, 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. The financial and statistical report shall be submitted in an electronic format approved by the department. 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 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. A schedule shall be required when necessary for a fair presentation of expense attributable to nursing facility patients.

81.6(3) *Submission of reports.* All nursing facilities, except the Iowa Veterans Home, shall submit reports to the department's accounting firm no later than three months after the close of the facility's established fiscal year. The Iowa Veterans Home shall submit the report to the department's accounting firm no later than three months after the close of each six-month period of the facility's established fiscal year. Failure to submit a report that meets the requirements of this rule within this time shall reduce payment to 75 percent of the current rate. The reduced rate shall be paid for no longer than three months, after which time no further payments will be made.

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 department's accounting firm 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 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.

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) Each facility which supplies transportation services as defined in Iowa Code section 601J.1, subsection 1, shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 601J and 820—[09,A] chapter 2 of the department of transportation rules 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.

(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. It includes salary amounts paid for managerial, administrative, professional, and other services; amounts paid by the facility for the personal benefit of the proprietor or immediate relative; the cost of assets and services which the proprietor or immediate relative receives from the facility; and deferred compensation.

(2) Reasonableness requires that the compensation allowance be 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.

i. Management fees 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 fees are an allowable cost when directly related to patient care. Legal fees related to defense against threatened state license revocation or Medicaid decertification are allowable costs only up to the date a final appeal decision is issued. However, in no case will legal fees related to Medicaid decertification be allowable costs following the decertification date.

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."*

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. 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) *Facility-requested rate adjustment.* A facility may request a rate adjustment for a period of time no more than 18 months prior to the facility's rate effective date. The request for adjustment shall be made to the department's accounting firm.

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 department's accounting firm of the date its 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
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

Standard	Measurement Period	Value	Source
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
Subcategory: Resident Satisfaction			
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. 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.	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
Long-Term Care Ombudsman: The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman.	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			
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. 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.	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
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.	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
Subcategory: Staffing			
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. 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.	Facility fiscal year ending on or before December 31 of the payment period	5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation 10 points if case-mix adjusted nursing hours are greater than mean plus one standard deviation	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.
Employee Turnover: The facility has overall employee turnover of 50% or less and CNA turnover of 55% or less.	Facility fiscal year ending on or before December 31 of the payment period	5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55% 10 points if overall turnover is less than or equal to 40% and CNA turnover is less than or equal to 45%	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

Standard	Measurement Period	Value	Source
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.	Calendar year ending December 31 of the payment period	5 points	Self-certification
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. 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.	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
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

Standard	Measurement Period	Value	Source
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
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):

Score	Amount of Add-on Payment
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.

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse nursing facilities for the portion of crossover claims not covered by Medicaid reimbursement pursuant to paragraph *"b"* and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph *"b."* The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year or by a mutually acceptable schedule consistent with Medicare interim payment schedules.

d. Application of savings. Effective May 1, 2003, savings in Medicaid reimbursements attributable to the limits on nursing facility crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

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]

441—81.7(249A) Continued review.

81.7(1) *Level of care.* The IME medical services unit shall review Medicaid members' need of continued care in nursing facilities, pursuant to the standards and subject to the appeals process in subrule 81.3(1).

81.7(2) *PASRR.* Within the fourth calendar quarter after the previous review, the PASRR contractor shall review all nursing facility residents admitted pursuant to paragraph 81.3(3)*"c"* to determine:

a. Whether nursing facility services continue to be appropriate for the resident, as opposed to care in a more specialized facility, and

b. Whether the resident needs specialized services for mental illness or mental retardation 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]

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. Effective December 1, 2009, 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, 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.

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 which 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, 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—78.1(2)*"f."*

(5) Fees charged by medical professionals for services requested by the facility which 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 which meet the Medicare definition of medical necessity and are provided by vendors enrolled in the Medicaid programs including:

(1) Physician services.

(2) Ambulance services.

(3) Hospital services.

(4) Hearing aids, braces and prosthetic devices.

(5) Therapy services.

d. Other supplies or services for which direct Medicaid payment may be available include:

(1) Drugs covered pursuant to 441—78.1(2).

(2) Dental services.

(3) Optician and optometrist services.

(4) Repair of medical equipment and appliances which 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.

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]

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 may be submitted electronically on software provided by the Iowa Medicaid enterprise or in writing on Form 470-0039.

a. When payment is made, the facility will receive a copy of Form 470-0039, Iowa Medicaid Long-Term Care Claim. The white copy of the form shall be signed and returned to the Iowa Medicaid enterprise as a claim for the next month. If the claim is submitted electronically, the facility will receive remittance advice of the claims paid.

b. When there has been a new admission or a discharge, the facility shall submit Form 470-0039 with the changes noted. When a change is necessary to adjust a previously paid claim, the facility shall submit Form 470-0040, Credit/Adjustment Request. Adjustments to electronically 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."*

441—81.12(249A) Closing of facility. When a facility is planning on closing, the department shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving medical assistance shall be approved by the local office of the department.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)*"a."*

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 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 including 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 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 nasalpharyngeal 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 mental retardation or a related condition. "Specialized services for mental retardation or a related condition" 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 mental retardation 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]

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. Field auditors of the department of inspections and appeals, or representatives of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. Field auditors of the department of inspections and appeals or representatives of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 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.

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 training and competency evaluation approved by the department of inspections and appeals if the nurse aide successfully completed a training and competency evaluation program before July 1, 1989. The aide would have satisfied this requirement if:

a. At least 60 hours were substituted for 75 hours; and

b. The aide has made up at least the difference in the number of hours in the program the aide completed and 75 hours in supervised practical nurse aide training or in regular in-service nurse education; or

c. The person was found to be competent (whether or not by the state) after completion of a nurse aide training of at least 100 hours' duration; or

d. 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

e. 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.

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 testing 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 by the department of inspections and appeals, it shall, at a minimum:

(1) Consist of no less than 75 clock hours of training.

(2) Include at least the subjects specified in 81.16(3).

(3) Include at least 15 hours of laboratory experience, 30 hours of classroom instruction (the first 16 hours of which must occur before the nurse aide has resident contact) and 30 hours of supervised clinical training. Supervised clinical training means training in a setting in which the trainee demonstrates knowledge while performing tasks on a resident under the general supervision of a registered nurse or licensed practical nurse.

(4) Ensure that students do not independently perform any services for which they have not been trained and found proficient by the instructor. It shall also ensure that students who are providing services to residents are under the general supervision of a licensed nurse or a registered nurse.

(5) Meet the following requirements for 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 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 qualified trainers to students shall not exceed one instructor for every ten students in the clinical setting.

(6) Contain information regarding competency evaluation through written or oral and skills testing.

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) No 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 be charged for any portion of the program including any fees for textbooks or other required evaluation or course materials.

(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 not 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 aides for the course, books, and tests.

2. Divide the total arrived at in No. 1 above by 12 to prorate the costs over a one-year period and establish a monthly rate.

3. The aide shall be reimbursed the monthly rate each month the aide works at the facility until one year from the time the 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.

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. 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]

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 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 date of eligibility is given on the Facility Card, Form 470-0371. 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.

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 by 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. Payment for the cost of relocating residents to other facilities;

2. Recovery of state costs related to the operation of a facility pending correction of deficiencies or closure;

3. Reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or by individuals used by the facility to provide services to residents; and

4. Funding of projects to improve the quality of life or quality of care of nursing facility residents through quality improvement initiative grants awarded pursuant to 441—Chapter 166.

[**ARC 9402B**, IAB 3/9/11, effective 4/1/11]

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.

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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.

NOTE: The Committee voted to retain this objection at their meeting held February 8, 1993.

CHAPTER 92
IOWACARE

PREAMBLE

This chapter defines and structures the IowaCare program administered by the department pursuant to Iowa Code Supplement chapter 249J. It is the department's intent that all state expenditures under the IowaCare program shall qualify for federal financial participation under Title XIX of the Social Security Act (Medical Assistance or Medicaid), as allowed by waivers of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services pursuant to Section 1115 of the Social Security Act (42 U.S.C. §1315). Therefore, this chapter shall remain in effect only as long as such waivers are effective. Further, this chapter shall be construed to comply with the requirements of Title XIX or with the terms of any applicable waiver of Title XIX requirements. To the extent that these rules may be found to be inconsistent with any applicable requirement of Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

441—92.1(249A,249J) Definitions.

"Applicant" means an individual who applies for medical assistance under the IowaCare program described in this chapter.

"Clean claim" means a claim that can be adjudicated in the Medicaid claims payment system to result in either a paid or denied status.

"Department" means the Iowa department of human services.

"Dependent child" means the child or stepchild of an applicant or member who is living in the applicant's or member's home and is under the age of 18 or is 18 years of age and will graduate from high school or an equivalent level of vocational or technical school or training leading to a certificate or diploma before reaching the age of 19. Correspondence school is not an allowable program of study. "Dependent child" shall also include a child attending college or a school of higher learning beyond high school if the parents will claim the child as a dependent on their state or federal income tax return.

"Enrollment period" means the entire period that a member receives IowaCare without a break, which may include multiple certification periods.

"Federal poverty level" means the poverty income guidelines revised annually and published in the Federal Register by the U.S. Department of Health and Human Services.

"Group health insurance" means any plan of or contributed by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of the employees or former employees.

"Initial application" means the first application for IowaCare or an application that is filed after a break in assistance of one month or more.

"IowaCare" means the medical assistance program explained in this chapter.

"Medical expansion services" means the services described in Iowa Code section 249J.6.

"Medical home" means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, other health care professionals, and where appropriate, the patient's family; utilizes the partnership to access all medical and nonmedical health-related services needed by the patient and the patient's family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the characteristics specified in Iowa Code section 135.158.

"Member" means an individual who is receiving assistance under the IowaCare program described in this chapter.

"Newborn" means an infant born to a woman as defined in paragraph 92.2(1)*"b."*

"Nonparticipating provider" means a hospital that is located in Iowa and licensed pursuant to Iowa Code chapter 135B but that is not an IowaCare provider pursuant to subrule 92.8(1).

"Provider-directed care coordination services" means provider-directed services in a clinical setting aimed at managing all aspects of a patient's care to ensure quality of care and safety. All aspects of care

are coordinated by the clinical team under the direction of a physician. The team must include a dedicated care coordinator.
[**ARC 9135B**, IAB 10/6/10, effective 10/1/10]

441—92.2(249A,249J) Eligibility. IowaCare eligibility shall be determined according to the requirements of rules 441—75.2(249A) to 441—75.4(249A), 441—75.7(249A), 441—75.10(249A), and 441—75.12(249A) and the provisions of this rule.

92.2(1) *Persons covered.* Medical assistance under IowaCare shall be available to the following people as provided in this chapter:

a. Persons 19 through 64 years of age who:

(1) Are not eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40) or 75.1(42), including persons unable to meet spenddown under 441—subrule 75.1(35); and

(2) Have countable income at or below 200 percent of the federal poverty level.

b. Pregnant women whose:

(1) Gross countable income is below 300 percent of the federal poverty level; and

(2) Allowable medical expenses reduce their countable income to 200 percent of the federal poverty level or below.

c. Newborn children born to women defined in paragraph *"b."*

92.2(2) *Citizenship.* To be eligible for IowaCare benefits, a person must meet the requirements in 441—subrule 75.11(2). A person who claims a qualified alien status shall provide documentation of this status.

92.2(3) *Other disqualification.* A person who has been disqualified from Medicaid for reasons other than excess income, excess resources, or lack of categorical eligibility is not eligible for IowaCare benefits.

92.2(4) *Group health insurance.* A person who has access to group health insurance is not eligible for IowaCare. The department shall use Form 470-4542, IowaCare Insurance Information Request, to obtain information to confirm the status of an IowaCare member's group health insurance. An applicant or member shall not be considered to have access to group health insurance if any of the following conditions exist:

a. The applicant or member is not enrolled in the available group health plan and states that:

(1) The coverage is unaffordable; or

(2) Exclusions for preexisting conditions apply; or

(3) The needed services are not services covered by the plan.

b. The applicant or member is enrolled in a group health plan but states that:

(1) Exclusions for preexisting conditions apply; or

(2) The needed services are not covered by the plan; or

(3) The limits of benefits under the plan have been reached; or

(4) The plan includes only catastrophic health care coverage.

92.2(5) *Payment of assessed premiums.* IowaCare will be canceled if premiums are not paid in accordance with 441—92.7(249A,249J). However, an application for IowaCare shall not be affected by any unpaid premiums from any previous certification period.

92.2(6) *Availability of funds.* Eligibility for IowaCare shall not be approved when the department has determined that there are insufficient funds available to pay for additional enrollment, in accordance with 441—92.14(249A,249J).
[**ARC 8505B**, IAB 2/10/10, effective 4/1/10; **ARC 9135B**, IAB 10/6/10, effective 10/1/10]

441—92.3(249A,249J) Application. Medicaid application policies in 441—76.1(249A) and 441—76.8(249A) apply to IowaCare except as follows:

92.3(1) An application for IowaCare may also be submitted on Comm. 239, IowaCare Application, or Form 470-4364, IowaCare Renewal Application. An applicant who submits an application on another form allowed under 441—76.1(249A) shall also sign Form 470-4194, IowaCare Premium Agreement, and submit it within ten days of the department's request.

92.3(2) A new application is required for each certification period.
[**ARC 9135B**, IAB 10/6/10, effective 10/1/10]

441—92.4(249A,249J) Application processing. Department staff shall process IowaCare applications. The department shall base eligibility decisions primarily on information declared by the applicant. A face-to-face interview is not required.

92.4(1) *Verification.* Applicants seeking eligibility under 92.2(1)*"b"* shall provide verification of medical expenses as required under 92.5(5)*"b."* IowaCare applicants shall not be required to provide verification of income, household members, disability, social security number, age, HAWK-I premium, group health insurance, or pregnancy, unless the verification is specifically requested in writing.

a. The department shall notify the person in writing of any further verification requested. The person shall have five working days to supply the requested information. The local office may extend the deadline for a reasonable period when the person is making every effort but is unable to secure the required information or verification from a third party.

b. Failure of the person to supply requested information or refusal by the person to authorize the department to secure the information from other sources shall serve as a basis for denial of an application or cancellation of IowaCare benefits.

c. If benefits are denied or canceled for failure to provide information and the information is provided within 14 calendar days of the effective date of the denial or cancellation, the department shall complete the eligibility determination as though the information were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information.

92.4(2) *Screening for full Medicaid.* The department shall screen each application for eligibility under coverage groups listed in 441—75.1(249A). If the applicant is eligible under another coverage group, the IowaCare application shall be considered an application for that coverage group.

92.4(3) *Time limit for decision.* The department shall make a determination of approval or denial as soon as possible, but no later than three working days after the filing date of the application, unless:

a. One or more conditions listed in 441—subrule 76.3(1), 76.3(3), 76.3(4), or 76.3(6) exist; or

b. The application is being processed for Medicaid eligibility under a coverage group listed in 441—75.1(249A).
[**ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—92.5(249A,249J) Determining income eligibility. The department shall determine the income of an applicant's household as of the date of decision. To be eligible, the household's income minus allowable deductions shall not exceed 200 percent of the federal poverty level for the household size.

92.5(1) *Household size.* The household size shall include the applicant and the applicant's dependent or unborn children and spouse living in the same home, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act. A person who is absent from the home shall not be included in the household size, unless the absence is temporary.

a. An applicant's spouse shall not be considered absent from the home when:

(1) The spouse's absence is due solely to a pattern of employment, including active duty in the uniformed services of the United States.

(2) The spouse is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday.

b. The conditions described in 441—paragraph 75.53(4)*"b"* shall be applied to determine whether a person's absence is temporary.

92.5(2) *Self-declaration of income.* Applicants shall self-declare the household's future unearned and earned income based on their best estimate.

a. Applicants who receive income on a regular basis shall declare their household's monthly income as described at 92.5(3) and 92.5(4).

b. Applicants who are self-employed, receive their income on an irregular basis, or are not currently employed shall declare their household's anticipated yearly income as described in 92.5(3) and 92.5(4).

92.5(3) *Earned income.* All earned income as defined in this subrule that is received by a person included in the household size shall be counted except for the earnings of a child who is a full-time student as defined in 441—subparagraphs 75.54(1)*"b"*(1), (2), and (3). Earned income shall include income in the form of a salary, wages, tips, or profit from self-employment.

a. For income from salary, wages, or tips, earned income shall mean the total gross amount of income irrespective of the expenses of employment.

b. For self-employment income, earned income shall mean the net profit from self-employment, defined as gross income less the costs of producing the income.

c. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining the net profit counted as earned income from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member verifies expenses in excess of 40 percent of the total gross income received, the net profit counted as earned income shall be determined in the same manner as specified at paragraph 92.5(3)*"b."*

92.5(4) *Unearned income.* Unearned income of all household members shall be counted unless exempted as income by:

a. 441—subrule 75.57(6), paragraph *"b," "c," "d," "e," "f," "g," "h," "i," "j," "k," "l," "m," "p," "q," "r," "t," "u," "v," "w," "x," "y," "z,"* or *"aa"*; or

b. 441—subrule 75.57(7), paragraph *"a," "b," "c," "d," "e," "f," "g," "h," "i," "j," "k," "l," "m,"* or *"q."*

92.5(5) *Deductions.* The department shall determine a household's countable income by deducting the following from the household's self-declared income:

a. Twenty percent of the household's self-declared earned income.

b. For women applying under 92.2(1)*"b,"* medical expenses incurred for a person included in the household size that are unpaid and not subject to payment by a third party. Verification of the unpaid expenses must be provided in order to receive the deduction. The medical expenses that can be deducted are:

(1) Health insurance premiums, deductibles, or coinsurance charges; and

(2) Medical and dental expenses.

92.5(6) *Disregard of changes.* A person found to be income-eligible upon application or recertification of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

92.5(7) *Unearned nonrecurring lump-sum income.* All unearned nonrecurring lump-sum income shall be disregarded.

92.5(8) *Earned lump-sum income.* Anticipated earned lump-sum income shall be prorated over the period for which the income is received.

441—92.6(249A,249J) Effective date. The department shall issue Form 470-4164, IowaCare Medical Card, to persons enrolled in the IowaCare program.

92.6(1) *Certification period.* IowaCare eligibility shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. The certification period shall continue for 12 consecutive months. EXCEPTIONS:

a. For women and newborns eligible under 92.2(1)*"b"* or *"c,"* the certification period shall continue until 60 days after the birth of the child.

b. Certification periods may be adjusted if two or more IowaCare members who were in two households are combined into one household for premium purposes.

92.6(2) *Retroactive eligibility.* IowaCare benefits shall also be available for the month preceding the month in which the application is filed if during that preceding month:

a. The applicant received Medicaid expansion services from a provider within the Medicaid expansion network; and

b. The applicant would have been eligible for IowaCare if application had been made.

92.6(3) *Care provided before eligibility.* No payment shall be made for medical care received before the effective date of eligibility.

92.6(4) *Reinstatement.* Eligibility for IowaCare may be reinstated without a new application when all information necessary to establish eligibility, including verification of any changes, is provided within 14 calendar days of the effective date of the cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. When eligibility can be reestablished, assistance shall be reinstated with an effective date of the first day of the month following the month of cancellation.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 9135B**, IAB 10/6/10, effective 10/1/10]

441—92.7(249A,249J) Financial participation. In addition to the copayments required by 441—subrule 79.1(13), IowaCare members, with the exception of newborns eligible pursuant to 92.2(1)*"c"* and members in households that include a considered person who pays a Medicaid premium, shall be assessed a sliding-scale monthly premium. A member shall be responsible for paying the premium for the first month after the month of decision and for the following three months, regardless of continued enrollment during the four-month period or during previous months, and for each month of continued enrollment after the required four months. If there is a break in enrollment of one month or more, a new four-month period of mandatory premiums shall be assessed, beginning with the month following the month of decision.

92.7(1) *Premium amount.* The monthly premium amount shall be established for the certification period determined pursuant to subrule 92.6(1) beginning with the first month of eligibility, based on projected monthly income for 12 months. On an initial application, no premium shall be assessed for months of eligibility before and including the month of decision, including the retroactive month.

a. The monthly premium is based on the household's countable monthly income as a percentage of the federal poverty level for a household of that size. If there is more than one IowaCare member in a household, a single premium is established for coverage of all of the members in the household. Effective for applications and recertifications received on or after June 1, 2011, premiums are as follows:

When there is one IowaCare member in the household and the household's income is at or below:	The member's premium amount is:
150% of federal poverty level	$0
160% of federal poverty level	$50
170% of federal poverty level	$54
180% of federal poverty level	$57
190% of federal poverty level	$60
200% of federal poverty level	$63

When there are two or more IowaCare members in the household and the household's income is at or below:	The household's premium amount is:
150% of federal poverty level	$0
160% of federal poverty level	$68
170% of federal poverty level	$72
180% of federal poverty level	$77
190% of federal poverty level	$81
200% of federal poverty level	$85

b. The listed premium amount is calculated based on the lowest income level in each 10 percent increment of the federal poverty level for a household of one if there is one IowaCare member in the household or of the federal poverty level for a household of two if there are two or more IowaCare members in the household.

(1) Households with income at or below 150 percent of the poverty level are not subject to a premium.

(2) Premiums for households with income over 150 percent of the poverty level are 3.5 percent of the lowest applicable income level. The department will update these amounts effective the second month after the month federal poverty level guidelines are released.

c. The cost of HAWK-I premiums paid for household members shall be deducted from the premium assessed according to this subrule.

d. The monthly premium established for a certification period shall not be increased due to an increase in household income or a change in household size.

e. The premium may be reduced prospectively during the certification period if a member declares a reduction in projected average monthly household income or an increase in household size or is granted a hardship exemption.

92.7(2) *Billing and payment.* Form 470-4165, IowaCare Billing Statement, shall be used for billing and collection.

a. Method of payment. Members shall submit premium payments to the following address: Iowa Medicaid Enterprise, IowaCare Premiums, P.O. Box 10391, Des Moines, Iowa 50306-9013.

b. Due date. When the department notifies a member of the amount of the premium, the member or household shall pay any premiums due as follows:

(1) The premium for each month is due the last calendar day of the month the premium is to cover. EXCEPTION: The premiums for the months covered in the initial billing are due the last calendar day of the following month.

(2) If the last calendar day falls on a weekend or a state or federal holiday, payment is due the first working day following the holiday or weekend.

c. Application of payment. The department shall apply premium payments received to the oldest unpaid month in the current certification period. When premiums for all months in the certification period have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

92.7(3) *Hardship exemption.* A member or household that submits a written statement indicating that payment of the monthly premium will be a financial hardship shall be exempted from premium payment for that month, except as provided in paragraph *"c."* If the statement is not postmarked by the premium due date, the member or household shall be obligated to pay the premium.

a. A partial payment submitted with a written statement indicating that full payment of the monthly premium will be a financial hardship that is postmarked or received on or before the end of the month for which the premium is due shall be considered a request for a hardship exemption. The exemption shall be granted for the balance owed for that month.

b. If the postmark is illegible, the date that the hardship declaration is initially received by the department or the department's designee shall be considered the date of the request.

c. A member or household shall not be exempted from premium payment for a month in which the member misrepresented the household's circumstances.

92.7(4) *Failure to pay premium.* If the member or household fails to pay the assessed premium or to declare a hardship by the date the premium is due, the department shall cancel IowaCare benefits effective 60 days after the due date and shall refer the unpaid premiums for collection. A member whose IowaCare benefits are canceled due to nonpayment of premiums must reapply to establish IowaCare eligibility.

92.7(5) *Refund of premium.* When a member's IowaCare coverage is canceled due to a circumstance listed in paragraph *"a,"* premiums paid for any period after the cancellation date shall be refunded, except to the extent that premiums are still due for any household members whose IowaCare coverage is not canceled.

a. Premiums may be refunded when a member's IowaCare coverage is canceled because the member:

(1) Is determined eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40);

(2) Has access to group health insurance coverage as defined in subrule 92.2(4);

(3) Reaches age 65;

(4) Dies; or

(5) No longer meets program requirements after the four mandatory premium months.

b. The amount of the refund shall be offset by any outstanding premiums owed.

c. Any excess premium received for a person who is not receiving IowaCare benefits shall be refunded:

(1) Two calendar months after eligibility ended unless an application or reapplication is pending, or

(2) Upon the person's request.

d. Any excess premium received for an IowaCare member shall be refunded:

(1) After two calendar months of a zero premium, or

(2) Upon the member's request.

[**ARC 7667B**, IAB 4/8/09, effective 4/1/09; **ARC 9135B**, IAB 10/6/10, effective 10/1/10; **ARC 9532B**, IAB 6/1/11, effective 7/6/11]

441—92.8(249A,249J) Benefits. Under IowaCare, payment will be made only for services and providers as specified in this rule. No payment will be made for any service provided elsewhere or by another provider.

92.8(1) *Provider network.* Except as provided in subrules 92.8(3) through 92.8(6), IowaCare members shall have medical assistance only for services provided to the member by:

a. The University of Iowa Hospitals and Clinics; or

b. Broadlawns Medical Center in Des Moines; or

c. A federally qualified health center that the department has designated as part of the IowaCare network using a phased-in approach based on the degree to which the area is underserved, medical home readiness, and the availability of funds; or

d. Any physician, advanced registered nurse practitioner, or physician assistant who is part of a medical institution listed in this subrule. Physician assistants are able to render covered services as auxiliary personnel of a physician pursuant to 441—subrule 78.1(13).

92.8(2) *Covered services.* Services shall be limited to the services covered by the Iowa Medicaid program pursuant to 441—Chapter 78 or 441—79.9(249A) and to medical home services required by subrule 92.8(7). All conditions of service provision shall apply in the same manner as under the regular Iowa Medicaid program and pursuant to 441—Chapter 78, 441—79.3(249A), 441—79.5(249A), 441—79.6(249A), 441—79.8(249A) through 441—79.14(249A), and applicable provider manuals. These conditions include, but are not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be required to meet the medical need of the patient.

92.8(3) *Obstetric and newborn coverage.* IowaCare members who qualify under 92.2(1)*"b"* or *"c"* are also eligible for the services specified in paragraph *"a"* or *"b"* from the providers specified in paragraph *"c"* or *"d."*

a. Covered services for pregnant women shall be limited to:

(1) Inpatient hospital services when the diagnosis-related group (DRG) submitted for payment is between 370 and 384 and the primary or secondary diagnosis code is V22 through V24.9.

(2) Obstetrical services provided in an outpatient hospital setting when the primary or secondary diagnosis code is V22 through V24.9.

(3) Services from another provider participating in Medicaid if the claim form reflects that the primary or secondary diagnosis code is V22 through V24.9.

b. Newborns will be eligible while hospitalized and for a period not to exceed 60 days from the date of birth.

(1) Inpatient hospital services shall be payable when the diagnosis-related group (DRG) submitted for payment is between 385 and 391.7.

(2) Services provided by a health care provider other than a hospital shall be covered as provided in subrule 92.8(2).

c. For persons who reside in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County, the services listed in this subrule are covered only when provided by the University of Iowa Hospitals and Clinics.

d. Persons who do not live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County may obtain the services listed in this subrule from any provider that participates in Iowa Medicaid.

92.8(4) *Routine preventive medical examinations.* A routine preventive medical examination is one that is performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

a. IowaCare members who qualify under paragraph 92.2(1)*"b"* or *"c"* and who have not been enrolled with a medical home are eligible to receive routine preventive medical examinations from:

(1) Any provider specified under subrule 92.8(1), or

(2) Any physician, advanced registered nurse practitioner, or physician assistant who participates in Iowa Medicaid, including but not limited to providers available through a free clinic, a rural health clinic, or a federally qualified health center that has not been designated as an IowaCare provider pursuant to paragraph 92.8(1)*"c."* Physician assistants are able to render covered services as auxiliary personnel of a physician pursuant to 441—subrule 78.1(13).

b. A provider that bills IowaCare for a routine preventive medical examination shall use diagnosis code V70 and evaluation and management CPT code 99202, 99203, 99204, 99212, 99213, or 99214, as appropriate to the level of service provided. Basic laboratory work may also be billed in association with the medical examination, as appropriate and necessary.

92.8(5) *Drugs for smoking cessation.* IowaCare members may obtain outpatient prescription drugs for smoking cessation that are related to another appropriately billed IowaCare service from any pharmacy participating in the Iowa Medicaid program.

92.8(6) *Medical home.* As a condition of participation in the IowaCare program, network providers designated pursuant to subrule 92.8(1) must also qualify as medical homes, pursuant to Iowa Code chapter 135, division XXII.

a. The provider shall meet medical home standards. If the Iowa department of public health adopts rules that provide statewide medical home standards or provide for a statewide medical home certification process, those rules shall apply to IowaCare medical home providers and shall take precedence over the requirements in this paragraph. At a minimum, medical homes shall:

(1) Have National Committee for Quality Assurance (NCQA) Level 1 certification or equivalent certification. Effective July 1, 2011, medical homes that achieve a higher level of accreditation from NCQA or equivalent shall be designated as such for purposes of payment.

(2) Provide provider-directed care coordination services.

(3) Provide members with access to health care and information.

(4) Provide wellness and disease prevention services.

(5) Create and maintain chronic disease information in a searchable disease registry.

(6) Demonstrate evidence of implementation of an electronic health record system.

(7) Participate in and report on quality improvement processes.

b. The provider shall execute a contract with the department to be an IowaCare medical home and receive enhanced medical home reimbursements pursuant to subrule 92.9(4). The contract shall include performance measurements and specify expectations and standards for a medical home.

c. If an IowaCare member resides in a designated county near a designated medical home provider, the department shall assign the member to that provider. If an IowaCare member who is assigned to a medical home chooses to go to another provider without a referral from the medical home:

(1) The service is not covered by the IowaCare program, and

(2) The provider may bill the member according to the provider's established criteria for billing other patients.

92.8(7) *Services from nonparticipating providers.*

a. A nonparticipating provider hospital may be reimbursed for covered IowaCare services subject to the following conditions and limitations:

(1) The patient is enrolled in IowaCare pursuant to the Iowa Medicaid enterprise eligibility verification system at the time the services are delivered.

(2) The services are emergency services, as designated by the department, and it is not medically possible to postpone provision of those services.

(3) It is not medically possible to transfer the member to an IowaCare provider, or the IowaCare provider does not have sufficient capacity to accept the member.

(4) The provision of emergency services is followed by an inpatient admission at the nonparticipating provider.

(5) Before submitting a medical claim for reimbursement, the treating nonparticipating provider has requested and received authorization for payment from the Iowa Medicaid enterprise medical services unit. The request shall include the claim listing the emergency and inpatient services.

b. If the conditions listed in paragraph *"a"* are met as specified, a nonparticipating provider may be reimbursed for covered services provided to the member from the point of emergency room admission to the point of discharge or transfer from the inpatient unit, up to the amount appropriated. This reimbursement does not include emergency or nonemergency transportation services.

c. Care coordination pool. A care coordination pool is established to provide payment for medically necessary services provided to IowaCare members for continuation of care provided by a participating IowaCare hospital. Reimbursement is available from designated care coordination pool funding subject to the following conditions:

(1) Payment may be made for continuing care that is related to an IowaCare member's hospital services as determined in a referral from the participating IowaCare hospital.

(2) Payment for continuing care is available to providers that are enrolled in the Iowa medical assistance program, regardless of whether the provider is a participating provider for IowaCare and regardless of the member's county of residence or medical home assignment.

(3) A provider of continuing care that does not participate in the IowaCare program must include information regarding the referral on the claim form.

(4) Payment shall be made only for services that are not otherwise covered under the IowaCare program. Payment shall not be made for services that would normally be provided by the IowaCare provider to other non-IowaCare patients.

(5) The type, scope, and duration of payable services shall be limited as determined by the department. Payable services are limited to:

1. Durable medical equipment.

2. Home health services.

3. Rehabilitation and therapy services, including intravenous antibiotics and parenteral therapy delivered at home.

(6) Types of items or services that are not covered include, but are not limited to:

1. Adult diapers.
2. Air compressors.
3. Bedside commodes.
4. Blood pressure kits or machines.
5. Cardiac event monitors.
6. Continuous passive motion machines.
7. Continuous positive air pressure (CPAP) machines.
8. Dental care (nonsurgical).
9. Eyeglasses, contact lenses, and eye prostheses.
10. Gel shoe inserts.
11. Hearing aids.
12. Heated oxygen.
13. Laboratory tests and radiology procedures.
14. Oral supplemental formula.
15. Outpatient pharmaceuticals not specifically identified in 92.8(7)*"c"*(5) above.
16. Ted hose, Sigvaris stockings, or Jobst stockings.
17. Tennis shoes.
18. Transcutaneous electrical nerve stimulation (TENS) units.
19. Transportation.
20. Work boots.

(7) All other medical assistance program policies affecting the payable services shall apply, including those regarding prior authorization and level of care determination.

(8) Payment is limited to the amount of available funds designated for the care coordination pool.

d. Laboratory test and radiology pool. A funding pool is established to provide payment for medically necessary laboratory tests and radiology services provided to enrolled IowaCare members when authorized by a federally qualified health center that has been designated by the department as part of the IowaCare regional provider network. Payment from the pool shall be subject to the following conditions and limitations:

(1) Payment may be made only for laboratory tests or radiology services which the participating federally qualified health center does not otherwise have the means to provide on site.

(2) Each participating federally qualified health center shall designate no more than four laboratory testing facilities and no more than four radiology facilities to which the center will refer IowaCare patients for these services. The designated providers must participate in the Iowa medical assistance program. Payment shall be made only to the designated providers.

(3) The designated provider must obtain a referral from the participating federally qualified health center for the services and must include information regarding the referral on the claim form.

(4) All other medical assistance policies for coverage of laboratory and radiology services shall apply, including requirements for prior authorization.

(5) Payment is limited to the amount of available funds designated for the laboratory test and radiology pool. If the amount appropriated for the pool is exhausted, laboratory tests and radiology services ordered by a participating federally qualified health center shall be provided or coordinated by the center.

92.8(8) *Referral protocols*. When an IowaCare primary care provider refers the member to an IowaCare specialty provider, the following conditions shall apply:

a. By January 1, 2012, IowaCare providers shall ensure that referral and patient access processes for IowaCare members are no more restrictive than the processes required for any other payor.

b. After an IowaCare provider makes a referral, the IowaCare provider receiving the referral shall report the following information to the referring provider in a manner chosen by the provider receiving the referral:

(1) The date an appointment has been scheduled. The appointment date shall be reported to the referring provider within 15 calendar days of receiving the referral. If the referral is denied, the receiving

provider shall offer a consultation by telephone, fax, E-mail, or Internet regarding the reason for the denial.

(2) If authorized by the IowaCare member, the outcome of the appointment, including whether the appointment was kept, the treatment plan, and any follow-up instructions. This report shall be made no later than 15 calendar days following the appointment date.

c. IowaCare providers shall work together to address any communication or coordination issues that arise. By October 1, 2011, IowaCare providers shall jointly develop and implement:

(1) A process to resolve disputes regarding care needs, payment and referrals that includes regular meetings between providers.

(2) A process to identify and address quality improvements with a goal to improve coordination of care between primary, specialty and hospital care. This process shall be monitored by the department but be managed and staffed by the providers.

[**ARC 9135B**, IAB 10/6/10, effective 10/1/10; **ARC 9728B**, IAB 9/7/11, effective 9/1/11; **ARC 9890B**, IAB 11/30/11, effective 1/4/12]

441—92.9(249A,249J) Claims and reimbursement methodologies.

92.9(1) *Claims.* Claims for Medicaid expansion services provided to IowaCare members shall be submitted to the Iowa Medicaid Enterprise, P.O. Box 150001, Des Moines, Iowa 50315, as required by 441—Chapter 80. To facilitate tracking of expenditures, clean claims for IowaCare services shall be submitted to the Iowa Medicaid enterprise within 20 days from ending date of service.

92.9(2) *Payment for hospital services provided by IowaCare network.* Effective July 1, 2010:

a. Inpatient hospital services provided by University of Iowa Hospitals and Clinics will be paid based on 100 percent of reasonable and allowable costs.

(1) An interim rate based on the Medicaid reimbursement rates and methodologies as of November 30, 2009, shall be used to price submitted claims.

(2) At the end of the cost reporting period, a reconciliation will be performed based on the hospital's CMS-2552 cost report as filed for the payment period and IowaCare claims data as extracted by the department from the Medicaid management information system. The aggregate payments under the interim methodology will be determined and compared to the IowaCare program costs as determined from the hospital's cost report. For purposes of this rule, aggregate payments include amounts received for the IowaCare program, outlier payments, and patient and third-party payments up to the allowed amount.

(3) If the aggregate payments exceed the hospital's IowaCare costs, the amount by which payments exceed actual costs will be requested and collected from the hospitals.

(4) If the aggregate payments are less than actual IowaCare costs, an additional payment equal to the difference will be made to the hospital.

b. Inpatient hospital services provided by Broadlawns Medical Center shall be paid at the Medicaid reimbursement rates and methodologies in effect on November 30, 2009.

c. Outpatient hospital services provided by University of Iowa Hospitals and Clinics or Broadlawns Medical Center shall be paid at the Medicaid reimbursement rates and methodologies in effect on November 30, 2009.

92.9(3) *Payment for nonhospital services provided by IowaCare network.* Effective July 1, 2010, IowaCare network providers shall be paid for nonhospital services at the Medicaid fee schedule amounts in effect on November 30, 2009, with the following exceptions:

a. For preventive examination codes, the fee schedule amounts shall be based on the Medicaid physician fee schedule in effect on the date of service.

b. Physician services provided to IowaCare members in a federally qualified health center shall be reimbursed based on the Medicaid physician fee schedule in effect on the date of service, limited to the amount appropriated for the fiscal year.

c. Physician services provided by University of Iowa Hospitals and Clinics physicians to IowaCare members will be reimbursed based on the Medicaid physician fee schedule in effect on the date of service, limited to the amount appropriated for the fiscal year.

92.9(4) *Medical home payments.*

a. In addition to any other IowaCare reimbursement, IowaCare providers that meet the medical home standards pursuant to subrule 92.8(6) and have contracted with the department shall receive a monthly medical home payment for each member assigned to the medical home by the department. The medical home payment shall begin the first day of the month following the member's assignment to the medical home.

(1) The medical home payment will be on a per-member, per-month basis in an amount determined by the department, but no more than $4 per member, per month.

(2) Effective July 1, 2011, the department shall implement a tiered per-member, per-month payment method that is based on the medical home's certification level as designated by a nationally recognized medical home accreditation organization.

b. IowaCare medical homes shall be eligible for a performance payment for achieving medical home performance benchmarks designated by the department as specified in the provider's contract with the department. The performance payment shall be paid by October 31 following the end of the state fiscal year and is in addition to any other IowaCare reimbursement.

92.9(5) *Payment for services provided by nonparticipating hospitals.* Nonparticipating hospitals shall be paid at the Medicaid reimbursement rates and methodologies in effect on December 1, 2009, up to the amount appropriated to the nonparticipating provider reimbursement fund created in 2009 Iowa Code Supplement section 249J.24A. No payment shall be made after appropriated funds are exhausted.

92.9(6) *Payment for services provided by other nonparticipating providers.* Nonparticipating providers other than hospitals shall be paid at the Medicaid reimbursement rates and methodologies in effect on the date of service.

[**ARC 9135B**, IAB 10/6/10, effective 10/1/10]

441—92.10(249A,249J) Reporting changes.

92.10(1) *Reporting requirements.* A member shall report any of the following changes no later than ten calendar days after the change takes place:

a. The member enters a nonmedical institution, including but not limited to a penal institution.

b. The member abandons Iowa residency.

c. The member obtains other health insurance coverage.

92.10(2) *Untimely report.* When a change is not timely reported, any incorrect program expenditures shall be subject to recovery in accordance with 441—92.13(249A,249J).

92.10(3) *Effective date of change.* After assistance has been approved, changes reported during the month that affect the member's eligibility or premium amount shall be effective the first day of the next calendar month unless:

a. Timely notice of adverse action is required as specified in 441—subrule 7.7(1); or

b. The certification has expired.

441—92.11(249A,249J) Reapplication. A new application is required when a member's 12-month certification period has expired or a member is seeking to regain eligibility after cancellation.

92.11(1) *Reapplication at least three days before end of certification period.* When a member submits an application before the last three working days of the member's current certification period, the department shall approve or deny the application by the last working day of the current certification period unless a condition described at 92.4(3)*"a"* or *"b"* applies.

92.11(2) *Reapplication within three days of end of certification period or later.* When a member submits an application during the last three working days of the member's current certification period or after the certification period ends, the department shall approve or deny the application as described at 92.4(3).

441—92.12(249A,249J) Terminating eligibility. IowaCare eligibility shall end when any of the following occur:

1. The certification period ends.

2. The member begins receiving medical assistance in a coverage group under 441—subrules 75.1(1) through 75.1(40).

3. The member does not pay premiums as required by 441—92.7(249A,249J).

4. The member no longer meets the nonfinancial eligibility requirements under 441—92.2(249A,249J).

5. The member is found to have been ineligible at the time the eligibility determination was made due to member misrepresentation or member or agency error.

6. The member dies.

441—92.13(249A,249J) Recovery. The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member and any unpaid premiums in accordance with 441—76.12(249A). For this purpose, unpaid premiums shall be treated as medical assistance incorrectly paid due to client error.

92.13(1) The department shall recover Medicaid funds expended on behalf of a member and any unpaid premiums from the member's estate in accordance with 441—76.12(249A).

92.13(2) Any funds recovered from third parties, including Medicare, by a provider other than a state mental health institute shall be submitted to the Iowa Medicaid enterprise, and an adjustment shall be made to a previously submitted claim.

[**ARC 9135B**, IAB 10/6/10, effective 10/1/10]

441—92.14(249A,249J) Discontinuance of the program. IowaCare is operated statewide and is funded on a fiscal-year basis (from July through June). When funds are expected to be expended before the end of the fiscal year, enrollment of new members into the program will be discontinued or limited to a reduced scope of services until funding is received for the next fiscal year.

92.14(1) *Suspension of enrollment.* To ensure equitable treatment, applications shall be approved on a first-come, first-served basis and enrollment will be suspended when the likely costs of caring for those already enrolled will exhaust the available funding during the year. "First-come, first-served" status is determined by the date the application is approved for eligibility and entered into the computer system.

92.14(2) *Enrollment for limited services.* Eligibility or payment for services received cannot be approved beyond the amount of funds available. Because funds are limited, applications may be approved for a reduced scope of services.

441—92.15(249A,249J) Right to appeal. Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed pursuant to 441—Chapter 7. However, households will not be entitled to an appeal hearing if the sole basis for denying or limiting services is due to discontinuance or limitation of the program pursuant to 441—92.14(249A,249J).

These rules are intended to implement Iowa Code chapter 249J.

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CHAPTER 126
STATE MEDICAL EXAMINER

[Prior to 4/20/88, see Medical Examiner, State[566] Ch 1]
[Prior to 6/30/99, see Public Safety Department[661] Ch 21]

641—126.1(144,331,691) Definitions.

"Autopsy" means the external and internal postmortem examination of a deceased person.

"County of appointment" means the county which requests a medical examiner to conduct an investigation, perform or order an autopsy, or prepare a report(s) in a death investigation case. The request may be authorized by the county attorney or the county medical examiner. The county of appointment shall be the county in which the death occurred.

641—126.2(691) Medical examiner coverage. Rescinded IAB 12/12/01, effective 1/16/02.

641—126.3(691) Fees for autopsies and related services and reimbursement for related expenses. Autopsies performed by the state medical examiner are provided on a fee-for-service basis. Costs of autopsies and related services and expenses are the responsibility of the county of appointment. The county of residence of the deceased shall reimburse the county of appointment.

126.3(1) *Fee schedule.* The fees collected under this subrule shall be considered repayment receipts as defined in Iowa Code section 8.2.

a. The following fees shall apply to autopsies conducted by the state medical examiner:

Autopsy	$1400
Copies of reports	$20

EXCEPTIONS: A copy of the autopsy report is automatically sent to the county medical examiner and to the county attorney without fee. A single copy of an autopsy report may be provided to the immediate next of kin of the deceased without fee. Copies of autopsy reports may be provided to public officials and physicians of record for official purposes without fee.

b. The following fee is for time spent reviewing case materials, preparing for deposition or court, testifying in deposition or court, and travel time.

State, deputy, or associate medical examiner(s) time for all court cases	$450 per hour with a one-hour minimum

c. A cremation permit fee of $75 will be assessed for each permit investigated and authorized by the state medical examiner's office.

126.3(2) *Expense reimbursement.* Other laboratory services associated with an autopsy, which shall include, but not be limited to, photography, toxicology, radiology, microbiology, and morgue fees, shall be billed by the department to the county of appointment. Moneys collected pursuant to this subrule shall be paid by the department to the laboratory or other entity providing the service.

126.3(3) *State medical examiner acting as county medical examiner.* When the state medical examiner acts in the capacity of county medical examiner, the state medical examiner shall receive from the county of appointment a fee of $100 per hour, with a one-hour minimum, for each report prepared plus the state medical examiner's actual expenses. Counties may not depend on the state medical examiner for full-time coverage.

[**ARC 9533B**, IAB 6/1/11, effective 7/6/11; **ARC 9880B**, IAB 11/30/11, effective 1/4/12]

641—126.4(691) Fees for tissue recovery. When the tissue recovery room located within the office of the state medical examiner is utilized by an authorized tissue recovery agency, a fee of $400 per case shall be assessed. The tissue recovery agency is responsible for this fee, payable to the office of the state medical examiner.

These rules are intended to implement Iowa Code section 691.6.

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REVENUE DEPARTMENT[701]

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ORGANIZATION, PUBLIC INSPECTION

[Prior to 10/7/87, see Revenue Department[730] Ch 6]

701—6.1(17A) Establishment, organization, general course and method of operations, methods by which and location where the public may obtain information or make submissions or requests.

6.1(1) *Establishment of the department.* By an Act of the general assembly (chapter 1245, Acts of the 71st GA), a department of revenue and finance was created in lieu of three separate state agencies. The department is administered by the director with a three-member state board of tax review established within the department for administrative and budgetary purposes. As to the organization and functions of the state board of tax review, see rules contained in 701—Chapters 1 to 5.

Effective July 1, 2003, the Iowa department of revenue and finance is titled the Iowa department of revenue.

The department of revenue in recognizing its responsibilities has adopted the following creed to guide and lend direction to its endeavors:

"The Department of Revenue is dedicated to serving the citizens of Iowa and other public officials, while performing the following mission:

"Collect all taxes due, which any person may be required by law to pay, but no more.

"In carrying out this mission the department resolves to provide the best service possible in a cordial and helpful manner and to provide maximum opportunity and incentive for the professional growth and development of all our employees."

The office of the department is maintained at the seat of government in the Hoover State Office Building, 1305 East Walnut Street, P.O. Box 10460, Des Moines, Iowa 50306.

6.1(2) *Organization of the department.* The department consists of the office of the director; the following divisions: compliance, property tax, policy and communications, revenue operations, internal services, and technology and information management; and the state board of tax review. For ease of administration, the director has organized the department's divisions in some instances into bureaus, sections, subsections and units.

a. The office of the director. The office of the director consists of the director and the following areas within this office: strategic planning, internal audit, clerk of the hearing section, public/private partnership, and research and fiscal analysis. The essential functions of the director's office include:

(1) Overall management of the agency and review of protest and revocation cases on appeal.

(2) Strategic planning and coordination of the future operations and goals of the department.

(3) Providing financial checks and balances within the department.

(4) The clerk of the hearing section receives all protests, tracks protests and coordinates protest processing.

(5) Public/private partnership provides for a working relationship between the public and private sector.

b. Divisions.

(1) Property tax division. The property tax division provides technical assistance and training to local assessing jurisdictions, ensures equal assessment of property, and is responsible for determining valuation for railroads, electric, water, and pipeline companies.

(2) Compliance division. The compliance division includes the examination section, investigative audit section, in-state field offices and out-of-state field offices. The essential functions of the compliance division include:

1. Examination, which includes office examination of returns, assessment, and review and approval of refund claims, and which identifies nonfilers and those that underreport income;

2. Investigative audit, which is responsible for audits for criminal prosecution, reviews cases for potential prosecution and represents the department in criminal proceedings and depositions;

3. In-state field offices, which provide assistance to taxpayers concerning procedure and perform audits; and

4. Out-of-state field offices, which perform audits for all taxes throughout the country from nine locations throughout the United States.

(3) Policy and communications division. The policy and communications division consists of audit services, taxpayer services, policy and tax research and data analysis. The essential functions of the policy and communications division include:

1. Audit services, which includes the development and review of audit programs and completed audits, manuals, and guidelines for auditors, and which coordinates the administrative process of protests and protest resolution;

2. Taxpayer services, which is responsible for responding to inquiries from the public, practitioners and other agencies, drafting brochures and graphics, completing returns, maintaining the department's library and Web page, and coordinating public education by the department;

3. Policy, which is responsible for the interpretation of legislation, statutes and cases, developing and maintaining rules for the department and monitoring tax-related issues considered by the general assembly and the United States Congress. This section also drafts declaratory orders, offers technical advice and completes studies and reports;

4. Tax research and data analysis, which provides research, data information, fiscal analysis and reporting, which includes fact-finding, defining issues, issue resolution, and projection of revenues, and evaluates the fiscal impact of tax legislation and policies on state budget.

(4) Internal services division. The essential functions of the internal services division include:

1. Central accounting, which includes operating budget development, maintenance and reporting; and

2. Employee resource team, which governs personnel activities, payroll, benefits, quality of the environment and customer service.

(5) Technology and information management division. This division consists of information resources management, application design and development, program management, program evaluation, operations, forms management, reporting, and technical planning and support. The essential functions of the technology and information management division include:

1. Application development, which includes system analysis, programming, database administration and support;

2. Forms management, which includes review and performing the function of compliance with federal and state law and managing electronic filing programs; and

3. Technical planning and support, which includes technical support to the agency on software and hardware issues, and which assists in application and development regarding technology-related issues.

(6) Revenue operations division. This division includes collections (accounts receivable, central collections, field office advanced collections), customer accounts, document processing, and data operations and information technology. The essential functions of the revenue operations division include:

1. Collections, which includes accounts receivable, central collections, field office advanced collections and customer accounts;

2. Document processing, which includes preparing tax information for processing, deposits and records; and

3. Data entry, which includes entry of all tax forms, files, and databases, and which edits taxpayer documents and mailing information.

6.1(3) *Methods by which and location where the public may obtain information or make submissions or requests.* The department of revenue maintains its principal office in the Hoover State Office Building, 1305 East Walnut Street, P.O. Box 10460, Des Moines, Iowa 50306.

a. Principal office. Members of the public wishing to obtain information or make submissions or requests on any matters may do so at the department's principal office. Applications for permits or licenses may be obtained and submitted at the principal office, and any assistance needed in filling out the applications will be provided if the taxpayer so desires. Requests for confidential information should

be submitted to the director, and the appropriate form will be provided and should be filled out and submitted to the director. Members of the public wishing to inspect information required to be made available to members of the public may do so in the director's office.

b. Regional offices. Regional offices do not have facilities for making available all matters that are available for public inspection under 701—6.2(17A). The regional offices and auditors do have copies of all rules and will make them available to the public. Members of the public needing forms or needing assistance in filling out forms are encouraged to contact the principal office.

This rule is intended to implement Iowa Code sections 421.1, 421.2, 421.9, 421.14, 421.17, 422.1 and 422.72.

[**ARC 9875B**, IAB 11/30/11, effective 1/4/12]

701—6.2(17A) Public inspection. Effective July 1, 1975, Iowa Code section 17A.3(1)*"c"* and *"d"* provides that the department shall index and make available for public inspection certain information. Pursuant to this requirement the department shall:

1. Make available for public inspection all rules;
2. Make available for public inspection and index by subject all written statements of law or policy, or interpretations formulated, adopted, or used by the department in the discharge of its functions;
3. Make available for public inspection and index by name and subject all final orders, decisions and opinions.

Section 17A.3(1)*"c"* and *"d"* also excepts certain matters from the public inspection requirement:

Except as provided by constitution or statute, or in the use of discovery or in criminal cases, the department shall not be required to make available for public inspection those portions of its staff manuals, instructions or other statements issued by the department which set forth criteria or guidelines to be used by its 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 the disclosure of such statements would: (1) enable law violators to avoid detection; or (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 state.

Identifying details which would clearly warrant an invasion of personal privacy or trade secrets will be deleted from any final order, decision or opinion which is made available for public inspection upon a proper showing by the person requesting such deletion as provided in rules 701—7.15(17A) and 7.42(17A).

Furthermore, the department shall not make available for public inspection or disclose information deemed confidential under Iowa Code sections 422.20 and 422.72.

Unless otherwise provided by statute, by rule or upon a showing of good cause by the person filing a document, all information contained in any petition or pleading shall be made available for public inspection.

All information accorded public inspection treatment shall be made available for inspection in the office of the Policy Section, Policy and Communications Division, Department of Revenue, Hoover State Office Building, P.O. Box 10457, Des Moines, Iowa 50306, during established office hours.

This rule is intended to implement Iowa Code chapter 17A.

[**ARC 9875B**, IAB 11/30/11, effective 1/4/12]

701—6.3(17A) Examination of records. Situations may occur that give rise to the need for state officials, other officers, agents or employees of the state, or other persons based on a court subpoena to review tax returns or information belonging to the department in order to fulfill duties and responsibilities or to assist in an investigation. However, there are guidelines that govern such reviews, which are as follows:

6.3(1) Upon the express written approval of the director of revenue or administrator of the compliance division, officers or employees of the state of Iowa may examine state tax returns and information belonging to the department to the extent required as part of their official duties and responsibilities. Written approval will be granted in those situations where the officers or employees of

the state of Iowa have (1) statutory authority to obtain information from the department of revenue and (2) the information obtained is used for tax administration purposes. Where information is obtained from the department of revenue on a regular basis, the director of revenue may enter into a formal agreement with the state agency or state official who is requesting the information. The agreement will cover the conditions and procedures under which specific information will be released. The following persons do not need written approval from the director of revenue or the administrator of the compliance division to examine state information and returns:

1. Assistant attorneys general assigned to the department of revenue.
2. Local officials acting as representatives of the state in connection with the collection of taxes or in connection with legal proceedings relating to the enforcement of tax laws.
3. The child support recovery unit of the department of human services and other state agencies and subdivisions of the state that are set forth in Iowa Code section 422.17 as amended by 1999 Iowa Acts, chapter 152, section 1, to secure a taxpayer's name and address per the terms of an interagency agreement. (Also see Iowa Code section 252B.9)
4. Workforce development department per the terms of an interagency agreement.
5. The legislative services agency regarding sample individual income tax information to be used for statistical purposes. (Also see Iowa Code section 422.72(1).)
6. The auditor of state, to the extent that the information is necessary to complete the annual audit of the department as required by Iowa Code section 11.2. (Also see Iowa Code section 422.72(1).)

Tax information and returns will not be released to officers and employees of the state who do not meet the requirements set forth above. (See Letter Opinions, November 25, 1981, Richards to Bair, Director of Revenue, and March 4, 1982, Richards to Johnson, Auditor, and Bair, Director of Revenue.)

The director may disclose state tax information, including return information, to tax officials of another state or the United States government for tax administration purposes provided that a reciprocal agreement exists which has laws that are as strict as the laws of Iowa protecting the confidentiality of returns and information.

6.3(2) The director of revenue must provide state tax returns and return information in response to a subpoena issued by the court based on Iowa R. Crim. P. 2.5 commanding the appearance before the attorney general or an assistant attorney general if the subpoena is accompanied by affidavits from such person and from a sworn peace officer member of the department of public safety affirming that the information is necessary for the investigation of a felony violation of Iowa Code chapter 124, "Controlled Substances," or 706B, "Money Laundering." Affidavits accompanying the subpoenas and the information provided by the director of revenue must remain a confidential record and may only be disseminated to a prosecutor, peace officer involved in the investigation, or to the taxpayer who filed the information. In addition, the court in connection with the filing of criminal charges or institution of a forfeiture action may also receive such confidential information.

A person who knowingly files a false affidavit with the director to secure information or who divulges information received under this rule in any manner prohibited by this rule commits a serious misdemeanor.

This rule is intended to implement Iowa Code sections 252B.9, 421.18, 421.19, 422.20, 422.72, and 452A.63.

701—6.4(17A) Copies of proposed rules. A trade or occupational association which has registered its name and address with the department of revenue may receive, by mail, copies of proposed rules. Registration of the association's name and address with the department is accomplished by written notification to the Administrator, Policy and Communications Division, Department of Revenue, Hoover State Office Building, P.O. Box 10457, Des Moines, Iowa 50319. In the written notification, the association must designate, by reference to rule 701—7.36(421,17A), the type of proposed rules and the number of copies of each rule it wishes to receive. If the association wishes to receive copies of proposed rules not enumerated in rule 701—7.36(421,17A), it may make a blanket written request at the time of registration or at any time prior to the adoption of such rules. A charge of 20 cents per

single-sided page shall be charged to cover the actual cost of providing each copy of the proposed rule. In the event the actual cost exceeds 20 cents for a single-sided page, it will be billed accordingly.

This rule does not prevent an association which has registered with the department in accordance with this rule from changing its designation of types of proposed rules or number of copies of proposed rules which the association desires to receive. If an association makes such changed designation, it must do so by written notification to the Administrator, Policy and Communications Division, Department of Revenue, Hoover State Office Building, P.O. Box 10457, Des Moines, Iowa 50319.

This rule is intended to implement Iowa Code section 17A.4.

[**ARC 9875B**, IAB 11/30/11, effective 1/4/12]

701—6.5(17A) Regulatory analysis procedures. Any small business as defined in Iowa Code section 17A.4A or organization of small businesses which has registered its name and address with the department of revenue shall receive by mail a copy or copies of any proposed rule which may have an impact on small business. Registration of the business's or organization's name and address with the department is accomplished by written notification to the Policy Section, Policy and Communications Division, Department of Revenue, Hoover State Office Building, P.O. Box 10457, Des Moines, Iowa 50306. In the written notification, the business or organization must state that it wishes to receive copies of rules which may have an impact on small business, the number of copies of each rule it wishes to receive, and must also designate, by reference to rule 701—7.36(421,17A), the types of proposed rules it wishes to receive. If the small business or organization of small businesses wishes to receive copies of proposed rules not enumerated in rule 701—7.36(421,17A), it may make a blanket written request at the time of registration or at any time prior to the adoption of the rules. A charge of 20 cents per single-sided page shall be imposed to cover the actual cost of providing each copy of the proposed rule. In the event the actual cost exceeds 20 cents for a single-sided page, it will be billed accordingly.

The administrative rules review committee, the administrative rules coordinator, at least 25 persons signing that request who qualify as a small business, or an organization representing at least 25 such persons may request issuance of a regulatory analysis by writing to the Policy Section, Policy and Communications Division, Department of Revenue, Hoover State Office Building, P.O. Box 10457, Des Moines, Iowa 50319. The request shall contain the following information: the name of the persons qualified as a small business and the name of the small business or the name of the organization as stated in its request for registration and an address; if a registered organization is requesting the analysis, a statement that the registered organization represents at least 25 persons; the proposed rule or portion of the proposed rule for which a regulatory analysis is requested; the factual situation which gives rise to the business's or organization's difficulties with the proposed rule; any of the methods for reducing the impact of the proposed rule on small business contained in Iowa Code section 17A.4A which may be particularly applicable to the circumstances; the name, address and telephone number of any person or persons knowledgeable regarding the difficulties which the proposed rule poses for small business and other information as the business or organization may deem relevant.

This rule is intended to implement Iowa Code section 17A.4A.

[**ARC 9875B**, IAB 11/30/11, effective 1/4/12]

701—6.6(422) Retention of records and returns by the department. The director may destroy any records, returns, reports or communications of a taxpayer after they have been in the custody of the department for three years, or at such later time when the statute of limitations for audit of the returns or reports has expired. The director may destroy any records, returns, reports or communications of a taxpayer before they have been in the custody of the department for three years provided that the amount of tax and penalty due has been finally determined.

This rule is intended to implement Iowa Code section 422.68.

701—6.7(68B) Consent to sell. In addition to being subject to any other restrictions in outside employment, self-employment or related activities imposed by law, an official of the department of revenue may only sell, either directly or indirectly, any goods or services to individuals, associations, or corporations subject to the authority of the department of revenue when granted permission subsequent

to completion and approval of an Iowa department of revenue application to engage in outside employment. The application to engage in outside employment must be approved by the official's immediate supervisor, division administrator, and the administration division administrator. Approval to sell may only be granted when conditions listed in Iowa Code section 68B.4 are met.

This rule is intended to implement Iowa Code section 68B.4.

701—6.8(421) Tax return extension in disaster areas. If a natural disaster is declared by the governor in any area of the state, the director may extend for a period of up to one year the due date for the filing of any tax return and may suspend any associated penalty or interest that would accrue during that period of time for any affected taxpayer whose principal residence or business is located in the covered area if the director determines it necessary for the efficient administration of the tax laws of this state. The director will notify the public of any possible extensions of tax filings as well as possible suspensions of penalty and interest. Notification will be made through different means available to the director including, but not limited to, press releases, media information, and the department's Web site. Persons eligible for extension shall notify the director that they qualify and shall include a notation of the reason for the extension request on the tax return.

This rule is intended to implement 2008 Iowa Acts, Senate File 2400.

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CHAPTER 7
PRACTICE AND PROCEDURE BEFORE THE DEPARTMENT OF REVENUE

[Prior to 12/17/86, Revenue Department[730]]

DIVISION I
INFORMAL, FORMAL, ADMINISTRATIVE AND JUDICIAL REVIEW PROCEDURES APPLICABLE TO CONTESTED CASES AND OTHER PROCEEDINGS COMMENCED PRIOR TO JULY 1, 1999

701—7.1(17A) Definitions. As used in the rules contained herein the following definitions apply, unless the context otherwise requires:

"Act" means the Iowa administrative procedure Act.

"Administrative law judge" means the person assigned to preside over a proceeding whether that be the director or an administrative law judge appointed according to Iowa Code chapter 17A.

"Agency" means each board, commission, department, officer, or other administrative office or unit of the state.

"Contested case" means a proceeding, including licensing, in which the legal rights, duties or privileges of a party are required by constitution or statute to be determined by an agency after an opportunity for an evidentiary hearing.

"Department" means the Iowa department of revenue.

"Department of inspections and appeals" means the state department created by Iowa Code chapter 10A.

"Director" means the director of the department or the director's authorized representative.

"Division of appeals and fair hearings" means the division of the department of inspections and appeals responsible for holding contested case proceedings which are authorized by Iowa Code chapter 10A.

"License" means the whole or a part of any permit, certificate, approval, registration, charter, or similar form of permission required by statute.

"Licensing" means the agency process respecting the grant, denial, renewal, revocation, suspension, annulment, withdrawal, or amendment of a license.

"Motion" has the same meaning as the term is defined in Iowa R. Civ. P. 1.431.

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

"Person" means any individual, estate, trust, fiduciary, partnership, corporation, association, governmental subdivision, or public or private organization of any character or any other person covered by the Act other than an agency.

"Petition" means application for declaratory ruling, initiation of rule-making proceedings or document filed in licensing.

"Pleadings" means protest, answer, reply or other similar document filed in a contested case proceeding.

"Presiding administrative law judge" means the administrative law judge who presides at the evidentiary hearing on the contested case.

"Proceeding" means licensing, rule making, declaratory rulings, contested cases, informal procedures.

"Protester" means any person entitled to file a protest which can culminate in a contested case proceeding.

"Review unit" means the unit composed of department employees designated by the director and the attorney general's staff who have been assigned by the director to review protests filed by taxpayers.

Unless otherwise specifically stated, the terms used in these rules promulgated by the department shall have the meaning defined by the Act.

This rule is intended to implement Iowa Code sections 10A.202(1m), 17A.22 and 421.14.

701—7.2(17A) Scope of rules. The rules contained in this chapter pertaining to practice and procedure are designed to implement the requirements of the Act and aid in the effective and efficient administration and enforcement of the tax laws of this state. These rules shall govern the practice, procedure and conduct of informal proceedings, contested case proceedings, licensing, rule making, and declaratory rulings involving:

1. Sales tax—Iowa Code sections 422.42 to 422.59.
2. Use tax—chapter 423.
3. Individual and fiduciary income tax—sections 422.4 to 422.31 and 422.110 to 422.112.
4. Franchise tax—sections 422.60 to 422.66.
5. Corporate income tax—sections 422.32 to 422.41 and 422.110 to 422.112.
6. Withholding tax—sections 422.16 and 422.17.
7. Estimated tax—sections 422.16, 422.17 and 422.85 to 422.92.
8. Motor fuel tax—chapter 452A.
9. Property tax—chapters 421, 425, 426A, 427, 427A, 428, 428A and 433 to 441.
10. Cigarette and tobacco tax—chapters 421B and 453A.
11. Inheritance, generation skipping transfer and estate tax—chapters 450, 450A, 450B and 451.
12. Local option taxes—chapter 422B.
13. Hotel and motel tax—chapter 422A.
14. Drug excise tax—chapter 453B.
15. Automobile rental excise tax—chapter 422C.
16. Environmental protection charge—chapter 424.
17. Other taxes as may be assigned to the department from time to time.

As the design of these rules is to facilitate business and advance justice, any rule contained herein, unless otherwise provided by law, may be suspended or waived by the department to prevent undue hardship in any particular instance or to prevent surprise or injustice.

This rule is intended to implement Iowa Code chapter 17A.

701—7.3(17A) Business hours. The principal office of the department in the Hoover State Office Building in Des Moines, Iowa, shall be open between the hours of 8 a.m. to 4:30 p.m. each weekday except Saturdays, Sundays and legal holidays as prescribed in Iowa Code section 4.1(34), for the purpose of receiving protests, pleadings, petitions, motions, requests for public information, copies of official documents, or for the opportunity to inspect public records.

All documents or papers required to be filed with the department by these rules shall be filed with the administrative law judge in the principal office of the department in the Hoover State Office Building, Des Moines, Iowa 50319. Requests for public information or copies of official documents or the opportunity to inspect public records shall be made in the director's office at the department's principal office.

701—7.4(17A) Computation of time, filing of documents. In computing any period of time prescribed or allowed by these rules or by an applicable statute, the day of the act, event or default from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, Sunday or legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday or legal holiday. Legal holidays are prescribed in Iowa Code section 4.1(34).

All documents or papers required to be filed with the department shall be considered as timely filed if they are either received by the department's principal office or are postmarked for delivery to the department's principal office within time limits as prescribed by law or by rules or orders of the department.

In all cases where the time for the filing of a protest or the performance of any other act shall be fixed by law, the time so fixed by law shall prevail over the time fixed in these rules.

701—7.5(17A) Form and style of papers. All pleadings, petitions, briefs and motions or other documents filed with the department shall be typewritten, shall have a proper caption, and a signature and copies as herein provided or as specified in some other rule.

7.5(1) Papers shall be typed on only one side of plain white paper. Pleadings, petitions, motions, orders and any other papers allowed or required to be filed by these rules may be on any size paper. Citations should be underscored.

7.5(2) The proper caption shall be placed in full upon the first paper filed.

7.5(3) The signature of the petitioner, party, or authorized representative shall be subscribed in writing to the original of all pleadings, petitions, briefs or motions and shall be an individual and not a firm name except that the signature of a corporation shall be the name of the corporation by one of its active officers. The name and mailing address of the party or the party's representative actually signing shall be typed or printed immediately beneath the written signature. The signature shall constitute a certification that the signer has read the document; that to the best of the signer's knowledge, information and belief every statement contained in the document is true and no such statement is misleading; and that it is not interposed for delay.

A taxpayer or the taxpayer's representative using E-mail or other electronic means to submit an income tax return, a sales tax or use tax return, a return for any other tax administered by the department, an application for a sales tax permit or other permit, a deposit form for remitting withholding tax or other taxes administered by the department, or any other document to the department may use an electronic signature or a signature designated by the department in lieu of a handwritten signature. To the extent that a taxpayer or the taxpayer's representative submits a tax return, deposit document, application or other document by E-mail or other electronic means to the department with an electronic signature or signature designated by the department, the taxpayer should include in the record of the document the taxpayer's federal identification number so that the taxpayer's identity is established. For purposes of this rule, "electronic signature" means an electronic sound, symbol, or process attached to or logically associated with a tax return, deposit document, or other document filed with the department and executed or adopted by a person with the intent to sign the return, deposit document, or other document filed with the department. For purposes of this rule, "signature designated by the department" means a symbol or other information provided by the department to the taxpayer or the taxpayer's representative that is to serve instead of the handwritten signature of the taxpayer.

In a situation where the taxpayer or the taxpayer's representative has submitted a return or other document to the department by E-mail, the taxpayer should include the taxpayer's E-mail address in the record of the document. However, notwithstanding the above information, a taxpayer may not submit a tax return or other document to the department with an electronic signature when a handwritten signature is required with the return or document by federal or state law.

7.5(4) Every pleading (other than protest) or motion or brief shall bear proof of service upon the opposing party as provided by the Iowa Rules of Civil Procedure.

7.5(5) Except as otherwise provided in these rules or ordered by the department, an original copy only of every pleading, brief, motion or petition shall be filed.

7.5(6) All copies shall be clear and legible but may be on any weight paper.

Upon motion of an opposing party or on its own, the department may, in its discretion, if a person or party has failed to comply with this rule, require such person or party to follow the provisions of this rule pointing out the defects and details needed to comply with the rule prior to filing.

This rule is intended to implement Iowa Code chapters 17A and 554D and section 421.17.

701—7.6(17A) Persons authorized to practice before the department. Due to the complex questions involved and the technical aspects of taxation, persons are encouraged to seek the aid, advice, assistance and counsel of practicing attorneys and certified public accountants.

The right to practice before the department in connection with any proceeding shall be limited to the following classes of persons:

1. Taxpayers who are natural persons representing themselves.
2. Attorneys duly qualified and entitled to practice in the courts of the state of Iowa.

3. Attorneys who are entitled to practice before the highest court of record of any other state and who have complied with Iowa Ct. R. 31.14.

4. Accountants who are authorized, permitted, or licensed under Iowa Code chapter 542C.

5. Duly authorized directors or officers of corporations representing the corporation of which they are respectively a director or officer, excluding attorneys who are acting in the capacity of a director or officer of a corporation and who have not met the requirements of the third classification above.

6. Partners representing their partnership.

7. Fiduciaries.

8. Government officials authorized by law.

9. Enrolled agents, currently enrolled under 31 CFR §10.6 for practice before the Internal Revenue Service, representing a taxpayer in proceedings under division II, Iowa Code chapter 422.

Any person appearing in any proceeding before the department on behalf of another must have on file with the department a power of attorney.

No person who has served as an official or employee of the department shall within a period of two years after the termination of such service or employment appear before the department or receive compensation for any services rendered on behalf of any person, firm, corporation, or association in relation to any case, proceeding, or application with respect to which the person was directly concerned and in which the person personally participated during the period of service or employment.

This rule is intended to implement Iowa Code chapter 17A.

701—7.7(17A) Resolution of tax liability. Unless a proper protest has been filed as provided hereinafter, persons interested in any tax liability, refund claim, licensing or any other tax matters shall discuss the resolution of such matters with appropriate personnel as designated by the billing.

In the event that a proper protest has been filed as provided hereinafter, the appropriate department personnel, when authorized by the review unit, shall have the authority to discuss the resolution of any matter in the protest either with the protester or the protester's representative. The appropriate personnel shall report their activities in this regard to the review unit and the unit shall be authorized to approve or reject any recommendations made by the appropriate personnel to resolve a protest.

This rule is intended to implement Iowa Code chapter 17A.

701—7.8(17A) Protests. Any person wishing to contest an assessment, denial of refund claim, or any other department action, except licensing, which may culminate in a contested case proceeding shall file a protest, in writing, with the department within the time prescribed by the applicable statute or rule for filing notice of application to the director for a hearing. The protest must be either delivered to the department by United States Postal Service, by ordinary, certified, or registered mail, directed to the attention of the administrative law judge, personally delivered to the office of the administrative law judge, or be served on the department by personal service during business hours. For the purpose of mailing, a protest is considered filed on the date of the postmark. It is considered filed the date personal service or personal delivery to the office of the administrative law judge is made. See Iowa Code section 622.105 for the evidence necessary to establish proof of mailing. The period for appealing agency action relating to refund claims is the same statutory period for contesting an assessment. For assessments issued before January 1, 1995, the time period for filing a protest to an assessment cannot be extended by filing a refund claim. Failure to timely file a written protest will be construed as a waiver of opposition to the matter involved unless on the director's own motion, pursuant to statutory authority, the power of abatement is exercised. The review unit may seek dismissal of protests which are not in the proper form as provided by this rule. See subrule 7.11(2) for dismissals.

For refund claims filed on or after January 1, 1995, if the department has not granted or denied a refund claim within six months of filing the claim, the refund claimant may file a protest. Even though a protest is so filed, the department is entitled to examine and inspect the refund claimant's records to verify the refund claim.

Notwithstanding the above, the taxpayer who fails to timely protest an assessment issued on or after January 1, 1995, may contest the assessment by paying the whole assessed tax, interest, and penalty

and by filing a refund claim within the time period provided by law for filing such claim. However, in the event that such assessment involves divisible taxes, which are not timely protested, namely, an assessment which is divisible into a tax on each transaction or event, the taxpayer can contest the assessment by paying a portion of the assessment and filing a refund claim within the time period provided by law. In this latter instance, the portion paid must represent any undisputed portion of the assessment and must also represent the liability on a transaction or event for which, if the taxpayer is successful in contesting the portion paid, the unpaid portion of the assessment would be canceled. *Flora v. United States*, 362 U.S. 145, 4 L.Ed. 2d 623, 80 S.Ct. 630 (1960); *Higginbotham v. United States*, 556 F.2d 1173 (4th Cir. 1977); *Steele v. United States*, 280 F.2d 89 (8th Cir. 1960); *Stern v. United States*, 563 F. Supp. 484 (D.Nev. 1983); *Drake v. United States*, 355 F. Supp. 710 (E.D. Mo. 1973). Any such protest filed is limited to the issues covered by the amounts paid for which a refund was requested and denied by the department. Thereafter, if the department does not grant or deny the refund within six months of the filing of the refund claim or if the department denies the refund, the taxpayer may file a protest as authorized by this rule.

All of the taxes administered by the department can be divisible taxes, except individual income tax, fiduciary income tax, corporation income tax, and franchise tax. The following noninclusive examples illustrate the application of the divisible tax concept.

EXAMPLE A: X is assessed withholding income taxes, penalty and interest, as a responsible party on eight employees. X fails to timely protest the assessment. X contends that X is not a responsible party. If X is a responsible party, X was required to make monthly deposits of the withholding taxes. In this situation, the withholding taxes are divisible. Therefore, X can pay an amount of tax, penalty and interest attributable to one employee for one month and file a refund claim within the time period provided by law since if X is successful on the refund claim the remaining unpaid portion of the assessment would be canceled.

EXAMPLE B: Y is assessed sales tax, interest, and penalty for electricity purchased and used to power a piece of machinery in Y's manufacturing plant. Y fails to timely protest the assessment. Y was billed monthly for electricity by the power company to whom Y had given an exemption certificate. Y contends that the particular piece of machinery is used directly in processing tangible personal property for sale and that, therefore, all of the electricity is exempt from sales tax. In this situation, the sales tax is divisible. Therefore, Y can pay an amount of tax, penalty and interest attributable to one month's electrical usage in that machinery and file a refund claim within the time period provided by law since if Y is successful on the refund claim the remaining unpaid portion of the assessment would be canceled.

The protest shall be brought by and in the name of the interested or affected person or by and in the full descriptive name of the fiduciary legally entitled to institute a proceeding on behalf of the person or by an intervenor in contested case proceedings. In the event of a variance in the name set forth in the protest and the correct name, a statement of the reason for the discrepancy shall be set forth in the protest.

A protest which is filed shall contain:

7.8(1) A caption in the following form:

BEFORE THE IOWA STATE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF _____	*	
(state taxpayer's name, address and	*	PROTEST
designate type of proceeding, e.g.,	*	DOCKET NO. _____
income tax refund claim)	*	(filled in by Department)

7.8(2) Substantially state in separate numbered paragraphs the following:

a. Proper allegations showing:

(1) Date of assessment.

(2) Date of refund denial.

(3) Whether, for assessments issued on or after January 1, 1995, protester failed to timely appeal the assessment and, if so, the date of payment and the date of filing the refund claim.

(4) Whether, for refund claims filed on or after January 1, 1995, the protest involves the appeal of a refund claim after six months from the date of filing the refund claim because the department failed to deny the claim.

(5) Attach a copy of the assessment, refund claim, and refund denial.

(6) Other items that the protester wishes to bring to the attention of the department.

b. The type of tax, the taxable period or periods involved and the amount in controversy;

c. List each error alleged to have been committed in a separate paragraph. For each error listed, provide an explanation of the error and all relevant facts related to the error;

d. Refer to any particular statute or statutes and any rule or rules involved, if known;

e. Description of records or documents which were not available or were not presented to department personnel prior to the filing of the protest, if any, and provide copies of any records or documents that were not previously presented to the department;

f. Any other matters deemed relevant and not covered in the above paragraphs;

g. The desire of protester to waive informal or contested case proceedings if it is desired; unless the protester so indicates a waiver, informal procedures will be initiated;

h. A statement setting forth the relief sought by protester;

i. The signature of the protester or that of the protester's representative, the addresses of the protester and of the protester's representative, and the telephone number of the protester or the protester's representative.

j. Attach a copy of power of attorney for protester's representative.

Upon receipt of the protest, the administrative law judge shall docket the protest in a docket kept for that purpose and shall assign a number to the case which number shall be placed on all subsequent pleadings filed in the case. An original and two copies of the protest shall be filed.

The protester may amend the protest at any time prior to the commencement of the evidentiary hearing. The department can request that protester amend the protest for purposes of clarification.

7.8(3) Denial of renewal of vehicle registration or denial of issuance or renewal, or suspension of driver's license. A person who has had an application for renewal of vehicle registration denied or has been denied the issuance of a driver's license or the renewal of a driver's license, or has had a driver's license suspended may file a protest with the department if the denial of the issuance or renewal or the suspension is because the person owes delinquent taxes.

The issues raised in a protest by the person, which are limited to a mistake of fact, may include but are not limited to:

1. The person has the same name as the obligor but is not the correct person.
2. The amount in question has been paid.
3. The person has made arrangements with the department to pay the amount.

701—7.9(17A) Identifying details. Any person may, at any time, petition the administrative law judge to delete identifying details concerning the person from any document relating to any proceedings as defined in rule 701—7.1(17A), prior to disclosure to members of the public.

If the petition concerns information which is not a part of a contested case, the petition shall be in the form of a request to delete identifying details; if part of a contested case, the petition shall be in the form of a motion to delete identifying details. All motions to delete shall conform to subrule 7.17(3).

The motion or request shall contain the following:

1. The name of the person requesting deletion and the docket number of the proceeding, if applicable.

2. The legal basis for their request for deletion; such as, release of the material would be a clearly unwarranted invasion of personal privacy or the material is a trade secret or of advantage to competitors. A corporation may not claim an unwarranted invasion of privacy.

3. A precise description of the document, report or other material in the possession of the department from which the deletion is sought, and a precise description of the information to be deleted. If deletion is sought from more than one document, each document and the materials sought to be deleted from it shall be listed in separate paragraphs. Also contained in each separate paragraph shall be a statement of the legal basis for the deletion requested in that paragraph, such as, the material sought to be deleted is a trade secret or its release would give advantage to competitors and serve no public purpose.

4. An affidavit in support of deletion must accompany each motion or request. The affidavit must be sworn to by a person familiar with the facts asserted within it and shall contain a clear and concise explanation of the facts justifying deletion, not merely the legal basis for deletion.

5. All affidavits shall contain a general statement that the information sought to be deleted is not available to the public from any source or combination of sources, direct or indirect, and if the grounds for deletion is that the release of information would give advantage to competitors, the general statement that the release would serve no public purpose.

A ruling on a request or motion shall not become the final decision of the department until 30 days after the date of the ruling unless there is an appeal to, or review on motion of, the director within 30 days of the date of the ruling.

701—7.10(17A) Docket. The administrative law judge shall maintain a docket of all proceedings and each of the proceedings shall be assigned a number. Every matter coming within the purview of these rules shall be assigned a docket number which shall be the official number for the purposes of identification. Upon receipt of a protest, petition for declaratory ruling or petition to initiate rule-making proceedings, the proceeding will be docketed and assigned a number, and the parties notified thereof. The number shall be placed by the parties on all papers thereafter filed in the proceeding.

701—7.11(17A) Informal procedures and dismissals of protests.

7.11(1) *Informal procedures.* Persons are encouraged to utilize the informal procedure provided herein so that a settlement may be reached between the parties without the necessity of initiating contested case proceedings. Therefore, unless the protester indicates a desire to waive the informal procedures in the protest or the department waives informal procedures upon notification to the protester, such informal procedures will be initiated as herein provided upon the filing of a proper protest.

a. Review unit. A review unit is created within the department and, subject to the control of the director, the unit will:

(1) Review and evaluate the validity of all protests made by taxpayers from the agency action.

(2) Determine the correct amount of tax owing or refund due.

(3) Determine the best method of resolving the dispute between the protester and the department.

(4) Assign protests to the appropriate divisions or sections of the department for resolution.

(5) Take further action regarding the protest, including any additions and deletions to the audit, as may be warranted by the circumstances to resolve the protest, including a request for an informal conference.

(6) Determine whether the protest complies with rule 701—7.8(17A) and request any amendments to the protest or additional information.

After assignment of the protest, the section or division responsible may concede any items contained in the protest which it determines should not be controverted by the department. If the protester has not waived informal procedures, the section or division responsible may request the protester and the protester's representative, if any, to attend an informal conference with the responsible section or division to explore the possibility of reaching a settlement without the necessity of initiating contested case proceedings or of narrowing the issues presented in the protest if no settlement can be made.

If informal procedures have been waived, findings dealing with the issues raised in the protest may be issued unless the issues may be more expeditiously determined in another manner or it is determined that findings are unnecessary. The protester will be notified of the decision on the issues in controversy.

Nothing herein will prevent the section or division responsible and the protester from mutually agreeing on the manner in which the protest will be informally reviewed.

b. *Settlements.* If a settlement is reached during informal procedures, the administrative law judge shall be notified. The administrative law judge shall issue an order and serve it upon all parties which order shall set forth that a settlement was reached and shall terminate the case.

7.11(2) *Dismissal of protests.*

a. Whether informal procedures have been waived or not, the failure of the protester to timely file a protest or to pursue the protest may be grounds for dismissal of the protest by the administrative law judge. If informal procedures have not been waived, the failure of the protester to present evidence or information requested by the review unit shall constitute grounds for the administrative law judge to dismiss the protest. For purposes of this subrule, an evasive or incomplete response will be treated as a failure to present evidence or information. The failure of protester to file a protest in the format required by rule 701—7.8(17A) may be grounds for dismissal of the protest by the administrative law judge.

b. If the department seeks to have the protest dismissed, the review unit shall file a motion to dismiss with the office of the administrative law judge and serve a copy of the motion on protester. Protester may file a resistance to the motion within 20 days of the date of service of the motion. If no resistance is so filed, the administrative law judge shall immediately enter an order dismissing the protest. If a resistance is filed, the review unit has 10 days from the date of the filing of the resistance to decide whether to withdraw its motion and so notify the administrative law judge and protester. If no such notice is issued by the review unit within the 10-day period, the administrative law judge shall issue a notice for a contested case proceeding on the motion as prescribed by rule 701—7.14(17A) except that the issue of the contested case proceeding shall be limited to the question of whether the protest shall be dismissed. Thereafter, the rules of the department pertaining to contested case proceedings shall apply in such dismissal proceedings.

c. If a motion to dismiss is filed and is unresisted, a protest so dismissed may be reinstated by the administrative law judge for good cause shown if an application for reinstatement is filed with the office of the administrative law judge within 30 days of the date the protest was dismissed. The application shall set forth all reasons and facts upon which the protester relies in seeking reinstatement of the protest. The review unit shall review the application and notify the protester whether the application is granted or denied. If the review unit denies the application to reinstate the protest, the protester has 30 days from the date the application for reinstatement was denied in which to request, in writing, a formal hearing before the administrative law judge on the reinstatement. When a written request is received, the administrative law judge shall issue a notice as prescribed in rule 701—7.14(17A) except that the issue of the contested case proceeding shall be limited to the question of whether the protest shall be reinstated. Thereafter, the rules of the department pertaining to contested case proceedings shall apply in such reinstatement proceedings.

d. Once contested case proceedings have been commenced, whether informal proceedings have been waived or not, it shall be grounds for a motion to dismiss that a protester has either failed to diligently pursue the protest or refuses to comply with requests for discovery set forth in rule 701—7.15(17A).

701—7.12(17A) Answer. The department may, in lieu of findings, file an answer. When findings are issued, the department will file an answer within 30 days of receipt of written notification from protester stating disagreement with the findings. The answer shall be filed with the department's administrative law judge.

In the event that the protester does not so respond in writing to the findings issued on matters covered by subrule 7.11(1) within 30 days after being notified, the department may seek dismissal of the protest pursuant to subrule 7.11(2).

The answer of the department shall be drawn in a manner as provided by the Iowa rules of civil procedure for answers filed in Iowa district courts.

Each paragraph contained in the answer shall be numbered to correspond, where possible, with the paragraphs of the protest. An original copy only of the answer shall be filed with the administrative law judge and shall be signed by the department's counsel or representative.

The department shall forthwith serve a copy of the answer upon the representative of record, or if there is no representative of record then upon the protester, and shall file proof of service with the administrative law judge at the time of filing of the answer. The department may amend its answer at any time prior to the commencement of the evidentiary hearing.

The provisions of rule 701—7.12(17A) shall be considered as a part of the informal procedures since a contested case proceeding, at the time of filing the answer, has not yet commenced. However, an answer shall be filed pursuant to this rule whether or not informal procedures have been waived by the protester or the department.

Notwithstanding the above portions of this rule, if a taxpayer, who has filed a protest on or after January 1, 1995, makes a written demand for a contested case proceeding, as authorized by subrule 7.14(2), after a period of six months from the filing of a proper protest, the department shall file its answer within 30 days after receipt of the demand. If the department fails to file its answer within this 30-day period, interest shall be suspended, if the protest involves an assessment, from the time that the department was required to answer until the date that the department files its answer and, if the protest involves a refund, interest shall accrue on the refund at double the rate from the time the department was required to answer until the date that the department files its answer.

This rule is intended to implement Iowa Code sections 10A.202(1)*"m,"*17A.22, 421.14 and 421.60.

701—7.13(17A) Subpoenas. Prior to the commencement of a contested case, the department shall have the authority to subpoena books, papers, records and shall have all other subpoena powers conferred upon it by law. Subpoenas in this case shall be issued by the department's administrative law judge.

This rule is intended to implement Iowa Code sections 10A.202(1)*"m,"* 17A.22 and 421.14.

701—7.14(17A) Commencement of contested case proceedings.

7.14(1) Payment of tax or bond required prior to contested case proceedings for assessments made prior to January 1, 1991.

a. Effective date—payment or bond required. Effective for contested case proceedings for unpaid tax, penalty, interest, or fees commenced in response to assessments made on or after January 1, 1987, and prior to January 1, 1991, the taxpayer must pay prior to the commencement of contested case proceedings, all of the assessed tax, penalty, interest, or fees or, upon a showing of good cause, a bond may be posted in lieu of payment of the amount of the assessment that is in dispute.

b. Cases applicable. The provisions of this subrule only apply to those contested case proceedings where a tax, penalty, interest, or fees, or any combination of them, which has not been previously paid prior to the commencement of contested case proceedings, is at issue.

c. Cases not applicable. This subrule does not apply to protest proceedings involving only the denial of refund claims. Nor does this subrule apply to a taxpayer's appeal or protest pending in informal procedures involving an unpaid tax, penalty, interest, or fees.

d. Time disputed tax, penalty, interest, or fees must be paid. Unless a bond has been posted as provided in subrule 7.14(1), paragraph *"f,"* all of the disputed tax, penalty, interest, or fees assessed computed to the date of payment must be paid in full, within 30 days after the date the answer is filed by the department. Undisputed amounts are not eligible for a bond and must be paid with the payment of the disputed amount, or with the posting of the bond.

e. Payment deemed made under protest. Unless the taxpayer declares otherwise in writing, the payment of that portion of the assessed tax, penalty, interest, or fees in dispute after the filing of the department's answer, shall be deemed to have been paid under protest and, if upon resolution of the protest, the amount paid is in excess of the correct tax, penalty, interest, or fees due, the excess shall be refunded to the taxpayer or other persons entitled with interest as provided by law, subject to any right of offset.

f. Bond in lieu of payment. Within 30 days after the date the answer is filed by the department, and upon filing an application showing good cause, the taxpayer may, in lieu of payment, post a bond securing the payment of that portion of the assessed tax, penalty, interest, or fees which is in dispute accrued to the date the bond is posted. A taxpayer is not permitted to refuse to pay the portion of the assessed amount not in dispute until all disputed issues have been resolved. The uncontested portion of the assessment must be paid and a bond is only permitted to be posted in lieu of payment of the amount in dispute. The bond shall be payable to the department for the use of the state of Iowa and shall be conditioned upon the full payment of the tax, penalty, interest, or fees that are found to be due which remain unpaid upon the resolution of the contested case proceedings. The bond shall be for the full amount of the assessed tax, penalty, interest, or fees that is in dispute, computed to the day the bond is posted. Provided upon application of the taxpayer or the department, the department's administrative law judge may, upon hearing, fix a greater or lesser amount to reflect changed circumstances, but only after ten days' prior notice is given to the department or the taxpayer as the case may be.

g. Type of bond. A personal bond, without a surety, is only permitted if the taxpayer posts with the department's administrative law judge, cash, a cashier's check, a certificate of deposit, or other marketable securities with a readily ascertainable value which is equal in value to the total amount of the bond required. If a surety bond is posted, the surety on the bond may be either personal or corporate. The provisions of this subrule and Iowa Code chapter 636 relating to personal and corporate sureties shall govern.

h. Procedure for posting bond. In the event the taxpayer desires to post bond in lieu of payment of the amount of the tax, penalty, interest, or fees claimed to be due which is in dispute, an application in writing, together with the bond must be filed with the administrative law judge within 30 days after the department's answer is filed. The application must state the reasons why good cause exists for posting a bond in lieu of payment. A copy of the application with a copy of the bond attached must be given the department's representative by ordinary mail and thereafter if the taxpayer and the department agree on the bond, it shall be approved by the administrative law judge. If an agreement on the bond is not reached and the department has not filed with the administrative law judge written objections to granting the bond within ten days after the postmark date of the notice of application, the administrative law judge shall approve the bond, if the bond is otherwise in proper form and in compliance with the law. In the event objections are filed by the department, the administrative law judge shall set the objections down for hearing with written notice to be given the taxpayer and the department at least ten days prior to the hearing. If upon hearing the department's objections are overruled, the bond shall be approved. If the objections are sustained, and the taxpayer fails to pay the amount of the tax, penalty, interest, or fees claimed to be due or cure the bond defects, if permitted by the administrative law judge's order, within 30 days after the administrative law judge's decision, the protest shall be dismissed and the dismissal shall be with prejudice, if the time for protesting the department action has elapsed.

i. Reasons constituting good cause. The financial hardship of the taxpayer as evidenced by the books and records of the taxpayer is an example of a good cause for posting a bond in lieu of paying the tax, penalty, interest, or fees in dispute. In addition, posting of a bond will be allowed upon agreement of the protester and the department.

j. Form of surety bond. The surety bond posted shall be in substantially the following form:

BEFORE THE IOWA STATE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF	*	
		SURETY BOND
(Taxpayer's Name,	*	
Address and designate	*	
proceeding, e.g., income,	*	
sales, etc.)	*	
	*	DOCKET NO.

KNOW ALL PERSONS BY THESE PRESENTS:

That we ____(taxpayer)____ as principal, and ____(surety)_____, as surety, of the county of _____ , and State of Iowa, are held and firmly bound unto the Iowa Department of Revenue for the use of the State of Iowa, in the sum of $ _____ dollars, lawful money of the United States, for the payment of which sum we jointly and severally bind ourselves, our heirs, devisees, successors and assigns firmly by these presents. The condition of the foregoing obligations are, that, whereas the above named principal has protested an assessment of tax, penalty, interest, or fees or any combination of them, made by the Iowa Department of Revenue, now if the principal _____ shall promptly pay the amount of the assessed tax, penalty, interest, or fees found to be due upon the resolution of the contested case proceedings, then this bond shall be void, otherwise to remain in full force and effect.

Dated the _____ day of _____, 20 ____.

_____
Principal

_____
Surety

_____
Surety

(corporate acknowledgment if surety is a corporation)

AFFIDAVIT OF PERSONAL SURETY

STATE OF IOWA
ss.
COUNTY OF)

I hereby swear or affirm that I am a resident of Iowa and am worth beyond my debts the amount set opposite my signature below in the column entitled, "Worth Beyond Debts", and that I have property in the State of Iowa, liable to execution equal to the amount set opposite my signature in the column entitled "Property in Iowa Liable to Execution".

Signature	Worth Beyond Debts	Property in Iowa Liable to Execution
_____	$ _____	$ _____
Surety (type name)		
_____	$ _____	$ _____
Surety (type name)		

Subscribed and sworn to before me the undersigned Notary Public this _____ day of _____, 20 ____.

(Seal)

Notary Public in and
for the State of Iowa

k. Duration of bond. The bond shall remain in full force and effect until the conditions of the bond have been fulfilled or until the bond is otherwise exonerated by the administrative law judge.

l. Exoneration of the bond. Upon conclusion of the contested case administrative proceedings, the bond shall be exonerated by the administrative law judge when any of the following events occur: upon full payment of the tax, penalty, interest, or fees found to be due; upon filing a bond for the purposes of judicial review; or if no additional tax, penalty, interest, or fees are found to be due that have not been previously paid, upon entry of the order resolving the contested case proceedings.

m. Failure to pay amount found to be due. If upon resolution of the contested case proceedings, the taxpayer fails to pay the tax, penalty, interest, or fees assessed or found to be due, the bond shall be forfeited by the administrative law judge and the department may sell or liquidate any property posted by the taxpayer, or bring suit against the surety on the bond and apply the amount recovered to the tax, penalty, interest, or fees due. Any excess over the amount due shall be refunded to the taxpayer or other persons entitled as provided by law, subject to any right of offset.

n. Dismissal of protest—failure to pay or post bond. The administrative law judge must dismiss the protest in the following circumstances:

(1) If the taxpayer fails to pay the amount of the assessed tax, penalty, interest, or fees or fails to post a bond with the administrative law judge for the amount of the assessment in dispute within 30 days after the filing of the department's answer;

(2) The taxpayer fails to pay the disputed tax, penalty, interest, or fees or fails to file an acceptable bond, if permitted by order of the administrative law judge, within 30 days after the order sustaining the department's objection to the bond. The dismissal shall be with prejudice if the time for protesting the department's action has elapsed at the time of dismissal. The dismissal of the protest cannot be avoided or circumvented when payment has not been made or a bond posted by a withdrawal of or amendment to the protest after the answer has been filed.

7.14(2) Demand or request for contested case proceedings. A demand or request by the protester for the commencement of contested case proceedings must be in writing and either be mailed to the department by United States Postal Service ordinary, certified, or registered mail directed to the attention of the administrative law judge, or be served on the department by personal service or by personal delivery of the demand or request to the office of the administrative law judge during business hours. The demand or request is considered filed on the date of the postmark or the date personal service is made. See Iowa Code section 622.105 for the evidence necessary to establish proof of mailing.

Contested case proceedings will be commenced by the department's administrative law judge by delivery of notice by ordinary mail directed to the parties, after a demand or request is made (1) by the protester and the filing of the answer, if one is required, which demand or request may include a date to be set for the hearing, or (2) upon filing of the answer, if a request or demand for contested case proceedings has not been made by the protester. The notice will be given by the department's administrative law judge. Both the department's administrative law judge and the presiding administrative law judge may grant a continuance of the hearing. Any change in the date of the hearing shall be set by the presiding administrative law judge. Either party may apply to the presiding administrative law judge for a specific date for the hearing. The notice shall include:

1. A statement of the time (which shall allow for a reasonable time to conduct discovery), place and nature of the hearing;
2. A statement of the legal authority and jurisdiction under which the hearing is held;
3. A reference to the particular sections of the statutes and rules involved;

4. A short and plain statement of the matters asserted, including the issues.

After the delivery of the notice commencing the contested case proceedings, the parties may file further pleadings or amendments to pleadings as they desire. However, any pleading or amendment thereto which is filed within seven days prior to the date scheduled for the hearing or filed on the date of the hearing shall constitute good cause for the party adversely affected by the pleading or amendment to seek and obtain a continuance.

This rule is intended to implement Iowa Code sections 10A.202(1*m*), 17A.12 and 421.8A.

701—7.15(17A) Discovery. The rules of the Supreme Court of the state of Iowa, as amended, applicable in civil proceedings with respect to depositions upon oral examination or written questions; written interrogatories; production of documents or things or permission to enter upon land or other property, for inspection and other purposes; physical and mental examinations; and requests for admission shall apply to discovery procedures in contested case proceedings. Disputes concerning discovery shall be resolved by the department's administrative law judge. If necessary a hearing shall be scheduled, with reasonable notice to the parties and upon hearing an appropriate order shall be issued by the department's administrative law judge.

When the department relies on a witness in a contested case, whether or not a departmental employee, who has made prior statements or reports with respect to the subject matter of the witness' testimony, it shall, on request, make such statements or reports available to a party for use on cross-examination, unless those statements or reports are otherwise expressly exempt from disclosure by constitution or statute. Identifiable departmental records that are relevant to disputed material facts involved in a contested case, shall, upon request, promptly be made available to the party unless the requested records are expressly exempt from disclosure by constitution or statute.

Evidence obtained in such discovery may be used in contested case proceedings if that evidence would otherwise be admissible in the contested case proceeding.

This rule is intended to implement Iowa Code sections 10A.202(1*m*), 17A.22 and 421.14.

701—7.16(17A) Prehearing conference. The administrative law judge, upon motion, or upon the written request of a party, shall direct the parties to appear at a specified time and place before the administrative law judge for a prehearing conference to consider:

1. The possibility or desirability of waiving any provisions of the Act relating to contested case proceedings by written stipulation representing an informed mutual consent.
2. The necessity or desirability of setting a new date for hearing.
3. The simplification of issues.
4. The necessity or desirability of amending the pleadings either for the purpose of clarification, amplification or limitation.
5. The possibility of agreeing to the admission of facts, documents or records not really controverted, to avoid unnecessary introduction of proof.
6. The procedure at the hearing.
7. Limiting the number of witnesses.
8. The names and identification of witnesses and the facts each party will attempt to prove at the hearing.
9. Conduct or schedule of discovery.
10. Such other matters as may aid, expedite or simplify in the disposition of the proceeding.

Since stipulations are encouraged it is expected and anticipated that the parties proceeding to a hearing will stipulate to evidence to the fullest extent to which complete or qualified agreement can be reached including all material facts that are not or should not fairly be in dispute.

Any action taken at the prehearing conference shall be recorded in an appropriate order, unless the parties enter upon a written stipulation as to such matters or agree to a statement thereof made on the record by the administrative law judge.

When an order is issued at the termination of the prehearing conference, a reasonable time shall be allowed to the parties to present objections on the ground that it does not fully or correctly embody

the agreements at such conference. Thereafter, the terms of the order or modification thereof shall determine the subsequent course of the proceedings relative to matters it includes, unless modified to prevent manifest injustice.

Without the necessity of proceeding to an evidentiary hearing in a contested case, the parties may agree in writing to informally dispose of the case by stipulation, agreed settlement, consent order or by another method agreed upon. If such informal disposition is utilized, the parties shall so indicate to the administrative law judge that the case has been settled.

If either party to the contested case proceeding fails to appear at the prehearing conference, or fails to request a continuance, or fails to submit evidence or arguments which the party wishes to be considered in lieu of appearance, the opposing party may move for dismissal. The motion shall be made in accordance with subrule 7.17(3).

This rule is intended to implement Iowa Code section 17A.12.

701—7.17(17A) Contested case proceedings. Unless the parties to a contested case proceeding have, by written stipulation representing an informed mutual consent, waived the provisions of the Act relating to such proceedings, contested case proceedings shall be initiated and culminate in an evidentiary hearing open to the public. Evidentiary hearings shall be held at the department's principal office, Hoover State Office Building, Des Moines, Iowa 50319, except that a case may be assigned for hearing elsewhere only for extraordinary circumstances or when the protester would otherwise be deprived of due process of law. By agreement of the parties, the hearing may be conducted at another place or by other means, for example, through the fiber optic network or by telephone. Parties shall be notified at least 30 days in advance of the date and place of the hearing.

7.17(1) *Conduct of proceedings.* A proceeding shall be conducted by an administrative law judge who, among other things, shall:

a. Open the record and receive appearances;
b. Administer oaths, and issue subpoenas;
c. Enter the notice of hearing into the record;
d. Receive testimony and exhibits presented by the parties;
e. In the administrative law judge's discretion, interrogate witnesses;
f. Rule on objections and motions;
g. Close the hearing;
h. Issue an order containing findings of fact and conclusions of law.

Evidentiary proceedings shall be oral and open to the public and shall be recorded either by mechanical means or by certified shorthand reporters. Parties requesting that the hearing be recorded by certified shorthand reporters shall bear the appropriate costs. The record of the oral proceedings or the transcription thereof shall be filed with and maintained by the department for at least five years from the date of the decision.

An opportunity shall be afforded to the parties to respond and present evidence and argument on all issues involved and to be represented by counsel at their own expense. Unless otherwise directed by the administrative law judge, evidence will be received in the following order:

(1) Protester (2) intervenor (if applicable) (3) department (4) rebuttal by protester (5) oral argument by parties (if necessary).

If the protester or the department appear without counsel or other representative who can reasonably be expected to be familiar with these rules, the administrative law judge shall explain to the parties the rules of practice and procedure and generally conduct a hearing in a less formal manner than that used when the parties have such representatives appearing upon their behalf. It should be the purpose of the administrative law judge to assist any party appearing without such representative to the extent necessary to allow the party to fairly present evidence, testimony and arguments on the issues. The administrative law judge shall take whatever steps may be necessary and proper to ensure that all evidence having probative value is presented and that each party is accorded a fair hearing.

If the parties have mutually agreed to waive the provisions of the Act in regard to contested case proceedings, the hearing will be conducted in a less formal manner than when an evidentiary hearing is conducted.

If a party fails to appear in a contested case proceeding after proper service of notice, the administrative law judge may, upon the judge's own motion or upon the motion of the party who has appeared, adjourn the hearing or proceed with the hearing and make a decision in the absence of the party.

Contemptuous conduct by any person appearing at a hearing shall be grounds for the person's exclusion from the hearing by the administrative law judge.

A stipulation by the parties of the issues or a statement of the issues in the notice commencing the contested case cannot be changed by the presiding administrative law judge without the consent of the parties. The presiding law judge shall not on their own motion change or modify the issues agreed upon by the parties. Notwithstanding the provisions of this paragraph, a party within a reasonable time prior to the hearing may request that a new issue be addressed in the proceedings, except that the request cannot be made after the parties have stipulated to the issues.

The department's administrative law judge may forward the appeal file to the division of appeals and fair hearings of the department of inspections and appeals for the purpose of scheduling and conducting a hearing on the protest. Before doing so the department's administrative law judge shall secure the consent of the division of appeals and fair hearings. The parties shall be notified whether or not the division of appeals and fair hearings will schedule and conduct the hearing.

7.17(2) *Rules of evidence.* In evaluating evidence, the department's experience, technical competence, and specialized knowledge may be utilized.

a. Oath. All testimony presented before the administrative law judge shall be given under oath which the administrative law judge has authority to administer.

b. Production of evidence and testimony. The administrative law judge may issue subpoenas to a party on request, as permitted by law, compelling the attendance of witnesses and the production of books, papers, records or other real evidence.

(1) *Subpoena.* When a subpoena is desired after the commencement of a contested case proceeding, the proper party shall indicate to the department's administrative law judge the name of the case, the docket number and the last-known addresses of the witnesses to be called. If evidence other than oral testimony is required, each item to be produced must be adequately described. When properly prepared by the department's administrative law judge, the subpoena will be returned to the requesting party for service. Service may be made in any manner allowed by law before the hearing date of the case which the witness is required to attend. No costs for serving a subpoena will be allowed if it is served by any person other than the sheriff. Subpoenas requested for discovery purposes shall be issued by the department's administrative law judge.

(2) Reserved.

c. Admissibility of evidence.

(1) *Evidence having probative value.* Although the administrative law judge is not bound to follow the technical common law rules of evidence, a finding shall be based upon the kind of evidence on which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs, and may be based upon such evidence even if it would be inadmissible in a jury trial. Therefore, the administrative law judge may admit and give probative effect to evidence on which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs. Irrelevant, immaterial, or unduly repetitious evidence shall be excluded. The administrative law judge shall give effect to the rules of privilege recognized by law. Evidence not provided to a requesting party through discovery shall not be admissible at the hearing. Subject to these requirements, when a hearing will be expedited and the interests of the parties will not be prejudiced substantially, any part of the evidence may be required to be submitted in verified written form by the administrative law judge.

Objections to evidentiary offers may be made at the hearing and the administrative law judge's ruling thereon shall be noted in the record.

(2) *Evidence of a federal determination.* Evidence of a federal determination whether it be a treasury department ruling or regulation or determination letter, a federal court decision or an internal revenue service assessment relating to issues raised in the proceeding shall be admissible, and the protester shall be presumed to have conceded the accuracy of it unless the protester specifically states wherein it is erroneous.

(3) *Copies of evidence.* A copy of any book, record, paper or document may be offered directly in evidence in lieu of the original, if the original is not readily available or if there is no objection. Upon request, the parties shall be given an opportunity to compare the copy with the original, if available.

(4) *Stipulations.* Approval of the presiding administrative law judge is not required for stipulations of the parties to be used in contested case proceedings. In the event the parties file a stipulation in the proceedings, the stipulation shall be binding on the parties and the presiding administrative law judge.

d. Exhibits.

(1) *Identification of exhibits.* Exhibits attached to a stipulation or entered in evidence which are offered by protesters shall be numbered serially, i.e., 1, 2, 3, etc.; whereas, those offered by the department shall be lettered serially, i.e., A, B, C, etc.; and those offered jointly shall be numbered and lettered, i.e., 1-A, 2-B, 3-C, etc.

(2) *Disposition of exhibits.* After an order has become final, either party desiring the return, at the party's expense, of any exhibit belonging to the party shall make application in writing to the administrative law judge within 30 days suggesting a practical manner of delivery; otherwise, exhibits may be disposed of as the administrative law judge deems advisable.

e. Official notice. The administrative law judge may take official notice of all facts of which judicial notice may be taken and of other facts within the specialized knowledge of the department. Parties shall be notified at the earliest practicable time, either before or during the hearing, or by reference in preliminary reports, preliminary decisions or otherwise, of the facts proposed to be noticed and their source, including any staff memoranda or data. The parties shall be afforded an opportunity to contest such facts prior to the issuance of the decision in the contested case proceeding unless the administrative law judge determines as a part of the record or decision that fairness to the parties does not require an opportunity to contest such facts.

f. Evidence outside the record. Except as provided by these rules, the administrative law judge shall not consider factual information or evidence in the determination of any proceeding unless the same shall have been offered and made a part of the record in the proceeding.

g. Presentation of evidence and testimony. In any hearing each party thereto shall have the right to present evidence and testimony of witnesses and to cross-examine any witness who testifies on behalf of an adverse party. Persons whose testimony has been submitted in written form, if available, shall also be subject to cross-examination by an adverse party. Opportunity shall be afforded each party for redirect examination and recross examination and to present evidence and testimony as rebuttal to evidence presented by another party, except that unduly repetitious evidence shall be excluded.

h. Offer of proof. An offer of proof may be made through the witness or by statement of counsel. The party objecting may cross-examine the witness without waiving any objection.

7.17(3) *Motions.* After commencement of contested case proceedings, appropriate motions may be filed by any party with the administrative law judge when facts requiring such motion come to the knowledge of the party. All motions shall state the relief sought and the grounds upon which the same are based.

Motions made prior to a hearing shall be in writing and a copy thereof served on all parties and attorneys of record. Such motions shall be ruled on by the administrative law judge. The administrative law judge shall rule on the motion by issuing an order. A copy of the order containing the ruling on the motion shall be mailed to the parties and authorized representatives. Motions may be made orally during the course of a hearing; however, the administrative law judge may request that it be reduced to writing and filed with the administrative law judge.

To avoid a hearing on a motion, it is advisable to secure the consent of the opposite party prior to filing the motion. If consent of the opposite party to the motion is not obtained, a hearing on the motion

may be scheduled and the parties notified. The burden will be on the party filing the motion to show good cause why the motion should be granted.

The party making the motion may annex thereto such affidavits as are deemed essential to the disposition of the motion, which shall be served with the motion and to which the opposite party may reply with counter affidavits.

a. Types of motions. Types of motions include but are not limited to:

(1) Motion for continuance.

(2) Motion for dismissal.

(3) Motion for summary judgment.

(4) Motion to delete identifying details in the decision.

b. Hearing on motions. Motions relating to proceedings prior to hearing in contested case proceedings shall be heard by the department's administrative law judge. Motions relating to the contested case hearing shall be heard by the presiding administrative law judge.

c. Summary judgment procedure. Summary judgment may be obtained under the following conditions and circumstances:

(1) A party may, after a reasonable time to complete discovery, after completion of discovery, or by agreement of the parties, move with or without supporting affidavits for a summary judgment in the party's favor upon all or any part of a party's claim or defense.

(2) The motion shall be filed not less than 45 days prior to the date the case is set for hearing, unless otherwise ordered by the administrative law judge. Any party resisting the motion shall file within 30 days from the time of service of the motion a resistance; statement of disputed facts, if any; and memorandum of authorities supporting the resistance. If affidavits supporting the resistance are filed, they must be filed with the resistance. The time fixed for hearing or normal submission on the motion shall be not less than 35 days after the filing of the motion, unless another time is ordered by the administrative law judge. The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

(3) Upon any motion for summary judgment pursuant to this rule, there shall be annexed to the motion a separate, short, and concise statement of the material facts as to which the moving party contends there is no genuine issue to be tried, including specific reference to those parts of the pleadings, depositions, answers to interrogatories, admissions on file, and affidavits which support such contentions and a memorandum of authorities.

(4) Supporting and opposing affidavits shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein. The administrative law judge may permit affidavits to be supplemented or opposed by depositions, answers to interrogatories, further affidavits, or oral testimony. When a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of the party's pleading, but the party's response must set forth specific facts, by affidavits or as otherwise provided in this rule, showing that there is a genuine issue for hearing. If the party does not so respond, summary judgment, if appropriate, shall be entered against the party.

(5) If on motion under this rule judgment is not rendered upon the whole case or for all the relief asked and a hearing is necessary, the administrative law judge at the hearing of the motion, by examining the pleadings and the evidence before the administrative law judge and by interrogating counsel, shall, if practicable, ascertain what material facts exist without substantial controversy and what material facts are actually and in good faith controverted. The administrative law judge shall thereupon make an order specifying the facts that appear without substantial controversy, including the extent to which the amount or other relief is not in controversy, and directing such further proceedings in the action as are just. Upon the hearing of the contested case the facts so specified shall be deemed established, and the hearing shall be conducted accordingly.

(6) Should it appear from the affidavits of a party opposing the motion that the party cannot for reasons stated present, by affidavit, facts essential to justify the party's opposition, the administrative

law judge may refuse the application for judgment, or may order a continuance to permit affidavits to be obtained, or depositions to be taken or discovery to be completed, or may make other order.

(7) An order on summary judgment that disposes of less than the entire case is appealable to the director at the same time that the proposed order is appealable pursuant to subrule 7.17(5).

7.17(4) *Briefs and oral argument.* At any time, upon the request of any party or in the administrative law judge's discretion, the administrative law judge may require the filing of briefs on any of the issues before the administrative law judge prior to or at the time of hearing or at a subsequent time. At the hearing, the parties should be prepared to make oral arguments as to the facts and law at the conclusion of the hearing if the administrative law judge so directs.

An original copy only of all briefs shall be filed. Filed briefs shall conform to the requirements of 701—7.5(17A).

If the parties agree on a schedule for submission of briefs, the schedule shall be binding on the parties and the presiding administrative law judge except that, for good cause shown, the time may be extended upon application of a party.

7.17(5) *Orders.* At the conclusion of the hearing, the administrative law judge, in the administrative law judge's discretion, may request the parties to submit proposed findings of fact and conclusions of law. Upon the request of any party, the administrative law judge shall allow the parties an opportunity to submit proposed findings of fact and conclusions of law.

The decision in a contested case is an order which shall be in writing or stated in the record. The order shall include findings of fact prepared by the person presiding at the hearing, unless the person is unavailable, and based solely on the evidence in the record and on matters officially noticed in the record, and shall include conclusions of law. The findings of fact and conclusions of law shall be separately stated. If a party has submitted proposed findings of fact, the order shall include a ruling upon each proposed finding. Each conclusion of law shall be supported by cited authority or by a reasoned opinion. If the issue of reasonable litigation costs was held in abeyance pending the outcome of the substantive issues in the contested case and the proposed order decides substantive issues in favor of protester, the proposed order shall include a notice of time and place for a hearing on the issue of whether reasonable litigation costs shall be awarded and on the issue of amount of such award, unless the parties agree otherwise.

When a motion has been made to delete identifying details in an order on the basis of personal privacy or trade secrets, the justification for such deletion or refusal to delete shall be made by the moving party and shall appear in the order.

When the director initially presides at a hearing or considers decisions on appeal from, or review of the administrative law judge, the order becomes the final order of the department for purposes of judicial review or rehearing unless there is an appeal to, or review on motion of a second agency within the time provided by statute or rule. When an administrative law judge presides at the hearing, the order becomes the final order of the department for purposes of judicial review or rehearing unless there is an appeal to, or review on motion of, the director within 30 days of the date of the order, or 10 days, excluding Saturdays, Sundays, and legal holidays, for a revocation order pursuant to rule 701—7.24(17A). However, if the contested case proceeding involves a question of an award of reasonable litigation costs, the proposed order on the substantive issues shall not be appealable to, or reviewable by the director on the director's motion, until the issuance of a proposed order on the reasonable litigation costs. If there is no such appeal or review within 30 days or 10 days, whichever is applicable, from the date of the proposed order on reasonable litigation costs, both the proposed order on the substantive issues and the proposed order on the reasonable litigation costs become the final orders of the department for purposes of judicial review or rehearing. On an appeal from, review of or applications for rehearing concerning the administrative law judge's order, the director has all the power which the director would initially have had in making the decision, however, the director will only consider those issues or selected issues presented at the hearing before the administrative law judge or any issues of fact or law raised independently by the administrative law judge, including the propriety of and the authority for raising issues. The parties will be notified of those issues which will be considered by the director.

Orders will be issued within a reasonable time after termination of the hearing. Parties shall be promptly notified of each order by delivery to them of a copy of the order by personal service or certified mail, return receipt requested, except in the case of an order revoking a sales or use tax permit or a motor fuel license which may be delivered by ordinary mail.

A cross-appeal may be taken within the 30-day period for taking an appeal to the director of revenue or in any event within 5 days after the appeal to the director is taken. If a cross-appeal is taken from a revocation order pursuant to rule 701—7.24(17A), the cross-appeal may be taken within the 10-day period for taking an appeal to the director or in any event within 5 days after the appeal to the director is taken.

7.17(6) *Expedited cases—when applicable.* In case a protest is filed where:

1. The case is not of precedential value, and

2. The parties desire a prompt resolution of the dispute, then the department and the protester may agree to have the case designated as an expedited case.

a. Agreement. The department and the protester shall execute an agreement to have the case treated as an expedited case. In this case, discovery is waived. The provisions of this agreement shall constitute a waiver of the rights set forth in Iowa Code chapter 17A for contested case proceedings.

b. Finality of decision. A decision entered in an expedited case proceeding shall not be reviewed by the director, state board of tax review, or any other court and shall not be treated as a precedent for any other case.

c. Discontinuance of proceedings. Any time prior to a decision being rendered, the taxpayer or the department may request that expedited case proceedings be discontinued if there are reasonable grounds to believe that the issues in dispute would be of precedential value.

d. Procedure. Upon return of an executed agreement for this procedure, the department shall within 14 days file its answer to the protest. The case shall be docketed for hearing as promptly as the presiding administrative law judge can reasonably hear the matter.

7.17(7) *Burden of proof.* The burden of proof with respect to assessments or denials of refunds in contested case proceedings involving notices of assessments or refund denials issued on or after January 1, 1995, is as follows:

a. The department must carry the burden of proof by clear and convincing evidence as to the issue of fraud with intent to evade tax.

b. The burden of proof is on the department for any tax periods for which the assessment was not made within six years after the return became due, excluding any extension of time for filing such return, except where the department's assessment is the result of the final disposition of a matter between the taxpayer and the Internal Revenue Service or where the taxpayer and the department signed a waiver of the statute of limitations to assess.

c. The burden of proof is on the department as to any new matter or affirmative defense raised by the department. "New matter" means an adjustment not set forth in the computation of the tax in the assessment or refund denial, as distinguished from a new reason for the assessment or refund denial. "Affirmative defense" is one resting on facts not necessary to support the taxpayer's case.

d. In all instances where the burden of proof is not expressly placed upon the department in this subrule, the burden of proof is upon the protester.

7.17(8) *Costs.* A prevailing taxpayer in a contested case proceeding related to the determination, collection, or refund of a tax, penalty, or interest may be awarded reasonable litigation costs by the department, incurred subsequent to the issuance of the notice of assessment or refund denial on or after January 1, 1995, based upon the following:

a. The reasonable expenses of expert witnesses.

b. The reasonable costs of studies, reports, and tests.

c. The reasonable fees of independent attorneys or independent accountants retained by the taxpayer. No such award is authorized for accountants or attorneys who represent themselves or who are employees of the taxpayer.

d. An award for reasonable litigation costs shall not exceed $25,000 per case.

e. No award shall be made for any portion of the proceeding which has been unreasonably protracted by the taxpayer.

f. For purposes of this subrule, "prevailing taxpayer" means a taxpayer who establishes that the position of the department in the contested case proceeding was not substantially justified and who has substantially prevailed with respect to the amount in controversy or has substantially prevailed with respect to the most significant issue or set of issues presented. If the position of the department, in issuance of the assessment or refund denial, was not substantially justified and if the matter is resolved or conceded before the contested case proceeding is commenced, there cannot be an award for reasonable litigation costs.

g. The definition of "prevailing taxpayer" is taken from the definition of "prevailing party" in 26 U.S.C. §7430. Therefore, federal cases determining whether the Internal Revenue Service's position was substantially justified will be considered in the determination of whether a taxpayer is entitled to an award of reasonable litigation costs to the extent that 26 U.S.C. §7430 is consistent with Iowa Code section 421.60(4).

h. The taxpayer has the burden of establishing the unreasonableness of the department's position.

i. Once a contested case has commenced, a concession by the department of its position or a settlement of the case either prior to the evidentiary hearing or any order issued does not per se either authorize an award of reasonable litigation costs or preclude such award.

j. If the department relied upon information provided or action conducted by federal, state, or local officials or law enforcement agencies with respect to the tax imposed by Iowa Code chapter 453B, an award for reasonable litigation costs shall not be made in a contested case proceeding involving the determination, collection, or refund of that tax.

k. The taxpayer who seeks an award of reasonable litigation costs must specifically request such award in the protest or it will not be considered.

l. A request for an award of reasonable litigation costs shall be held in abeyance until the concession or settlement of the contested case proceeding or the issuance of a proposed order in the contested case proceeding, unless the parties agree otherwise.

m. At the hearing held for the purpose of deciding whether an award for reasonable litigation costs should be awarded, consideration shall be given to the following points:

(1) Whether the department's position was substantially justified;

(2) Whether the protester is the prevailing taxpayer;

(3) The burden is upon protester to establish how the alleged reasonable litigation costs were incurred. This requires a detailed accounting of the nature of each cost, the amount of each cost, and to whom the cost was paid or owed;

(4) Whether alleged litigation costs are reasonable or necessary;

(5) Whether protester has met its burden of demonstrating all of these points.

This rule is intended to implement Iowa Code sections 10A.202(1)*"m,"* 17A.15(3), 421.60, 422.57(1) and 452A.68.

701—7.18(17A) Interventions. Interventions shall be governed by the Iowa rules of civil procedure.

701—7.19(17A) Record and transcript. The record in a contested case shall include:

1. All pleadings, motions and rulings;
2. All evidence received or considered and all other submissions;
3. A statement of all matters officially noticed;
4. All questions and offers of proof, objections, and rulings thereon;
5. All proposed findings and exceptions;
6. The order of the administrative law judge.

Oral hearings regarding proceedings on appeal to or considered on motion of the director which are recorded by mechanical means shall not be transcribed for the record of such appeal or review unless a party, by written notice, or the director, orally or in writing, requests such transcription. A transcription

will be made only of that portion of the oral hearing relevant to the appeal or review if so requested and no objection is made by any other party to the proceeding or the director.

701—7.20(17A) Rehearing. Any party may file an application with the director for a rehearing in the contested case, stating the specific grounds therefor and the relief sought. The application must be filed within 20 days after the department has issued a final order. See subrule 7.17(5) as to when a proposed order becomes a final order. A copy of such application shall be timely mailed by the applicant to all parties in conformity with rule 701—7.21(17A). The director shall have 20 days from the filing of the application to grant or deny the rehearing. If the application is granted, a notice will be served on the parties stating the time and place of the rehearing. An application for rehearing shall be deemed denied if not granted by the director within 20 days after filing.

The application for rehearing which is filed shall contain:

1. A caption in the following form:

BEFORE THE IOWA STATE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF _____	*	APPLICATION
(state the taxpayer's name, address	*	FOR
and designate type of proceeding,	*	REHEARING
e.g., income tax refund claim)	*	DOCKET NO. _____

2. Substantially state in separate numbered paragraphs the following:

a. Clear and concise statements of the reasons for requesting a rehearing and each and every error which the party alleges to have been committed during the contested case proceedings;

b. Clear and concise statements of all relevant facts upon which the party relies;

c. Refer to any particular statute or statutes and any rule or rules involved;

d. The signature of the party or that of the party's representative, the addresses of the party or the party's representative, and the telephone number of the party or the party's representative.

No applications for rehearing shall be entertained by the department's administrative law judges.

This rule is intended to implement Iowa Code section 17A.16(2).

701—7.21(17A) Service. All papers or documents required by 701—Chapter 7 to be filed with the department, administrative law judge, with the opposing party or other person shall be served by ordinary mail unless another rule specifically refers to another method. All notices required by 701—Chapter 7 to be served on parties or persons by the department or administrative law judge shall be served by ordinary mail unless another rule specifically refers to another method.

This rule is intended to implement Iowa Code chapter 17A.

701—7.22 Reserved.

701—7.23(17A) Ex parte communications.

7.23(1) *Administrative law judges.* Iowa Code section 17A.17 provides that individuals assigned to render a proposed or final decision or to make findings of fact and conclusions of law in a contested case shall not communicate, directly or indirectly, in connection with any issue of fact or law in that contested case, with any party, or any person with a personal interest in or engaged in prosecuting or advocating in either the case under consideration or a pending factually related case involving the same parties, except

upon notice and opportunity for all parties to participate. Therefore, if the administrative law judge desires to communicate with any party or person with a personal interest in or engaged in prosecuting or advocating in either the case under consideration before the administrative law judge or a pending factually related case involving the same parties, the administrative law judge shall notify such persons or parties indicating the time and place at which all affected persons or parties may meet to discuss the matters.

7.23(2) *Parties or their representatives.* Iowa Code section 17A.17 provides further that parties or their representatives in a contested case shall not communicate, directly or indirectly, in connection with any issue of fact or law in that contested case, with individuals assigned to render a proposed or final decision or to make findings of fact and conclusions of law in that contested case, except upon notice and opportunity for all parties to participate. Therefore, if any party or their representative desires to discuss certain matters with the administrative law judge the party should notify the administrative law judge and the opposing party of the desire to meet with the administrative law judge and the administrative law judge upon notification of the desire shall advise the parties or their representatives in writing of the time and place at which the affected persons or parties may meet to discuss any matters.

7.23(3) *Sanctions.* Any party to a contested case proceeding may file a timely and sufficient affidavit asserting personal bias of an individual participating in the making of any proposed or final decision in that case. The department shall determine the matter as part of the record in the case. When the department in these circumstances makes such a determination with respect to a department member, that determination shall be subject to de novo judicial review in any subsequent review proceeding of the case.

The recipient of a prohibited communication as provided in section 17A.17 may be required to submit the communication if written or a summary of the communication if oral for inclusion in the record of the proceeding. As sanctions for violations of any prohibited communication provided in section 17A.17 a decision may be rendered against a party who violates these rules, or for reasonable cause shown the director may censor, suspend, or revoke a privilege to practice before the department, or for reasonable cause shown after notice and opportunity to be heard, the director may censor, suspend, or dismiss any departmental personnel.

701—7.24(17A) Licenses.

7.24(1) *Denial of license, refusal to renew license.* When the department is required by constitution or statute to provide notice and an opportunity for an evidentiary hearing prior to the refusal or denial of a license, a notice, as prescribed in 7.14(17A), shall be served by the department upon the licensee or applicant. Prior to the refusal or denial of a license, the department shall give 30 days' written notice to the applicant or licensee in which to appear at a hearing to show cause why a license should not be refused or denied. In addition to the requirements of 7.14(17A), the notice shall contain a statement of facts or conduct and the provisions of law which warrant the denial of the license or the refusal to renew a license. If the licensee so desires, the licensee may file a petition as provided in 7.24(3) with the administrative law judge within the 30 days prior to the hearing. The department may, in its discretion, file an answer to a petition filed by the licensee prior to the hearing. Thereafter, the rules contained in this chapter governing contested case proceedings shall apply.

When a licensee has made timely and sufficient application for the renewal of a license or a new license with reference to any activity of a continuing nature, the existing license does not expire until the application has been finally determined by the department, and, in case the application is denied or the terms of the new license limited, until the last date for seeking judicial review of the department's order or a latter date fixed by order of the department or the reviewing court. See 195—subrule 20.4(1) regarding gambling license applications.

7.24(2) *Revocation of license.* The department shall not revoke, suspend, annul or withdraw any license until written notice is served by personal service or restricted certified mail pursuant to 7.14(17A) within the time prescribed by the applicable statute and the licensee whose license is to be revoked, suspended, annulled or withdrawn is given an opportunity to show at an evidentiary hearing conducted pursuant to the rules governing contested case proceedings in this chapter compliance

with all lawful requirements for the retention of the license. However, in the case of the revocation, suspension, annulment, or withdrawal of a sales or use tax permit, written notice will be served pursuant to 7.14(17A) only if the permit holder requests that this be done following notification, by ordinary mail, of the director's intent to revoke, suspend, annul, or withdraw the permit. In addition to the requirements of 7.14(17A) the notice shall contain a statement of facts or conduct and the provisions of law which warrant the revocation, suspension, annulment, or withdrawal of the license. A licensee whose license may be revoked, suspended, annulled, or withdrawn may file a petition as provided in 7.24(3) with the administrative law judge prior to the hearing. The department may, in its discretion, file an answer to a petition filed by the licensee prior to the hearing. Thereafter, the rules contained in this chapter governing contested case proceedings shall apply.

Notwithstanding the above, if the department finds that public health, safety or welfare imperatively requires emergency action, and incorporates a finding to that effect in an order to the licensee, summary suspension of a license shall be ordered pending proceedings for revocation as provided herein. These proceedings shall be promptly instituted and determined. When a summary suspension as provided herein is ordered, a notice of the time, place and nature of the evidentiary hearing shall be attached to the order.

7.24(3) *Petition.* When a person desires to file a petition as provided in 7.24(1) and 7.24(2), the petition to be filed shall contain:

a. A caption in the following form:

BEFORE THE IOWA STATE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

	*	
IN THE MATTER OF _____		PETITION
(state taxpayer's name, address and type of license)	*	DOCKET NO. _____
		(filled in by Department)
	*	

b. Substantially state in separate numbered paragraphs the following:

(1) The full name and address of the petitioner;

(2) Refer to the type of license and the relevant statutory authority;

(3) Clear, concise and complete statements of all relevant facts showing why petitioner's license should not be revoked, refused, or denied;

(4) Whether a similar license has previously been issued to or held by petitioner or revoked and if revoked the reasons therefor;

(5) The signature of the petitioner or petitioner's representative, the address of petitioner and of petitioner's representative, and the telephone number of petitioner or petitioner's representative.

701—7.25(17A) Declaratory rulings—in general. Any oral or written advice or opinion rendered to members of the public by departmental personnel not pursuant to a petition for declaratory ruling is not binding upon the department. However, departmental personnel, including field personnel, ordinarily will discuss substantive tax issues with members of the public or their representatives prior to the receipt of a petition for a declaratory ruling, but such oral or written opinions or advice are not binding on the department. This should not be construed as preventing members of the public or their representatives from inquiring whether the department will issue a declaratory ruling on a particular question. In these cases, however, the name of the taxpayer shall be disclosed. The department will also discuss questions relating to certain procedural matters as, for example, submitting a request for a declaratory ruling or submitting a petition to initiate rule-making procedures. Members of the public may, of course, seek

oral technical assistance from a departmental employee in regard to the proper preparation of a return or report required to be filed with the department. Such oral advice is advisory only and the department is not bound to recognize it in the examination of the return, report or records.

7.25(1) *Uniform rules on declaratory rulings.* The department hereby adopts, subject to the exceptions and amendments listed in subrule 7.25(2), the rules of the governor's task force on uniform rules of agency procedure relating to declaratory rulings which are printed in Volume I, pages 2 through 4, of the Iowa Administrative Code as uniform rules X.1(17A) through X.7(17A), as its rules on declaratory rulings the same as if those uniform rules were reprinted herein in full.

7.25(2) *Exceptions and amendments to uniform rules on declaratory rulings.* The following exceptions and amendments are adopted to the uniform rules on declaratory rulings.

a. Add at the end of uniform rule X.1(17A), page 3, the following item of additional information:

9. Whether the petitioner is presently under audit by the department.

b. Whenever the context requires, the term "agency" when it appears in uniform rules X.1(17A) through X.7(17A), pages 2 through 4, means the department of revenue.

c. Add at the end of uniform rule X.5(17A), page 3, the following additional reason for refusal to issue a declaratory ruling:

11. The petition requests a ruling on an issue presently under investigation or audit or in rule-making proceedings or in litigation in a contested case or court proceedings.

701—7.26(17A) Department procedure for rule making—in general. Prior to the initiation of rule-making proceedings as provided for in this rule, rules which are proposed for adoption are approved by the director. The channeling of rules varies with the circumstances. When a division determines that a rule or rules should be made on a particular subject, the subject matter of the rule or rules is prepared which is reviewed by the policy section of the technical services division and the director. After approval by the director, a draft of the rule is prepared and the rule-making proceedings are initiated.

When a petition for the promulgation, amendment, or repeal of a rule is received from an interested person, a copy of the petition is given to the appropriate section or division, the director, and the legal division for their views and comments as to the propriety of the petition. If it is determined the petition discloses sufficient justification, rule-making proceedings will be initiated.

7.26(1) *Uniform rules for procedure for rule making.* The department hereby adopts, subject to the exceptions and amendments listed in subrule 7.26(2), the rules of the governor's task force on uniform rules of agency procedure relating to rule making which are printed in Volume I, page 1 and pages 5 through 14, of the Iowa Administrative Code as uniform rules X.1(17A) through X.17(17A), as its rules for rule-making procedure the same as if these uniform rules were reprinted herein in full.

7.26(2) *Exceptions and amendments to uniform rules on procedure for rule making.* The following exceptions and amendments are adopted to the uniform rules for rule-making procedure:

a. Whenever the context requires, the term "agency" when it appears in the uniform rules herein adopted means the department of revenue.

b. Inquiries concerning the status of a petition for rule making provided for in uniform rule X.3(17A), page 1 of the uniform rules, may be made to the Deputy Director of Revenue, Hoover State Office Building, Des Moines, Iowa 50319.

c. The subscription price for copies of future Notices of Intended Action for subscribers is fixed for a one-year basis as provided for in uniform rule X.4(3), page 6 of the uniform rules.

d. The Office of the Deputy Director of Revenue, Hoover State Office Building, Des Moines, Iowa 50319, is designated as the office where interested persons may submit argument, data and views on proposed rules as provided for in uniform subrule X.5(1), page 6 of the uniform rules.

e. The Office of the Deputy Director of Revenue, Hoover State Office Building, Des Moines, Iowa 50319, is designated as the office for registering small businesses or organizations of small business for the small business impact list provided for in uniform subrule X.6(3), page 8 of the uniform rules.

f. There are no known categories of rules exempt from the usual public notice and participation requirements as authorized by uniform subrule X.10(2), page 11 of the uniform rules.

g. The Office of the Deputy Director of Revenue, Hoover State Office Building, Des Moines, Iowa 50319, is the designated office for delivery of a request for a concise statement of reason, provided for in subrule X.11(1), page 11 of the uniform rules.

These rules are intended to implement Iowa Code sections 17A.22 and 421.14 and to implement the uniform rules on agency procedure as accepted and approved by the governor.

701—7.27(9C,91C) Procedure for nonlocal business entity bond forfeitures. Upon the failure of a transient merchant or an out-of-state contractor to pay any taxes payable, the amount of bond posted with the secretary of state by the transient merchant or out-of-state contractor necessary to pay the tax shall be forfeited. The following subrules of this rule shall govern the procedure for that forfeiture.

7.27(1) *Definitions.*

a. "Nonlocal business entity" is either an out-of-state contractor or a transient merchant as those terms are defined in paragraphs *"b"* and *"f."*

b. "Out-of-state contractor" means a general contractor, subcontractor, architect, engineer, or other person who contracts to perform in this state construction or installation of structures or other buildings or any other work covered by Iowa Code chapter 103A and whose principal place of business is outside Iowa.

c. "Taxes payable by a transient merchant" refers to all taxes administered by the department, and penalties, interest, and fees which the department has previously determined to be due by assessment or due as a result of an appeal from an assessment.

d. "Taxes payable by an out-of-state contractor" means tax, penalty, interest, and fees which the department, another state agency, or a subdivision of the state, has determined to be due by assessment or due as a result of an appeal from an assessment. The tax assessed must accrue as the result of a contract to perform work covered by Iowa Code chapter 103A.

e. "Taxes payable" means any amount referred to in subparagraphs *"c"* and *"d"* above.

f. "Transient merchant" shall be defined, for the purposes of this rule, as that phrase is defined in Iowa Code section 9C.1.

7.27(2) *Increases in existing bonds.* If an out-of-state contractor has on file with the secretary of state a bond for any particular contract and for that particular contract the contractor has tax due and owing but unpaid and this tax is greater than the amount of the bond, the department shall require the out-of-state contractor to increase the bond on file with the secretary of state in an amount sufficient to pay tax liabilities which will become due and owing under the contract in the future.

7.27(3) *Responsibility for notification.* Concerning taxes payable by an out-of-state contractor, which are not administered by the department of revenue, it shall be the duty of the department or subdivision of Iowa state government to which the taxes are owed to notify the department of revenue of the taxes payable by the out-of-state contractor in order to institute bond forfeiture proceedings or an increase in the amount of the bond which the out-of-state contractor must post.

7.27(4) *Initial notification.* After it is determined that a bond ought to be forfeited, notice of this intent shall be sent to a nonlocal business entity and its surety of record, if any. Notice sent to a nonlocal business entity or its surety shall be sent to the last known address as reflected in the records of the secretary of state. The notice sent to an out-of-state contractor shall also be mailed to the contractor's registered agent for service of process, if any, within Iowa. This notice may be sent by ordinary mail. The notice shall state the intent to demand forfeiture of the nonlocal business entity's bond, the amount of bond to be forfeited, the nature of the taxes alleged to be payable, the period for which these taxes are due, and the department or subdivision of Iowa to which the taxes are payable. The notice shall also state the statutory authority for the forfeiture and the right to a hearing upon timely application.

7.27(5) *Protest to bond forfeiture.* The application of a nonlocal business entity for a hearing shall be written and substantially in the form set out for protests to other departmental action in 701—7.8(17A). The caption of the application shall be basically in the form set out in subrule 7.8(1) except the type of proceeding shall be designated as a bond forfeiture collection. The body of the application for hearing must substantially resemble the body of the protest described in subrule 7.8(2). However, referring to subrule 7.8(2), paragraph *"a,"* the nonlocal business entity shall state the date of the notice described

in subrule 7.27(4). With regard to subrule 7.8(2), paragraph *"c,"* in the case of a tax payable which is not administered by the department, the errors alleged may be errors on the part of other departments or subdivisions of the state of Iowa. The application for hearing shall be filed with the department's administrative law judge in the manner described in 701—7.8(17A). The docketing of an application for hearing shall follow the procedure for the docketing of a protest under that rule.

7.27(6) *Prehearing, hearing and rehearing procedures.* The following Chapter 7 rules are applicable to preliminary and contested case proceedings under this rule: 701—7.3(17A) to 701—7.7(17A), 701—7.9(17A) to 701—7.13(17A), 701—7.15(17A) to 701—7.21(17A), 701—7.23(17A), and subrule 7.14(2). The strictures of subrule 7.14(1) are not applicable to contested cases arising under this rule.

7.27(7) *Sureties and state departments other than revenue.* A surety shall not have standing to contest the amount of any tax payable.

If there exist taxes payable by an out-of-state contractor and these taxes are payable to a department or subdivision of state government other than the department of revenue, that department or subdivision shall be the real party in interest to any proceeding conducted under this rule, and it shall be the responsibility of that department or subdivision to provide its own representation and otherwise bear the expenses of representation.

Rules 7.1(17A) to 7.27(9C,91C) are intended to implement Iowa Code sections 9C.4, 17A.1(2), 17A.2(2), 17A.11, 91C.7, and 421.8A.

701—7.28 and **7.29** Reserved.

701—7.30(421) Definitions which apply to rules 701—7.31(421) to 701—7.35(421).

7.30(1) The term *"entity"* means any taxpayer other than an individual or sole proprietorship.

7.30(2) The term *"last-known address"* does not necessarily mean the taxpayer's actual address but instead means the last address that the taxpayer makes known to the department by tax type. Thus, for instance, receipt by the department of a taxpayer's change of address from a third person not authorized to act on behalf of the taxpayer (e.g., an employer who had filed a form W-2 showing a new taxpayer address) is not notice to the department of a change of address of the taxpayer. However, the filing by the taxpayer of a tax return for a year subsequent to the year for which a notice is required would be notification to the department of a change of address, provided a reasonable amount of time is allowed to process and transfer such information to the department's central computer system. The meaning of this phrase is important, and taxpayers should be aware of their need to update their address with the department in order to receive refunds of tax and notices of assessments and denial of a claim for refund. When such a notice is sent to a "taxpayer's last-known address" the notice is legally effective even if the taxpayer never receives it.

7.30(3) The term *"taxpayer interview"* means any in-person contact from and after January 1, 1995, between an employee of the department and a taxpayer or a taxpayer's representative which has been initiated by a department employee.

7.30(4) The term *"taxpayer representative"* or *"authorized taxpayer representative"* means an individual authorized to practice before the department under rule 701—7.6(17A); an individual who has been named as an authorized representative on a fiduciary return of income form filed under Iowa Code section 422.14, or a tax return filed under Iowa Code chapter 450, "Inheritance Tax," 450A, "Generation Skipping Tax," or 451, "Estate Tax"; or for proceedings before the department any other individual the taxpayer designates who is named on a valid power of attorney if appearing on behalf of another.

This rule is intended to implement Iowa Code section 421.60.

701—7.31(421) Abatement of unpaid tax. For assessment notices issued on or after January 1, 1995, if the statutory period for appeal has expired, the director may abate any portion of unpaid tax, penalties or interest which the director determines is erroneous, illegal, or excessive. The authority of the director to compromise and settle doubtful and disputed claims for taxes or tax refunds or tax liability of doubtful collectability is not covered by this rule.

This authority exists pursuant to Iowa Code section 421.5.

7.31(1) *Assessments qualifying for abatement.* To be subject to an abatement, an assessment or a portion of an assessment for which abatement is sought must not have been paid and must have exceeded the amount due as provided by the Iowa Code and the administrative rules issued by the department interpreting the Iowa Code. If a taxpayer fails to timely appeal an assessment that is based on the Iowa Code or the department's administrative rules interpreting the Iowa Code within the statutory period, then the taxpayer cannot request an abatement of the assessment, or a portion thereof.

7.31(2) *Procedures for requesting abatement.* The taxpayer must make a written request to the director for abatement of that portion of the assessment that is alleged to be erroneous, illegal, or excessive. A request for abatement which is filed must contain:

a. The taxpayer's name and address, social security number, federal identification number, or any permit number issued by the department;

b. A statement on the type of proceeding, e.g., individual income tax, request for abatement; and

c. The following information:

(1) The type of tax, the taxable period or periods involved, and the amount thereof that was excessive or erroneously or illegally assessed;

(2) Clear and concise statements of each and every error which the taxpayer alleges to have been committed by the director in the notice of assessment and which causes the assessment to be erroneous, illegal, or excessive. Each assignment of error must be separately numbered;

(3) Clear and concise statements of all relevant facts upon which the taxpayer relies (documents verifying the correct amount of tax liability must be attached to this request);

(4) Refer to any particular statute or statutes and any rule or rules involved, if known;

(5) The signature of the taxpayer or that of the taxpayer's representative and the addresses of the taxpayer and the taxpayer's representative;

(6) Description of records or documents which were not available or were not presented to department personnel prior to the filing of this request, if any; and provide copies of any records or documents that were not previously presented to the department; and

(7) Any other matters deemed relevant and not covered in the above paragraphs.

This rule is intended to implement Iowa Code section 421.60.

701—7.32(421) Time and place of taxpayer interviews. The time and place of taxpayer interviews are to be fixed by an employee of the department and employees are to endeavor to schedule a time and place that are reasonable under the circumstances.

7.32(1) *Time of taxpayer interviews.* The department will schedule the day(s) for a taxpayer interview during a normally scheduled workday(s) of the department, during the department's normal business hours. The department will schedule taxpayer interviews throughout the year without regard to seasonal fluctuations in the business of particular taxpayers or their representatives. The department will, however, work with taxpayers or their representatives to try to minimize any adverse effects in scheduling the date and time of a taxpayer interview.

7.32(2) *Type of taxpayer interview.* The department will determine whether a taxpayer interview will be an office interview (i.e., an interview conducted at a department office) or a field interview (i.e., an interview conducted at the taxpayer's place of business or residence, or some other location that is not a department office) based on which form of interview will be more conducive to effective and efficient tax administration.

The department will grant a request to hold an office interview at a location other than a department office in case of a clear need, such as when it would be unreasonably difficult for the taxpayer to travel to a department office because of the taxpayer's advanced age or infirm physical condition, or when the taxpayer's books, records, and source documents are too cumbersome for the taxpayer to bring to a department office.

7.32(3) *Place of taxpayer interview.* The department will make an initial determination of the place for an interview, including the department region office to which an interview will be assigned, based on the address shown on the return for the tax period to be examined. Requests by taxpayers to transfer

the place of interview will be resolved on a case-by-case basis, using the criteria set forth in paragraph *"c"* of this subrule.

a. Office taxpayer interviews. An office interview of an individual or sole proprietorship generally is based on the residence of the individual taxpayer. An office interview of a taxpayer which is an entity generally is based on the location where the taxpayer entity's original books, records, and source documents are maintained.

b. Field taxpayer interviews. A field interview generally will take place at the location where the taxpayer's original books, records, and source documents pertinent to the interview are maintained. In the case of a sole proprietorship or taxpayer entity, this usually will be the taxpayer's principal place of business. If an interview is scheduled by the department at the taxpayer's place of business, which is a small business and the taxpayer represents to the department in writing that conducting the interview at the place of business would essentially require the business to close or would unduly disrupt business operations, the department upon verification will change the place of interview.

c. Requests by taxpayers to change place of interview. The department will consider, on a case-by-case basis, written requests by taxpayers or their representatives to change the place that the department has set for an interview. In considering these requests, the department will take into account the following factors:

(1) The location of the taxpayer's current residence;

(2) The location of the taxpayer's current principal place of business;

(3) The location where the taxpayer's books, records, and source documents are maintained;

(4) The location at which the department can perform the interview most efficiently;

(5) The department resources available at the location to which the taxpayer has requested a transfer; and

(6) Other factors that indicate that conducting the interview at a particular location could pose undue inconvenience to the taxpayer.

A request by a taxpayer to transfer the place of interview generally will be granted under the following circumstances:

1. If the current residence of the taxpayer in the case of an individual or sole proprietorship, or the location where the taxpayer's books, records, and source documents are maintained, in case of a taxpayer entity, is closer to a different department office than the office where the interview has been scheduled, the department normally will agree to transfer the interview to the closer department office.

2. If a taxpayer does not reside at the residence where an interview has been scheduled, the department will agree to transfer the examination to the taxpayer's current residence.

3. If, in the case of an individual, a sole proprietorship, or a taxpayer entity, the taxpayer's books, records, and source documents are maintained at a location other than the location where the interview has been scheduled, the department will agree to transfer the interview to the location where the taxpayer's books, records, and source documents are maintained.

4. The location of the place of business of a taxpayer's representative generally will not be considered in determining the place for an interview. However, the department in its sole discretion may determine, based on the factors described in paragraph *"c"* of this subrule, to transfer the place of interview to the representative's office.

5. If any applicable period of limitations of assessment and collection provided in the Iowa Code will expire within 13 months from the date of a taxpayer's request to transfer the place of interview, the department may require, as a condition to the transfer, that the taxpayer agree in writing to extend the limitations period up to one year.

6. The department is not required to transfer an interview to an office that does not have adequate resources to conduct the interview.

7. Notwithstanding any other provision of this rule, employees of the department may decline to conduct an interview at a particular location if it appears that the possibility of physical danger may exist at that location. In these circumstances, the department may transfer an interview to a department office and take any other steps reasonably necessary to protect its employees.

8. Nothing in this rule shall be interpreted as precluding the department from initiating the transfer of an interview if the transfer would promote the effective and efficient conduct of the interview. Should a taxpayer request that such a transfer not be made, the department will consider the request according to the principles and criteria set forth in paragraph *"c"* of this subrule.

9. Regardless of where an examination takes place, the department may visit the taxpayer's place of business or residence to establish facts that can only be established by direct visit, such as inventory or asset verification. The department generally will visit for these purposes on a normal workday of the department during the department's normal business hours.

7.32(4) *Audio recordings of taxpayer interviews.*

a. A taxpayer is permitted, upon advance notice to the department, to make an audio recording of any interview of the taxpayer by the department relating to the determination or collection of any tax. The recording of the interview is at the taxpayer's own expense and must be with the taxpayer's own equipment.

Requests by taxpayers to make audio recordings must be addressed to the department employee who is conducting the interview and must be received by no later than ten calendar days before the interview. If ten calendar days' advance notice is not given, the department may, in its discretion, conduct the interview as scheduled or set a new date.

The department employee conducting the interview will approve the request to record the interview if:

(1) The taxpayer (or representative) supplies the recording equipment;

(2) The department may produce its own recording of the proceedings;

(3) The recording takes place in a suitable location; and

(4) All participants in the proceedings other than department personnel consent to the making of the audio recording, and all participants identify themselves and their role in the proceedings.

b. A department employee is also authorized to record any taxpayer interview, if the taxpayer receives prior notice of the recording and is provided with a transcript or a copy of the recording upon the taxpayer's request.

Requests by taxpayers (or their representatives) for a copy or transcript of an audio recording produced by the department must be addressed to the employee conducting the interview and must be received by the department no later than 30 calendar days after the date of the recording. Taxpayers must pay the costs of duplication or transcription.

c. At the beginning of the recording of an interview the department employee conducting the interview must state the employee's name, the date, the time, the place, and the purpose of the interview.

At the end of the interview, the department employee will state that the interview has been completed and that the recording has ended.

d. When written records are presented or discussed during the interview being recorded, they must be described in sufficient detail to make the audio recording a meaningful record when matched with the other documentation contained in the case file.

This rule is intended to implement Iowa Code section 421.60.

701—7.33(421) Mailing to the last-known address. If the department fails to mail a notice of assessment to the taxpayer's last-known address or fails to personally deliver the notice to the taxpayer, on or after January 1, 1995, interest is waived for the month the failure occurs through the month of correct mailing or personal delivery.

In addition, on or after January 1, 1995, if the department fails to mail a notice of assessment or denial of a claim for refund to the taxpayer's last-known address or fails to personally deliver the notice to a taxpayer and, if applicable, to the taxpayer's authorized representative, the time period to appeal the notice of assessment or a denial of a claim for refund is suspended until the notice or claim denial is correctly mailed or personally delivered or for a period not to exceed one year, whichever is the lesser period.

Collection activities, except when a jeopardy situation exists, shall be suspended and the statute of limitations for assessment and collection of the tax shall be tolled during the period in which interest is waived.

7.33(1) The department will make the determination of the taxpayer's last-known address on a tax-type-by-tax-type basis. However, a notice of assessment or refund claim denial will be considered to be mailed to the last-known address if it is mailed to an address used for another tax type.

A notice of assessment mailed to one of two addresses used by a taxpayer was sufficient. L. P. Marvin, Sr., 40TC 982.Dec. 26, 313; U.C. Massengale, (CA-4) 69-1 USTC paragraph 9310, 408 F.2d 1372.

7.33(2) The last-known address is the address used on the most recent filed and processed return. The following principles, established by case law, for the Internal Revenue Service (IRS) also will be applied in determining the taxpayer's last-known address for purposes of this rule.

Although the taxpayer filed a tax return showing a new address, the IRS had not processed the return sufficiently for the new address to be available by computer to the IRS agent who sent the notice of deficiency. Before a change of address is considered available, a reasonable amount of time must be allowed to process and transfer information to the IRS' central computer system. *Diane Williams v. Commissioner of Internal Revenue*, U.S. Court of Appeals, 9th Circuit; 935 F. 2d 1066. Affirming the Tax Court, 57 TCM 1357, Dec. 45, 953(M), TAC Memo. 1989-439.

If the department knows the taxpayer has moved but does not know the new mailing address, the prior mailing address is the proper place to send a deficiency notice. M. Kaestner, CDC 71-2 USTC paragraph 9512, 329 F. Supp. 1082. Aff'd per curiam, (CA-9) 73-1 USTC paragraph 9266, 473 F. 2d 1294. H. Kohn, DC Mass, 85-2 USTC paragraph 9725.

Knowledge acquired by a collection agent regarding the taxpayer's address in an unrelated investigation was not required to be imputed to the examination division responsible for mailing a notice of deficiency. R. H. Wise, DC Mont., 88-1 USTC paragraph 9365, 688 F. Supp. 1164.

However, information acquired by the department in a related investigation of the taxpayer is binding upon the department, e.g., where the taxpayer files a power of attorney showing a change of address.

7.33(3) Procedures for notifying the department of a change in taxpayer's address. The department generally will use the address on the most recent filed and properly processed return by tax type as the address of record for all notices of assessment and denial of claims for refund. If a taxpayer no longer wishes the address of record to be the address on the most recently filed return, the taxpayer must give clear and concise written notification of a change in address to the department. Notifications of a change in address should be addressed to: Changes in Name or Address, Iowa Department of Revenue, P.O. Box 10413, Des Moines, Iowa 50306.

If after a joint return or married filing separately on a combined return is filed either taxpayer establishes a separate residence, each taxpayer should send clear and concise written notification of a current address to the department.

If a department employee contacts a taxpayer in connection with the filing of a return or an adjustment to a taxpayer's return, the taxpayer may provide clear and concise written notification of a change of address to the department employee who initiated the contact.

A taxpayer should notify the U.S. Postal Service facility serving the taxpayer's old address of the taxpayer's new address in order that mail from the department can be forwarded to the new address. However, notification to the U.S. Postal Service does not constitute the clear and concise written notification that is required to change a taxpayer's address of record with the department.

This rule is intended to implement Iowa Code section 421.60.

701—7.34(421) Power of attorney. No attorney, accountant, or other representative will be recognized as representing any taxpayer in regard to any claim, appeal, or other matter relating to the tax liability of such taxpayer in any hearing before or conference with the department, or any member or agent thereof, unless there is first filed with the department a written authorization.

7.34(1) A power of attorney is required by the department when the taxpayer wishes to authorize an individual to perform one or more of the following acts on behalf of the taxpayer:

a. To receive copies of any notices or documents sent by the department, its representatives or its attorneys.

b. To receive, but not to endorse and collect, checks in payment of any refund of Iowa taxes, penalties, or interest.

c. To execute waivers (including offers of waivers) of restrictions on assessment or collection of deficiencies in tax and waivers of notice of disallowance of a claim for credit or refund.

d. To execute consents extending the statutory period for assessment or collection of taxes.

e. To fully represent the taxpayer(s) in any hearing, determination, final or otherwise, or appeal.

f. To enter into any compromise with the director of revenue's office.

g. To execute any release from liability required by the department of revenue prerequisite to divulging otherwise confidential information concerning taxpayer(s).

h. Other acts as stipulated by the taxpayer.

7.34(2) A power of attorney or any supplemental notification intended to be utilized as a power of attorney must contain the following information to be valid:

a. Name and address of the taxpayer;

b. Identification number of the taxpayer (i.e., social security number, federal identification number, or any state-issued tax identification number relative to matters covered by the power of attorney);

c. Name, mailing address, and PTIN (preparer's tax identification number), FEIN (federal employer identification number) or SSN (social security number) of the representative;

d. Description of the matter(s) for which representation is authorized which, if applicable, must include:

(1) The type of tax(es) involved;

(2) The specific year(s) or period(s) involved; and

(3) In estate matters, decedent's date of death; and

e. A clear expression of the taxpayer's intention concerning the scope of authority granted to the recognized representative(s) as provided in 7.34(1).

7.34(3) A power of attorney may not be used for tax periods that end more than three years after the date on which the power of attorney is received by the department. A power of attorney may concern an unlimited number of tax periods which have ended prior to the date on which the power of attorney is received by the department; however, each tax period must be separately stated.

7.34(4) The individual who must execute a power of attorney depends on the type of taxpayer involved as follows:

a. Individual taxpayer. In matters involving an individual taxpayer, a power of attorney must be signed by the individual.

b. Husband and wife. In matters involving a joint return or married taxpayers who have elected to file separately on a combined return in which both husband and wife are to be represented by the same representative(s), the power of attorney must be executed by both husband and wife.

In any matters concerning a joint return or married taxpayers who have elected to file separately on a combined return in which both husband and wife are not to be represented by the same representatives, the power of attorney must be executed by the spouse who is to be represented. However, the recognized representative of such spouse cannot perform any act with respect to a tax matter that the spouse represented cannot perform alone.

c. Corporation. In the case of a corporation, a power of attorney must be executed by an officer of the corporation having authority to legally bind the corporation, who must certify that the officer has such authority.

d. Association. In the case of an association, a power of attorney must be executed by an officer of the association having authority to legally bind the association, who must certify that the officer has such authority.

e. Partnership. In the case of a partnership, a power of attorney must be executed by all partners, or if executed in the name of the partnership, by the partner or partners duly authorized to act for the partnership, who must certify that the partner(s) has such authority.

7.34(5) A power of attorney is not needed for individuals who have been named as an authorized representative on a fiduciary return of income filed under Iowa Code section 422.14 or a tax return filed under Iowa Code chapter 450, 450A or 451.

7.34(6) A new power of attorney for a particular tax type(s) and tax period(s) revokes a prior power of attorney for that tax type(s) and tax period(s), unless the taxpayer has indicated on the power of attorney form that a prior power of attorney is to remain in effect. For a previously designated representative to remain as the taxpayer's representative when a subsequent power of attorney form is filed, a taxpayer must attach a copy of the previously submitted power of attorney form which designates the representative that the taxpayer wishes to retain. To revoke a designated power of attorney without appointing a new power of attorney, see 7.34(7).

EXAMPLE A. A taxpayer executes a power of attorney for the taxpayer's accountant to represent the taxpayer during an audit of the taxpayer's books and records. After the department issues a notice of assessment, the taxpayer wishes to have the taxpayer's attorney-at-law as an authorized representative in addition to the taxpayer's accountant. The taxpayer may use one of two options to designate the accountant and the attorney-at-law as the taxpayer's representatives: (1) the taxpayer may complete and submit to the department a new power of attorney, Form IA2848 or federal Form 2848, designating both the accountant and the attorney-at-law as the taxpayer's authorized representatives. By submitting a new power of attorney form, the prior power of attorney designations are revoked, leaving only the subsequent new power of attorney form effective; or (2) the taxpayer may properly complete a new power of attorney form by including the designated attorney-at-law's name, address, PTIN, FEIN or SSN, tax type(s) and tax period(s) on the first page and checking the appropriate box on page 2 of Form IA2848 or page 2 of federal Form 2848. In addition, to retain the accountant as the taxpayer's representative, the taxpayer must also attach to the new completed power of attorney form a copy of the previously submitted power of attorney form designating the accountant as the taxpayer's representative.

EXAMPLE B. Same factual scenario as in Example A applies; however, the taxpayer seeks to use power of attorney Form IA14-101 (a form that preceded the current Form IA2848). In this situation, the taxpayer must attach a statement to the completed Form IA14-101. The statement must state that the previously designated accountant is to be retained and the attorney-at-law is to be added. Such notification must also include the names, PTIN, SSN or FEIN of all the parties, addresses, tax types(s) and tax period(s) of representation.

EXAMPLE C. A taxpayer wishes to designate an additional power of attorney and retain a prior power of attorney. However, the taxpayer does not wish to utilize an IA2848 or federal 2848 form. In this situation, the taxpayer must send written notification to the department designating the new power of attorney's name, address, PTIN, SSN or FEIN, the tax type(s), the tax period(s) of representation and the name, address, and PTIN, SSN or FEIN of the previously designated power of attorney that the taxpayer seeks to retain for that tax period.

In each of the foregoing examples, the original power of attorney will continue to automatically receive the notices concerning the specified tax matter, unless such authority is explicitly revoked by the taxpayer. Also see subrule 7.34(13) regarding notices.

7.34(7) A taxpayer may revoke a power of attorney without authorizing a new representative by filing a statement of revocation with the department. The statement of revocation must indicate that the authority of the previous power of attorney is revoked and must be signed by the taxpayer. Also, the name and address of each representative whose authority is revoked must be listed (or a copy of the power of attorney must be attached).

7.34(8) A representative may withdraw from representation in a matter in which a power of attorney has been filed by filing a statement with the department. The statement must be signed by the representative and must identify the name and address of the taxpayer(s) and the matter(s) from which the representative is withdrawing.

7.34(9) A properly completed Iowa power of attorney, Form IA14-101 or IA2848, or properly designated federal form as described in this subrule, satisfies the requirements of this rule.

In addition to the Iowa power of attorney, Form IA2848 or IA14-101, the department can accept Internal Revenue Service Form 2848, if references to the "Internal Revenue Service" are crossed out

and "Iowa Department of Revenue" is inserted in lieu thereof, as long as such a form contains specific designation by the taxpayer for the state-related taxes at issue. Designation must include, but is not limited to, name, address, PTIN, SSN or FEIN of the representative, the tax type(s) and tax period(s). In addition, the department will accept any other document which satisfies the requirements of this rule.

7.34(10) The department will not recognize as a valid power of attorney a power of attorney form attached to a tax return filed with the department except in the instance of a form attached to a fiduciary return of income form, inheritance tax return, generation skipping tax return, or estate tax return.

7.34(11) The department will accept either the original, an electronically scanned and transmitted power of attorney form, or a copy of a power of attorney. A copy of a power of attorney received by facsimile transmission (fax) will be accepted. All copies, facsimiles and electronically scanned and transmitted power of attorney forms must include a valid signature of the taxpayer to be represented.

7.34(12) If an individual desires to represent a taxpayer through correspondence with the department, the individual must submit a power of attorney even though no personal appearance is contemplated.

7.34(13) Any notice or other written communication (or copy thereof) required or permitted to be given to the taxpayer in any matter before the department must be given to the taxpayer and, unless restricted by the taxpayer, to the taxpayer's first designated power of attorney who is representing the taxpayer for the tax type(s) and tax period(s) contained in the notice. Due to limitations of the department's automated systems, it is the general practice of the department to limit distribution of copies of documents by the department to the taxpayer's first designated power of attorney. Determination of the first designated power of attorney will be based on the earliest execution date of the power of attorney and the first name designated on a power of attorney form listing more than one designated representative.

7.34(14) Information from power of attorney forms, including the representative's PTIN, SSN or FEIN, is utilized by department personnel to:

a. Determine whether a representative is authorized to receive or inspect confidential tax information;

b. Determine whether the representative is authorized to perform the acts set forth in subrule 7.34(1);

c. Send copies of computer-generated notices and communications to the representative as authorized by the taxpayer; and

d. Ensure that the taxpayer's representative receives all notices and communications authorized by the taxpayer, but notices and communications are not sent to a representative with the same or similar name.

7.34(15) Procedure for waiver. Any person who believes that the application of this rule would result in hardship or injustice to that person may petition the department for a waiver in the manner set out in Section II of the governor's Executive Order Number 11, issued September 13, 1999, until superceded by a uniform departmental waiver rule.

This rule is intended to implement Iowa Code section 421.60.

701—7.35(421) Taxpayer designation of tax type and period to which voluntary payments are to be applied.

7.35(1) A taxpayer may designate in separate written instructions accompanying the payment the type of tax and tax periods to which any voluntary payment is to be applied. The taxpayer may not designate the application of payments which are the result of enforced collection.

7.35(2) Enforced collection includes, but is not limited to garnishment of wages, bank accounts, or payments due the taxpayer, or seizure of assets.

This rule is intended to implement Iowa Code section 421.60.

DIVISION II
INFORMAL, FORMAL, ADMINISTRATIVE AND JUDICIAL REVIEW PROCEDURES
APPLICABLE TO CONTESTED CASES AND OTHER PROCEEDINGS

COMMENCED ON OR AFTER JULY 1, 1999

701—7.36(421,17A) Applicability and scope of rules. Effective July 1, 1999, the rules contained in this division pertain to practice and procedure and are designed to implement the requirements of the Act, and aid in the effective and efficient administration and enforcement of the tax laws of this state and other activities of the department. These rules shall govern the practice, procedure and conduct of the informal proceedings, contested case proceedings, licensing, rule making, and declaratory orders involving taxation and other areas within the department's jurisdiction which includes the following:

1. Sales tax—Iowa Code sections 422.42 to 422.59;
2. Use tax—Iowa Code chapter 423;
3. Individual and fiduciary income tax—Iowa Code sections 422.4 to 422.31 and 422.110 to 422.112;
4. Franchise tax—Iowa Code sections 422.60 to 422.66;
5. Corporate income tax—Iowa Code sections 422.32 to 422.41 and 422.110 to 422.112;
6. Withholding tax—Iowa Code sections 422.16 and 422.17;
7. Estimated tax—Iowa Code sections 422.16, 422.17 and 422.85 to 422.92;
8. Motor fuel tax—Iowa Code chapter 452A;
9. Property tax—Iowa Code chapters 421, 425, 426A, 427, 427A, 428, 428A and 433 to 441;
10. Cigarette and tobacco tax—Iowa Code chapters 421B and 453A;
11. Inheritance, generation skipping transfer, and estate tax—Iowa Code chapters 450, 450A, 450B and 451;
12. Local option taxes—Iowa Code chapter 422B;
13. Hotel and motel tax—Iowa Code chapter 422A;
14. Drug excise tax—Iowa Code chapter 453B;
15. Automobile rental excise tax—Iowa Code chapter 422C;
16. Environmental protection charge—Iowa Code chapter 424;
17. Replacement taxes—Iowa Code chapter 437A;
18. Statewide property tax—Iowa Code chapter 437A;
19. Set-off procedures—Iowa Code section 421.17(29);
20. Other taxes and activities as may be assigned to the department from time to time; and
21. The Taxpayer's Bill of Rights—Iowa Code section 421.60.

As the purpose of these rules is to facilitate business and advance justice, any rule contained herein, pursuant to statutory authority, may be suspended or waived by the department to prevent undue hardship in any particular instance or to prevent surprise or injustice.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202.

701—7.37(421,17A) Definitions. These definitions apply to the rules contained in Division II, unless the text otherwise states to the contrary:

"Act" means the Iowa administrative procedure Act.

"Affiliate or subsidiary of an entity dominant in its field of operation" means an entity which is at least 20 percent owned by an entity that is dominant in its field of operation, or by a partner, officer, director, majority stockholder or the equivalent, of an entity dominant in that field of operation.

"Agency" means each board, commission, department, officer, or other administrative office or unit of the state.

"Contested case" means a proceeding, including licensing, in which the legal rights, duties or privileges of a party are required by constitution or statute to be determined by an agency after an opportunity for an evidentiary hearing. This term also includes any matter defined as a no factual dispute contested case under 1998 Iowa Acts, chapter 1202, section 14.

"Declaratory order" is an order issued pursuant to 1998 Iowa Acts, chapter 1202, section 13.

"Department" means the Iowa department of revenue.

"Department of inspections and appeals" means the state department created by Iowa Code chapter 10A.

"Director" means the director of the department or the director's authorized representative.

"Division of administrative hearings" means the division of the department of inspections and appeals responsible for holding contested case proceedings pursuant to Iowa Code chapter 10A.

"Dominant in its field of operation" means having more than 20 full-time equivalent positions and more than $1 million in annual gross revenues.

"Intervene" means to file a petition with the department requesting that the petitioner be allowed to intervene in the processing of a declaratory order currently under the department's consideration.

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

"License" means the whole or a part of any permit, certificate, approval, registration, charter, or similar form of permission required by statute.

"Licensing" means the department process respecting the grant, denial, renewal, revocation, suspension, annulment, withdrawal, or amendment of a license.

"Motion" has the same meaning as the term is defined in Iowa R. Civ. P. 1.431.

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

"Person" means any individual; estate; trust; fiduciary; partnership, including limited liability partnership; corporation, including limited liability corporation; association; governmental subdivision; or public or private organization of any character or any other person covered by the Act other than an agency.

"Petition" means application for declaratory order, request to intervene in a declaratory order under consideration, application for initiation of proceedings to adopt, amend or repeal a rule or document filed in licensing.

"Pleadings" means protest, answer, reply or other similar document filed in a contested case proceeding, including contested cases involving no factual dispute.

"Presiding officer" means the person designated to preside over a proceeding involving the department. A presiding officer of a contested case involving the department will be either the director or a qualified administrative law judge appointed, pursuant to Iowa Code chapter 17A, by the division of administrative hearings established pursuant to 1998 Iowa Acts, chapter 1202, section 3. In cases in which the department is not a party, at the director's discretion, the presiding officer may be the director or the director's designee. A presiding officer of an administrative appeal is the director of the department.

"Proceeding" means informal, formal and contested case proceedings.

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

"Protester" means any person entitled to file a protest which can culminate in a contested case proceeding.

"Provision of law" means the whole or part of the Constitution of the United States of America or the Constitution of the State of Iowa, or of any federal or state statute, court rule, executive order of the governor, or rule of the department.

"Review unit" means the unit composed of department employees designated by the director and the attorney general's staff who have been assigned by the director to review protests filed by taxpayers.

"Rule" means a statement by the department of general applicability that implements, interprets, or prescribes law or policy, or that describes the organization, procedure, or practice requirements of the department. Notwithstanding any other statute, the term includes an executive order or directive of the governor which creates an agency or establishes a program or which transfers a program between agencies established by statute or rule. The term includes the amendment or repeal of an existing rule, but does not include the excluded items set forth in Iowa Code section 17A.2(10).

"Small business" means any entity including, but not limited to, an individual, partnership, corporation, joint venture, association, or cooperative. A "small business" is not an affiliate of an entity

dominant in its field or operation. A small business has either 20 or fewer full-time equivalent positions or less than $1 million in annual gross revenues in the preceding fiscal year.

Unless otherwise specifically stated, the terms used in these rules promulgated by the department shall have the meanings defined by the Act.

This rule is intended to implement Iowa Code chapter 17A and Iowa Code section 421.14.

701—7.38(421,17A) Applicability of rules set forth in Division I of Chapter 7. Many of the rules governing informal, administrative and judicial review proceedings were not required to be changed by 1998 Iowa Acts, chapter 1202. Accordingly, the following rules are incorporated by reference into this division and will govern their respective topics in relation to proceedings under this division:

701—7.4(17A) Computation of time, filing of documents;

701—7.5(17A) Form and style of papers;

701—7.7(17A) Resolution of tax liability;

701—7.18(17A) Interventions;

701—7.27(9C,91C) Procedure for nonlocal business entity bond forfeitures;

701—7.30(421) Definitions which apply to rule 701—7.31(421) to 701—7.35(421);

701—7.31(421) Abatement of unpaid tax;

701—7.32(421) Time and place of taxpayer interviews;

701—7.33(421) Mailing to the last-known address;

701—7.34(421) Power of attorney; and

701—7.35(421) Taxpayer designation of tax type and period to which voluntary payments are to be applied.

701—7.39(17A) Business hours. The principal office of the department in the Hoover State Office Building in Des Moines, Iowa, shall be open between the hours of 8 a.m. and 4:30 p.m. each weekday except Saturdays, Sundays and legal holidays as prescribed in Iowa Code section 4.1(34), for the purpose of receiving protests, pleadings, petitions, motions, requests for public information, copies of official documents, or for the opportunity to inspect public records.

All documents or papers required to be filed with the department by these rules shall be filed with the designated clerk of the hearings section in the principal office of the department in the Hoover State Office Building, Des Moines, Iowa 50319. Requests for public information or copies of official documents or the opportunity to inspect public records shall be made in the director's office at the department's principal office.

All documents or papers filed with an administrative law judge appointed by the division of administrative hearings to be a presiding officer shall be filed with the Department of Inspections and Appeals, Division of Administrative Hearings, Third Floor, Lucas State Office Building, Des Moines, Iowa 50319.

701—7.40(17A) Persons authorized to represent themselves or others. Due to the complex questions involved and the technical aspects of taxation, persons are encouraged to seek the aid, advice, assistance and counsel of practicing attorneys and certified public accountants.

The right to represent one's self or others in connection with any proceeding before the department or administrative hearings division shall be limited to the following classes of persons:

1. Taxpayers who are natural persons representing themselves;
2. Attorneys duly qualified and entitled to practice in the courts of the state of Iowa;
3. Attorneys who are entitled to practice before the highest court of record of any other state and who have complied with Iowa Ct. R. 31.14;
4. Accountants who are authorized, permitted, or licensed under Iowa Code chapter 542C;
5. Duly authorized directors or officers of corporations representing the corporation of which they are respectively a director or officer, excluding attorneys who are acting in the capacity of a director or officer of a corporation and who have not met the requirements of the third classification above;
6. Partners representing their partnership;

7. Fiduciaries;
8. Government officials authorized by law; or
9. Enrolled agents, currently enrolled under 31 CFR §10.6 for practice before the Internal Revenue Service, representing a taxpayer in proceedings under division II of Iowa Code chapter 422.

No person who has served as an official or employee of the department shall within a period of two years after the termination of such service or employment appear before the department or receive compensation for any services rendered on behalf of any person, firm, corporation, or association in relation to any case, proceeding, or application with respect to which the person was directly concerned and in which the person personally participated during the period of service or employment.

Any person appearing in any proceeding involving the department, regardless of whether the department is a party, must have on file with the department a valid Iowa power of attorney.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202.

701—7.41(17A) Protest. Any person wishing to contest an assessment, denial of refund claim, or any other department action, except licensing, which may culminate in a contested case proceeding shall file a protest, in writing, with the department within the time prescribed by the applicable statute or rule for filing notice of application to the director for a hearing. The protest must be either delivered to the department by electronic means, United States Postal Service or a common carrier, by ordinary, certified, or registered mail, directed to the attention of the clerk of the hearings section for the department, personally delivered to the clerk of the hearings section for the department, or be served on the clerk of the hearings section for the department by personal service during business hours. For the purpose of mailing, a protest is considered filed on the date of the postmark. If a postmark date is not present on the mailed article, then the date of receipt of protest will be considered the date of mailing. Any document, including a protest, is considered filed the date personal service or personal delivery to the office of the clerk of the hearings section for the department is made. See Iowa Code section 622.105 for the evidence necessary to establish proof of mailing.

The period for appealing department action relating to refund claims is the same statutory period for contesting an assessment. Failure to timely file a written protest will be construed as a waiver of opposition to the matter involved unless, on the director's own motion, pursuant to statutory authority, the powers of abatement or settlement are exercised. The review unit, created within the department by the director to review protests as provided in 701—7.44(17A), may seek dismissal of protests which are not in the proper form as provided by this rule. See subrule 7.44(2) for dismissals.

If the department has not granted or denied a filed refund claim within six months of filing the claim, the refund claimant may file a protest. Even though a protest is so filed, the department is entitled to examine and inspect the refund claimant's records to verify the refund claim.

Notwithstanding the above, the taxpayer who fails to timely protest an assessment may contest the assessment by paying the whole assessed tax, interest, and penalty and by filing a refund claim within the time period provided by law for filing such claim. However, in the event that such assessment involves divisible taxes, which are not timely protested, namely, an assessment which is divisible into a tax on each transaction or event, the taxpayer can contest the assessment by paying a portion of the assessment and filing a refund claim within the time period provided by law. In this latter instance, the portion paid must represent any undisputed portion of the assessment and must also represent the liability on a transaction or event for which, if the taxpayer is successful in contesting the portion paid, the unpaid portion of the assessment would be canceled. *Flora v. United States,* 362 U.S. 145, 4 L.Ed. 2d 623, 80 S.Ct. 630 (1960); *Higginbotham v. United States,* 556 F.2d 1173 (4th Cir. 1977); *Steele v. United States,* 280 F.2d 89 (8th Cir. 1960); *Stern v. United States,* 563 F.Supp. 484 (D. Nev. 1983); *Drake v. United States,* 355 F. Supp. 710 (E.D. Mo. 1973). Any such protest filed is limited to the issues covered by the amounts paid for which a refund was requested and denied by the department. Thereafter, if the department does not grant or deny the refund within six months of the filing of the refund claim or if the department denies the refund, the taxpayer may file a protest as authorized by this rule.

All of the taxes administered and collected by the department can be divisible taxes, except individual income tax, fiduciary income tax, corporation income tax, franchise tax, and statewide property tax. The following noninclusive examples illustrate the application of the divisible tax concept.

EXAMPLE A. X is assessed withholding income taxes, penalty and interest, as a responsible party on eight employees. X fails to timely protest the assessment. X contends that X is not a responsible party. If X is a responsible party, X was required to make monthly deposits of the withholding taxes. In this situation, the withholding taxes are divisible. Therefore, X can pay an amount of tax, penalty and interest attributable to one employee for one month and file a refund claim within the time period provided by law since if X is successful on the refund claim the remaining unpaid portion of the assessment would be canceled.

EXAMPLE B. Y is assessed sales tax, interest, and penalty for electricity purchased and used to power a piece of machinery in Y's manufacturing plant. Y fails to timely protest the assessment. Y was billed monthly for electricity by the power company to whom Y had given an exemption certificate. Y contends that the particular piece of machinery is used directly in processing tangible personal property for sale and that, therefore, all of the electricity is exempt from sales tax. In this situation, the sales tax is divisible. Therefore, Y can pay an amount of tax, penalty and interest attributable to one month's electrical usage in that machinery and file a refund claim within the time period provided by law since if Y is successful on the refund claim the remaining unpaid portion of the assessment would be canceled.

The protest shall be brought by and in the name of the interested or affected person or by and in the full descriptive name of the fiduciary legally entitled to institute a proceeding on behalf of the person or by an intervenor in contested case proceedings. In the event of a variance in the name set forth in the protest and the correct name, a statement of the reason for the discrepancy shall be set forth in the protest. A protest which is filed shall contain:

7.41(1) A caption in the following form:

BEFORE THE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF _____ (state taxpayer's name and address and designate type of proceeding, e.g., income tax refund claim).	}	PROTEST DOCKET NO._____ (filled in by department)

7.41(2) Substantially state in separate numbered paragraphs the following:

a. Proper allegations showing:

(1) Date of assessment;

(2) Date of refund denial;

(3) Whether the protester failed to timely appeal the assessment and, if so, the date of payment and the date of filing the refund claim;

(4) Whether the protest involves the appeal of a refund claim after six months from the date of filing the refund claim because the department failed to deny the claim;

(5) Attach a copy of the assessment, refund claim, and refund denial;

(6) Other items that the protester wishes to bring to the attention of the department; and

(7) Request for attorney fees, if applicable.

b. The type of tax, the taxable period or periods involved and the amount in controversy;

c. Each error alleged to have been committed listed in a separate paragraph. For each error listed, provide an explanation of the error and all relevant facts related to the error;

d. Reference to any particular statute or statutes and any rule or rules involved, if known;

e. Description of records or documents which were not available or were not presented to department personnel prior to the filing of the protest, if any, and provide copies of any records or documents that were not previously presented to the department;

f. Any other matters deemed relevant and not covered in the above paragraphs;

g. The desire of protester to waive informal or contested case proceedings if it is desired; unless the protester so indicates a waiver, informal procedures will be initiated;

h. A statement setting forth the relief sought by the protester;

i. The signature of the protester or that of the protester's representative, the addresses of the protester and of the protester's representative, and the telephone number of the protester or the protester's representative; and

j. Attach a copy of power of attorney for protester's representative.

Upon receipt of the protest, the clerk of the hearings section for the department shall register the receipt of the protest, docket the protest, and shall assign a number to the case. The assigned number shall be placed on all subsequent pleadings filed in the case. An original and two copies of the protest shall be filed with the clerk of the hearings section of the department.

The protester may amend the protest at any time prior to the commencement of the evidentiary hearing. The department can request that protester amend the protest for purposes of clarification.

Upon the filing of an answer or if a demand for contested case is made by the protester, the clerk of the hearings section of the department will transfer the protest file to the division of administrative hearings established by 1998 Iowa Acts, chapter 1202, section 3, within 30 days of the date of the filing of the answer or the demand for contested case, unless the director determines not to transfer the case. If a party objects to a determination under 701—7.50(17A), the transfer, if any, would be made after the director makes a ruling on the objection.

7.41(3) Denial of renewal of vehicle registration or denial of issuance or renewal, or suspension, of a driver's license. A person who has had an application for renewal of vehicle registration denied or has been denied the issuance of a driver's license or the renewal of a driver's license, or has had a driver's license suspended may file a protest with the clerk of the hearings section for the department if the denial of the issuance or renewal or the suspension is because the person owes delinquent taxes.

The issues raised in a protest by the person, which are limited to a mistake of fact, may include but are not limited to:

1. The person has the same name as the obligor but is not the correct person;
2. The amount in question has been paid; or
3. The person has made arrangements with the department to pay the amount.

701—7.42(17A) Identifying details. Any person may file a motion to delete identifying details concerning the person from any document relating to any proceedings as defined in rule 701—7.37(17A) prior to disclosure to members of the public. Such a motion must be filed with the clerk of the hearings section for the department if the motion is filed prior to the commencement of a contested case, which is before the Notice for Hearing is issued. If the motion is filed during a contested case proceeding pending before an administrative law judge and before the administrative law judge has entered a proposed decision on the case or has entered a closing order, the motion must be filed with and ruled upon by the administrative law judge. Otherwise, the motion must be filed with the clerk of the hearings section and ruled upon by the director. The motion shall be filed simultaneously with the presentation of the privacy or trade secret information under circumstances whereby the information may be disclosed to the public and before the issuance of any opinion, order or decision.

If the motion concerns information which is not a part of a contested case, the motion shall be in the form of a request to delete identifying details; if part of a contested case, the motion shall be in the form of a motion to delete identifying details. All motions to delete shall conform to subrule 7.50(4). The motion or request shall contain the following:

1. The name of the person requesting deletion and the docket number of the proceeding, if applicable;
2. The legal basis for the request for deletion, which is either that the material would be a clearly unwarranted invasion of personal privacy or the material is a trade secret. A corporation may not claim an unwarranted invasion of privacy;
3. A precise description of the document, report, or other material in the possession of the department from which the deletion is sought, and a precise description of the information to be deleted.

If deletion is sought from more than one document, each document and the materials sought to be deleted from it shall be listed in separate paragraphs. Also contained in each separate paragraph shall be a statement of the legal basis for the deletion requested in that paragraph, which is that the material sought to be deleted is a clearly unwarranted invasion of privacy or is a trade secret and the material serves no public purpose;

4. An affidavit in support of deletion must accompany each motion or request. The affidavit must be sworn to by a person familiar with the facts asserted within it and shall contain a clear and concise explanation of the facts justifying deletion, not merely the legal basis for deletion or conclusionary allegations;

5. All affidavits shall contain a general and truthful statement that the information sought to be deleted is not available to the public from any source or combination of sources, direct or indirect, and a general statement that the release would serve no public purpose;

6. The burden of showing that deletion is justified shall be on the movant. The burden is not carried by mere conclusionary statements or allegations, for example, that the release of the material would be a clearly unwarranted invasion of personal privacy or that the material is a trade secret;

7. In the event that the matter sought to be deleted is part of the pleadings, motions, evidence, and the record in a contested case proceeding otherwise open for public inspection, and that the matter would otherwise constitute confidential tax information shall not be grounds for deletion (1992 Op. Att'y Gen. 1.); and

8. The ruling on the motion shall be strictly limited to the facts and legal bases presented by the movant, and the ruling shall not be based upon any facts or legal bases not presented by the movant.

701—7.43(17A) Docket. The clerk of the hearings section for the department shall maintain a docket of all proceedings, and each of the proceedings shall be assigned a number. Every matter coming within the purview of these rules shall be assigned a docket number which shall be the official number for the purposes of identification. Upon receipt of a protest, petition for declaratory order or petition to initiate rule-making proceedings, the proceeding will be docketed and assigned a number, and the parties notified thereof. The number shall be placed by the parties on all papers thereafter filed in the proceeding. After the transfer of a case to the division of administrative hearings for contested case proceedings, that division may assign a docket number to the case and in that event, the docket number shall be placed by the parties on all papers thereafter filed in the proceeding.

701—7.44(17A) Informal procedures and dismissals of protests.

7.44(1) *Informal procedures.* Persons are encouraged to utilize the informal procedures provided herein so that a settlement may be reached between the parties without the necessity of initiating contested case proceedings. Therefore, unless the protester indicates a desire to waive the informal procedures in the protest or the department waives informal procedures upon notification to the protester, such informal procedures will be initiated as herein provided upon the filing of a proper protest.

a. Review unit. A review unit is created within the department and, subject to the control of the director, the unit will:

(1) Review and evaluate the validity of all protests made by taxpayers from the department action.

(2) Determine the correct amount of tax owing or refund due.

(3) Determine the best method of resolving the dispute between the protester and the department.

(4) Take further action regarding the protest, including any additions and deletions to the audit, as may be warranted by the circumstances to resolve the protest, including a request for an informal conference.

(5) Determine whether the protest complies with rule 701—7.41(17A) and request any amendments to the protest or additional information.

The review unit may concede any items contained in the protest which it determines should not be controverted by the department. If the protester has not waived informal procedures, the review unit may request the protester and the protester's representative, if any, to attend an informal conference with the review unit to explore the possibility of reaching a settlement without the necessity of initiating contested

case proceedings or of narrowing the issues presented in the protest if no settlement can be made. The review unit may request clarification of the issues from the protester or further information from the protester or third persons.

Findings dealing with the issues raised in the protest may be issued unless the issues may be more expeditiously determined in another manner or it is determined that findings are unnecessary. The protester will be notified of the decision on the issues in controversy.

Nothing herein will prevent the review unit and the protester from mutually agreeing on the manner in which the protest will be informally reviewed.

b. Settlements. If a settlement is reached during informal procedures, the clerk of the hearings section must be notified. A closing order shall be issued by the director and served upon all parties, stating that a settlement was reached by the parties and that the case is terminated.

7.44(2) *Dismissal of protests.*

a. Whether informal procedures have been waived or not, the failure of the protester to timely file a protest or to pursue the protest may be grounds for dismissal of the protest by the director or the director's designee. If the protest is so dismissed, the protester may file an application for reinstatement of the protest for good cause as provided in paragraph *"c"* of this subrule. Such application must be filed within 30 days of the date of the dismissal notice. Thereafter, the procedure in paragraph *"c"* of the subrule should be followed. If informal procedures have not been waived, the failure of the protester to present evidence or information requested by the review unit shall constitute grounds for the director or the director's designee to dismiss the protest. For purposes of this subrule, an evasive or incomplete response will be treated as a failure to present evidence or information. The failure of protester to file a protest in the format required by rule 701—7.41(17A) may be grounds for dismissal of the protest by the director or the director's designee.

b. If the department seeks to have the protest dismissed, the review unit shall file a motion to dismiss with the clerk of the hearings section for the department and serve a copy of the motion on the protester. Protester may file a resistance to the motion within 20 days of the date of service of the motion. If no resistance is so filed, the director or the director's designee shall immediately enter an order dismissing the protest. If a resistance is filed, the review unit has ten days from the date of the filing of the resistance to decide whether to withdraw its motion and so notify the clerk of the hearings section for the department and protester. If no such notice is issued by the review unit within the ten-day period, the protest file will be transferred to the division of administrative hearings, which shall issue a notice for a contested case proceeding on the motion as prescribed by rule 701—7.47(17A), except that the issue of the contested case proceeding shall be limited to the question of whether the protest shall be dismissed. Thereafter, the rules of the department pertaining to contested case proceedings shall apply in such dismissal proceedings.

c. If a motion to dismiss is filed and is unresisted, a protest so dismissed may be reinstated by the director or the director's designee for good cause as interpreted by the Iowa Supreme Court in the case of *Purethane, Inc. v. Iowa State Board of Tax Review,* 498 N.W.2d 706 (Iowa 1993) if an application for reinstatement is filed with the clerk of the hearings section for the department within 30 days of the date the protest was dismissed. The application shall set forth all reasons and facts upon which the protester relies in seeking reinstatement of the protest. The review unit shall review the application and notify the protester whether the application is granted or denied. If the review unit denies the application to reinstate the protest, the protester has 30 days from the date the application for reinstatement was denied in which to request, in writing, a formal hearing on the reinstatement. When a written request is received, the protest file will be transferred to the division of administrative hearings which shall issue a notice as prescribed in rule 701—7.47(17A), except that the issue of the contested case proceeding shall be limited to the question of whether the protest shall be reinstated. Thereafter, the rules of the department pertaining to contested case proceedings shall apply in such reinstatement proceedings.

d. Once contested case proceedings have been commenced, whether informal proceedings have been waived or not, it shall be grounds for a motion to dismiss that a protester has either failed to diligently pursue the protest or refuses to comply with requests for discovery set forth in rule 701—7.47(17A). Such a motion must be filed with the presiding officer.

e. Notwithstanding other provisions of this subrule, if the director finds that a protest is not timely filed, including a failure within a reasonable time to file a protest in proper form after notice to protester by the hearings section, the director, without the filing of a motion to dismiss, may dismiss the protest and shall notify the protester that the protest has been dismissed. With respect to a protest so dismissed, thereafter the provisions of paragraph *"c"* of this subrule shall apply.

701—7.45(17A) Answer. The department may, in lieu of findings, file an answer. When findings are issued, the department will file an answer within 30 days of receipt of written notification from protester stating disagreement with the findings. The answer shall be filed with the clerk of the hearings section for the department.

In the event that the protester does not so respond in writing to the findings issued on matters covered by subrule 7.44(1) within 30 days after being notified, the department may seek dismissal of the protest pursuant to subrule 7.44(2).

The answer of the department shall be drawn in a manner as provided by the Iowa Rules of Civil Procedure for answers filed in Iowa district courts.

Each paragraph contained in the answer shall be numbered or lettered to correspond, where possible, with the paragraphs of the protest. An original copy only of the answer shall be filed with the clerk of the hearings section for the department and shall be signed by the department's counsel or representative.

The department shall forthwith serve a copy of the answer upon the representative of record or, if there is no representative of record, then upon the protester and shall file proof of service with the clerk of the hearings section of the department at the time of filing of the answer. The department may amend its answer at any time prior to the commencement of the evidentiary hearing.

The provisions of rule 701—7.45(17A) shall be considered as a part of the informal procedures since a contested case proceeding, at the time of filing the answer, has not yet commenced. However, an answer shall be filed pursuant to this rule whether or not informal procedures have been waived by the protester or the department.

Notwithstanding the above portions of this rule, if a taxpayer makes a written demand for a contested case proceeding, as authorized by rule 701—7.47(17A), after a period of six months from the filing of a proper protest, the department shall file its answer within 30 days after receipt of the demand. If the department fails to file its answer within this 30-day period, interest shall be suspended, if the protest involves an assessment, from the time that the department was required to answer until the date that the department files its answer and, if the protest involves a refund, interest shall accrue on the refund at double the rate from the time the department was required to answer until the date that the department files its answer.

The department's answer may contain a statement setting forth whether the case should be transferred to the division of administrative hearings or the director should retain the case for hearing.

The department's answer should set forth the basis for retention of the case by the director as provided in subrule 7.50(1). If the answer fails to allege that the case should be retained by the director, the case should be transferred to the division of administrative hearings for contested case proceedings, unless the director determines on the director's own motion that the case should be retained by the director.

This rule is intended to implement Iowa Code chapter 17A and Iowa Code sections 421.14 and 421.60.

701—7.46(17A) Subpoenas. Prior to the commencement of a contested case, the department shall have the authority to subpoena books, papers, and records and shall have all other subpoena powers conferred upon it by law. Subpoenas in this case shall be issued by the director or the director's designee. Once a contested case is commenced, subpoenas must be issued by the presiding officer.

This rule is intended to implement Iowa Code chapter 17A and Iowa Code section 421.14.

701—7.47(17A) Commencement of contested case proceedings. A demand or request by the protester for the commencement of contested case proceedings must be in writing and filed with the clerk of the hearings section by electronic means, by mail via the United States Postal Service or common carrier by

ordinary, certified, or registered mail in care of the clerk of the hearings section of the department, or by personal service on the office of the clerk of the hearings section for the department during business hours. The demand or request is considered filed on the date of the postmark. If the demand or request does not indicate a postmark date, then the date of receipt or the date personal service is made is considered the date of filing. See Iowa Code section 622.105 for the evidence necessary to establish proof of mailing.

At the request of a party or the presiding officer made prior to the issuance of the hearing notice, the presiding officer shall hold a telephone conference with the parties for the purpose of selecting a mutually agreeable hearing date, which date shall be the hearing date contained in the hearing notice. The notice shall be issued within one week after the mutually agreeable hearing date is selected.

Contested case proceedings will be commenced by the presiding officer by delivery of notice by ordinary mail directed to the parties after a demand or request is made (1) by the protester and the filing of the answer, if one is required, which demand or request may include a date to be set for the hearing, or (2) upon filing of the answer, if a request or demand for contested case proceedings has not been made by the protester. The notice will be given by the presiding officer.

The presiding officer may grant a continuance of the hearing. Any change in the date of the hearing shall be set by the presiding officer. Either party may apply to the presiding officer for a specific date for the hearing. The notice shall include:

1. A statement of the time (which shall allow for a reasonable time to conduct discovery), place and nature of the hearing;
2. A statement of the legal authority and jurisdiction under which the hearing is held;
3. A reference to the particular sections of the statutes and rules involved; and
4. A short and plain statement of the matters asserted, including the issues.

After the delivery of the notice commencing the contested case proceedings, the parties may file further pleadings or amendments to pleadings as they desire. However, any pleading or amendment thereto which is filed within seven days prior to the date scheduled for the hearing or filed on the date of the hearing shall constitute good cause for the party adversely affected by the pleading or amendment to seek and obtain a continuance.

This rule is intended to implement Iowa Code sections 17A.12 and 421.8A.

701—7.48(17A) Discovery. The rules of the Supreme Court of the state of Iowa applicable in civil proceedings with respect to depositions upon oral examination or written questions; written interrogatories; production of documents or things or permission to enter upon land or other property, for inspection and other purposes; physical and mental examinations; and requests for admission shall apply to discovery procedures in contested case proceedings. Disputes concerning discovery shall be resolved by the presiding officer. If necessary a hearing shall be scheduled, with reasonable notice to the parties and upon hearing an appropriate order shall be issued by the presiding officer.

When the department relies on a witness in a contested case, whether or not a departmental employee, who has made prior statements or reports with respect to the subject matter of the witness' testimony, it shall, on request, make such statements or reports available to a party for use on cross-examination, unless those statements or reports are otherwise expressly exempt from disclosure by constitution or statute. Identifiable departmental records that are relevant to disputed material facts involved in a contested case shall, upon request, promptly be made available to the party unless the requested records are expressly exempt from disclosure by constitution or statute.

Evidence obtained in such discovery may be used in contested case proceedings if that evidence would otherwise be admissible in the contested case proceeding.

This rule is intended to implement Iowa Code chapter 17A and Iowa Code section 421.14.

701—7.49(17A) Prehearing conference. Upon the motion of the presiding officer, or upon the written request of a party, the presiding officer shall direct the parties to appear at a specified time and place before the presiding officer for a prehearing conference to consider:

1. The possibility or desirability of waiving any provisions of the Act relating to contested case proceedings by written stipulation representing an informed mutual consent;

2. The necessity or desirability of setting a new date for hearing;
3. The simplification of issues;
4. The necessity or desirability of amending the pleadings either for the purpose of clarification, amplification or limitation;
5. The possibility of agreeing to the admission of facts, documents or records not really controverted, to avoid unnecessary introduction of proof;
6. The procedure at the hearing;
7. Limiting the number of witnesses;
8. The names and identification of witnesses and the facts each party will attempt to prove at the hearing;
9. Conduct or schedule of discovery; and
10. Such other matters as may aid, expedite or simplify in the disposition of the proceeding.

Any action taken at the prehearing conference shall be recorded in an appropriate order, unless the parties enter upon a written stipulation as to such matters or agree to a statement thereof made on the record by the presiding officer.

When an order is issued at the termination of the prehearing conference, a reasonable time shall be allowed to the parties to present objections on the grounds that it does not fully or correctly embody the agreements at such conference. Thereafter, the terms of the order or modification thereof shall determine the subsequent course of the proceedings relative to matters it includes, unless modified to prevent manifest injustice.

If either party to the contested case proceeding fails to appear at the prehearing conference, fails to request a continuance, or fails to submit evidence or arguments which the party wishes to be considered in lieu of appearance, the opposing party may move for dismissal. The motion shall be made in accordance with subrule 7.50(4).

This rule is intended to implement Iowa Code section 17A.12.

701—7.50(17A) Contested case proceedings. Unless the parties to a contested case proceeding have, by written stipulation representing an informed mutual consent, waived the provisions of the Act relating to such proceedings, contested case proceedings shall be initiated and culminate in an evidentiary hearing open to the public.

Evidentiary hearings in which the presiding officer is an administrative law judge employed by the division of administrative hearings, shall be held at the location designated in the notice of evidentiary hearing. Generally, the location for evidentiary hearings in such cases will be at the principal office of the Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.

If the director retains a contested case, generally, the location for the evidentiary hearing will be at the main office of the department at the Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50309. However, the department retains the discretion to change the location of the evidentiary hearing if necessary. The location of the evidentiary hearing will be designated in the notice of hearing issued by the director.

7.50(1) *Determination of presiding officer.* If the director retains a contested case for evidentiary hearing and the department is a party, the initial presiding officer will be the director. If the department is not a party to the contested case retained by the director, the presiding officer may be the director or the director's designee. Upon determining that a case will be retained and not transferred to the division of administrative hearings, the director shall issue written notification to the parties of the determination which states the basis for retaining the case for evidentiary hearing.

The director may determine to retain a contested case for evidentiary hearing and decision upon the filing by the department of its answer under rule 701—7.45(17A). If the answer failed to allege that the case should be retained by the director and the case was transferred to the division of administrative hearings for contested case proceedings, either party may, within a reasonable time after the issuance of the hearing notice provided in rule 701—7.47(17A), make application to the director to recall and retain the case for hearing and decision. Any such application shall be served upon the assigned administrative law judge or presiding officer.

A protester may file a written objection to the director's determination to retain the case for evidentiary hearing and request that the contested case be heard by an administrative law judge or presiding officer and request a hearing on the objection. Such an objection must be filed with the clerk of the hearings section for the department within 20 days of the notice issued by the director of the director's determination to retain the case. The director may retain the case only upon a finding that one or more of the following apply:

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

b. A qualified administrative law judge is unavailable to hear the case within a reasonable time;

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

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

e. The case involves an issue or issues the resolution of which would create important precedent;

f. The case involves complex or extraordinary questions of law or fact;

g. The case involves issues or questions of law or fact that, based on the director's discretion, should be retained by the director;

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

i. The request was not timely filed;

j. The request is not consistent with a specified statute; and

k. An assignment of the administrative law judge will result in lengthening the time for issuance of a proposed decision, after the case is submitted, beyond a reasonable time as provided in subrule 7.50(7). In making this determination, the director shall consider whether the assigned administrative law judge has a current backlog of submitted cases for which decisions have not been issued for one year after submission.

The director shall issue a written ruling specifying the grounds for the decision within 20 days after a request for an administrative law judge is filed. If a party objects to the director's determination to retain a case for evidentiary hearing, transfer of the protest file, if any, will be made after the director makes a final determination on the objection. If the ruling is contingent upon the availability of a qualified administrative law judge, the parties shall be notified at least ten days prior to the hearing if a qualified administrative law judge will be available.

If there is no factual conflict or credibility of evidence offered in issue, either party, after the contested case has been heard and a proposed decision is pending with a presiding officer other than the director for at least one year, may make application to the director to transfer the case to the director for decision. In addition, if the aforementioned criteria exist, the director, on the director's own motion, may issue a notice to the parties of the director's intention to transfer the case to the director for decision. The opposing party may file, within 20 days after service of such application or notice by the director, a resistance setting forth in detail why the case should not be transferred. If the director approves the transfer of the case, the director shall issue a final contested case decision. The director or a party may request that the parties be allowed to submit proposed findings of fact and conclusions of law.

The director has the right to require that any presiding officer, other than the director, be a licensed attorney in the state of Iowa, unless the contested case only involves licensing. In addition, any presiding officer must possess, upon determination by the director, sufficient technical expertise and experience in the areas of taxation and presiding over proceedings to effectively determine the issues involved in the proceeding.

Except as provided otherwise by another provision of law, all rulings by an administrative law judge acting as presiding officer are subject to appeal to the director.

7.50(2) *Conduct of proceedings.* A proceeding shall be conducted by a presiding officer who, among other things, shall:

a. Open the record and receive appearances;

b. Administer oaths and issue subpoenas;

c. Enter the notice of hearing into the record;

d. Receive testimony and exhibits presented by the parties;

e. In the presiding officer's discretion, interrogate witnesses;
f. Rule on objections and motions;
g. Close the hearing; and
h. Issue an order containing findings of fact and conclusions of law.

The presiding officer may resolve preliminary procedural motions by telephone conference in which all parties have an opportunity to participate. Other telephone proceedings may be held with the consent of all parties. The presiding officer will determine the location of the parties and witnesses for telephone hearing. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when location is chosen. Parties shall be notified at least 30 days in advance of the date and place of the hearing.

Evidentiary proceedings shall be oral and open to the public and shall be recorded either by mechanical means or by certified shorthand reporters. Parties requesting that the hearing be recorded by certified shorthand reporters shall bear the appropriate costs. The record of the oral proceedings or the transcription thereof, shall be filed with and maintained by the department for at least five years from the date of the decision. An opportunity shall be afforded to the parties to respond and present evidence and argument on all issues involved and to be represented by counsel at their own expense. Unless otherwise directed by the presiding officer, evidence will be received in the following order: (1) protester, (2) intervenor (if applicable), (3) department, (4) rebuttal by protester, (5) oral argument by parties (if necessary).

If the protester or the department appears without counsel or other representative who can reasonably be expected to be familiar with these rules, the presiding officer shall explain to the parties the rules of practice and procedure and generally conduct a hearing in a less formal manner than that used when the parties have such representatives appearing upon their behalf. It should be the purpose of the presiding officer to assist any party appearing without such representative to the extent necessary to allow the party to fairly present evidence, testimony, and arguments on the issues. The presiding officer shall take whatever steps may be necessary and proper to ensure that all evidence having probative value is presented and that each party is accorded a fair hearing.

If the parties have mutually agreed to waive the provisions of the Act in regard to contested case proceedings, the hearing will be conducted in a less formal manner than when an evidentiary hearing is conducted.

If a party fails to appear in a contested case proceeding after proper service of notice, the presiding officer may, upon the presiding officer's own motion or upon the motion of the party who has appeared, adjourn the hearing, enter a default decision, or proceed with the hearing and make a decision on the merits in the absence of the party.

Contemptuous conduct by any person appearing at a hearing shall be grounds for the person's exclusion from the hearing by the presiding officer.

A stipulation by the parties of the issues or a statement of the issues in the notice commencing the contested case cannot be changed by the presiding officer without the consent of the parties. The presiding officer shall not, on the presiding officer's own motion, change or modify the issues agreed upon by the parties. Notwithstanding the provisions of this paragraph, a party within a reasonable time prior to the hearing may request that a new issue be addressed in the proceedings, except that the request cannot be made after the parties have stipulated to the issues.

7.50(3) *Rules of evidence.* In evaluating evidence, the department's experience, technical competence, and specialized knowledge may be utilized.

a. Oath. All testimony presented before the presiding officer shall be given under oath which the presiding officer has authority to administer.

b. Production of evidence and testimony. The presiding officer may issue subpoenas to a party on request, as permitted by law, compelling the attendance of witnesses and the production of books, papers, records, or other real evidence.

c. Subpoena. When a subpoena is desired after the commencement of a contested case proceeding, the proper party shall indicate to the presiding officer the name of the case, the docket number and the last-known addresses of the witnesses to be called. If evidence other than oral testimony is required, each

item to be produced must be adequately described. When properly prepared by the presiding officer, the subpoena will be returned to the requesting party for service. Service may be made in any manner allowed by law before the hearing date of the case which the witness is required to attend. No costs for serving a subpoena will be allowed if it is served by any person other than the sheriff. Subpoenas requested for discovery purposes shall be issued by the presiding officer.

d. Admissibility of evidence.

(1) Evidence having probative value. Although the presiding officer is not bound to follow the technical common law rules of evidence, a finding shall be based upon the kind of evidence on which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs, and may be based upon such evidence even if it would be inadmissible in a jury trial. Therefore, the presiding officer may admit and give probative effect to evidence on which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs. Irrelevant, immaterial, or unduly repetitious evidence shall be excluded. The presiding officer shall give effect to the rules of privilege recognized by law. Evidence not provided to a requesting party through discovery shall not be admissible at the hearing. Subject to these requirements, when a hearing will be expedited and the interests of the parties will not be prejudiced, substantially any part of the evidence may be required to be submitted in verified written form by the presiding officer.

Objections to evidentiary offers may be made at the hearing and the presiding officer's ruling thereon shall be noted in the record.

(2) Evidence of a federal determination. Evidence of a federal determination whether it be a treasury department ruling, regulation or determination letter, a federal court decision or an Internal Revenue Service assessment relating to issues raised in the proceeding shall be admissible, and the protester shall be presumed to have conceded the accuracy of it unless the protester specifically states wherein it is erroneous.

(3) Copies of evidence. A copy of any book, record, paper or document may be offered directly in evidence in lieu of the original, if the original is not readily available or if there is no objection. Upon request, the parties shall be given an opportunity to compare the copy with the original, if available.

(4) Stipulations. Approval of the presiding officer is not required for stipulations of the parties to be used in contested case proceedings. In the event the parties file a stipulation in the proceedings, the stipulation shall be binding on the parties and the presiding officer.

e. Exhibits.

(1) Identification of exhibits. Exhibits attached to a stipulation or entered in evidence which are offered by protesters shall be numbered serially, i.e., 1, 2, 3, etc.; whereas, those offered by the department shall be lettered serially, i.e., A, B, C, etc.; and those offered jointly shall be numbered and lettered, i.e., 1-A, 2-B, 3-C, etc.

(2) Disposition of exhibits. After an order has become final, either party desiring the return, at the party's expense, of any exhibit belonging to the party, shall make application in writing to the clerk of the hearings section for the department within 30 days suggesting a practical manner of delivery; otherwise, exhibits may be disposed of as the clerk of the hearings section for the department deems advisable.

f. Official notice. The presiding officer may take official notice of all facts of which judicial notice may be taken. Parties shall be notified at the earliest practicable time, either before or during the hearing, or by reference in preliminary reports, preliminary decisions or otherwise, of the facts proposed to be noticed and their source, including any staff memoranda or data. The parties shall be afforded an opportunity to contest such facts prior to the issuance of the decision in the contested case proceeding unless the presiding officer determines as a part of the record or decision that fairness to the parties does not require an opportunity to contest such facts.

g. Evidence outside the record. Except as provided by these rules, the presiding officer shall not consider factual information or evidence in the determination of any proceeding unless the same shall have been offered and made a part of the record in the proceeding.

h. Presentation of evidence and testimony. In any hearing each party thereto shall have the right to present evidence and testimony of witnesses and to cross-examine any witness who testifies on behalf of an adverse party. Persons whose testimony has been submitted in written form, if available, shall also be

subject to cross-examination by an adverse party. Opportunity shall be afforded each party for re-direct examination and re-cross examination and to present evidence and testimony as rebuttal to evidence presented by another party, except that unduly repetitious evidence shall be excluded.

i. Offer of proof. An offer of proof may be made through the witness or by statement of counsel. The party objecting may cross-examine the witness without waiving any objection.

7.50(4) *Motions.* After commencement of contested case proceedings, appropriate motions may be filed by any party with the presiding officer when facts requiring such motion come to the knowledge of the party. All motions shall state the relief sought and the grounds upon which the same are based.

Motions made prior to a hearing shall be in writing and a copy thereof served on all parties and attorneys of record. Such motions shall be ruled on by the presiding officer. The presiding officer shall rule on the motion by issuing an order. A copy of the order containing the ruling on the motion shall be mailed to the parties and authorized representatives. Motions may be made orally during the course of a hearing; however, the presiding officer may request that it be reduced to writing and filed with the presiding officer.

To avoid a hearing on a motion, it is advisable to secure the consent of the opposing party prior to filing the motion. If consent of the opposing party to the motion is not obtained, a hearing on the motion may be scheduled and the parties notified. The burden will be on the party filing the motion to show good cause why the motion should be granted.

The party making the motion may affix thereto such affidavits as are deemed essential to the disposition of the motion, which shall be served with the motion and to which the opposing party may reply with counter affidavits.

a. Types of motions. Types of motions include, but are not limited to:

(1) Motion for continuance. Motions for continuance should be filed no later than ten days before the scheduled date of the contested case hearing unless the grounds for the motion are first known to the moving party within ten days of the hearing, in which case the motion shall be promptly filed and shall set forth why it could not be filed at least ten days prior to the hearing. Grounds for motion for continuance include, but are not limited to, the following:

1. Unavailability of a party, a party's representative or a witness;
2. Incompletion of discovery; and
3. Possibility of settlement of the case.

(2) Motion for dismissal;

(3) Motion for summary judgment;

(4) Motion to delete identifying details in the decision;

(5) Motion for default; and

(6) Motion to vacate default.

b. Hearing on motions. Motions subsequent to the commencement of a contested case proceeding shall be determined by the presiding officer.

c. Summary judgment procedure. Summary judgment may be obtained under the following conditions and circumstances:

(1) A party may, after a reasonable time to complete discovery, after completion of discovery, or by agreement of the parties, move with or without supporting affidavits for a summary judgment in the party's favor upon all or any part of a party's claim or defense.

(2) The motion shall be filed not less than 45 days prior to the date the case is set for hearing, unless otherwise ordered by the presiding officer. Any party resisting the motion shall file within 30 days from the time of service of the motion a resistance; statement of disputed facts, if any; and memorandum of authorities supporting the resistance. If affidavits supporting the resistance are filed, they must be filed with the resistance. The time fixed for hearing or normal submission on the motion shall be not less than 35 days after the filing of the motion, unless another time is ordered by the presiding officer. The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

(3) Upon any motion for summary judgment pursuant to this rule, there shall be affixed to the motion a separate, short, and concise statement of the material facts as to which the moving party contends there is no genuine issue to be tried, including specific reference to those parts of the pleadings, depositions, answers to interrogatories, admissions on file, and affidavits which support such contentions and a memorandum of authorities.

(4) Supporting and opposing affidavits shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein. The presiding officer may permit affidavits to be supplemented or opposed by depositions, answers to interrogatories, further affidavits, or oral testimony. When a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of the party's pleading, but the party's response must set forth specific facts, by affidavits or as otherwise provided in this rule, showing that there is a genuine issue for hearing. If the party does not so respond, summary judgment, if appropriate, shall be entered against the party.

(5) If on motion under this rule judgment is not rendered upon the whole case or for all the relief asked and a hearing is necessary, the presiding officer at the hearing of the motion, by examining the pleadings and the evidence before the presiding officer and by interrogating counsel, shall, if practicable, ascertain what material facts exist without substantial controversy and what material facts are actually, and in good faith, controverted. The presiding officer shall thereupon make an order specifying the facts that appear without substantial controversy, including the extent to which the amount or other relief is not in controversy, and directing such further proceedings in the action as are just. Upon the hearing of the contested case, the facts so specified shall be deemed established, and the hearing shall be conducted accordingly.

(6) Should it appear from the affidavits of a party opposing the motion that the party cannot for reasons stated present, by affidavit, facts essential to justify the party's opposition, the presiding officer may refuse the application for judgment, may order a continuance to permit affidavits to be obtained, may order depositions be taken or discovery be completed, or may make any other order appropriate.

(7) An order on summary judgment that disposes of less than the entire case is appealable to the director at the same time that the proposed order is appealable pursuant to subrule 7.50(7).

7.50(5) *Briefs and oral argument.* At any time, upon the request of any party or in the presiding officer's discretion, the presiding officer may require the filing of briefs on any of the issues before the presiding officer prior to or at the time of hearing, or at a subsequent time. At the hearing, the parties should be prepared to make oral arguments as to the facts and law at the conclusion of the hearing if the presiding officer so directs.

An original copy only of all briefs shall be filed. Filed briefs shall conform to the requirements of 701—7.5(17A).

If the parties agree on a schedule for submission of briefs, the schedule shall be binding on the parties and the presiding officer except that, for good cause shown, the time may be extended upon application of a party.

7.50(6) *Defaults.* If a party fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

a. Where appropriate and not contrary to law, any party may move for default against a party who has failed to file a required pleading or has failed to appear after proper service.

b. A default decision or a decision rendered on the merits after a party failed to appear or participate in a contested case proceeding becomes a final department action unless, within 15 days after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided in subrule 7.50(7). A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, and such affidavit(s) must be attached to the motion.

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

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

e. "Good cause" for purposes of this rule shall have the same meaning as "good cause" as interpreted in the case of *Purethane, Inc. v. Iowa State Board of Tax Review,* 498 N.W.2d 706 (Iowa 1993).

f. A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party as provided in subrule 7.50(12).

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

h. A default decision may award any relief consistent with the request for relief by the party in whose favor the default decision is made and embraced in the contested case issues; but unless the defaulting party has appeared, it cannot exceed the relief demanded.

i. A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for a stay.

7.50(7) *Orders.* At the conclusion of the hearing, the presiding officer in the presiding officer's discretion, may request the parties to submit proposed findings of fact and conclusions of law. Upon the request of any party, the presiding officer shall allow the parties an opportunity to submit proposed findings of fact and conclusions of law. In addition to or in lieu of the filing of briefs, upon the request of all of the parties waiving any contrary contested case provisions of law or of these rules, the presiding officer shall allow the parties to submit proposed findings of fact and conclusions of law and the presiding officer may sign and adopt as the decision or proposed decision one of such proposed findings of fact and conclusions of law without any changes.

The decision in a contested case is an order which shall be in writing or stated in the record. The order shall include findings of fact prepared by the person presiding at the hearing, unless the person is unavailable, and based solely on the evidence in the record and on matters officially noticed in the record, and shall include conclusions of law. The findings of fact and conclusions of law shall be separately stated. If a party has submitted proposed findings of fact, the order shall include a ruling upon each proposed finding. Each conclusion of law shall be supported by cited authority or by a reasoned opinion. The decision must include an explanation of why the relevant evidence in the record supports each material finding of fact. If the issue of reasonable litigation costs was held in abeyance pending the outcome of the substantive issues in the contested case and the proposed order decides substantive issues in favor of protester, the proposed order shall include a notice of time and place for a hearing on the issue of whether reasonable litigation costs shall be awarded and on the issue of the amount of such award, unless the parties agree otherwise. All decisions and orders in a contested case proceeding shall be based solely on the legal bases and arguments presented by the parties. In the event that the presiding officer believes that a legal basis or argument for a decision or order exists, but has not been presented by the parties, the presiding officer shall notify the parties and give them an opportunity to file a brief that addresses such legal basis or argument.

When a motion has been made to delete identifying details in an order on the basis of personal privacy or trade secrets, the justification for such deletion or refusal to delete shall be made by the moving party and shall appear in the order.

When the director initially presides at a hearing or considers decisions on appeal from or review of a proposed decision by the presiding officer other than the director, the order becomes the final order of the department for purposes of judicial review or rehearing unless there is an appeal to or review on motion of a second agency within the time provided by statute or rule. When a presiding officer other than the director presides at the hearing, the order becomes the final order of the department for purposes

of judicial review or rehearing unless there is an appeal to or review on motion of the director within 30 days of the date of the order, or 10 days, excluding Saturdays, Sundays, and legal holidays, for a revocation order pursuant to rule 701—7.55(17A). However, if the contested case proceeding involves a question of an award of reasonable litigation costs, the proposed order on the substantive issues shall not be appealable to or reviewable by the director on the director's motion until the issuance of a proposed order on the reasonable litigation costs. If there is no such appeal or review within 30 days or 10 days, whichever is applicable, from the date of the proposed order on reasonable litigation costs, both the proposed order on the substantive issues and the proposed order on the reasonable litigation costs become the final orders of the department for purposes of judicial review or rehearing. On an appeal from, review of, or application for rehearing concerning the presiding officer's order, the director has all the power which the director would initially have had in making the decision; however, the director will only consider those issues or selected issues presented at the hearing before the presiding officer or any issues of fact or law raised independently by the presiding officer, including the propriety of and the authority for raising issues. The parties will be notified of those issues which will be considered by the director.

Notwithstanding the provisions of this rule, where a presiding officer other than the director issues an interlocutory decision or ruling which does not dispose of all the issues, except reasonable litigation costs, in the contested case proceeding, the party adversely affected by the interlocutory decision or ruling may apply to the director within 20 days (10 days for a revocation proceeding) of the date of issuance of the interlocutory decision or ruling to grant an appeal in advance of the proposed decision. The application shall be served on the parties and the presiding officer. The party opposing the application shall file any resistance within 15 days of the service of the application unless, for good cause, the director extends the time for such filing. The director, in the exercise of discretion, may grant the application on finding that such interlocutory decision or ruling involves substantial rights and will materially affect the proposed decision and that a determination of its correctness before hearing on the merits will better serve the interests of justice. The order of the director granting the appeal may be on terms setting forth the course of proceedings on appeal, including advancing the appeal for prompt submission, and the order shall stay further proceedings below. The presiding officer, at the request of the director, shall promptly forward to the director all or a portion of the file or record in the contested case proceeding.

In the event of an appeal to or review of the proposed order by the director, the administrative hearings division shall be promptly notified of the appeal or review by the director. The administrative hearings division shall, upon such notice, promptly forward the record of the contested case proceeding and all other papers associated with the case to the director.

A decision by the director may reverse or modify any finding of fact if a preponderance of the evidence will support a determination to reverse or modify such a finding of fact, or may reverse or modify any conclusion of law that the director finds to be in error.

Orders will be issued within a reasonable time after termination of the hearing. Parties shall be promptly notified of each order by delivery to them of a copy of the order by personal service, regular mail, certified mail, return receipt requested, or any other method to which the parties may agree. For example, a copy of the order can be submitted by electronic mail if both parties agree.

A cross-appeal may be taken within the 30-day period for taking an appeal to the director of revenue or in any event within 5 days after the appeal to the director is taken. If a cross-appeal is taken from a revocation order pursuant to rule 701—7.55(17A), the cross-appeal may be taken within the 10-day period for taking an appeal to the director or in any event within 5 days after the appeal to the director is taken.

Upon issuance of a closing order or the proposed decision by a presiding officer other than the director, such presiding officer no longer has jurisdiction over the contested case. Thereafter, any further proceedings associated with or related to the contested case must occur before the director.

7.50(8) *Stays.* During the pendency of judicial review of the final contested case order of the department, the party seeking judicial review may file an application for a stay with the director. The application shall set forth the reasons in detail why the applicant is entitled to a stay and shall specifically address the following four factors:

a. The extent to which the applicant is likely to prevail when the court finally disposes of the matter;

b. The extent to which the applicant will suffer irreparable injury if the stay is not granted;

c. The extent to which the grant of a stay to the applicant will substantially harm the other parties to the proceedings; and

d. The extent to which the public interest relied on by the department is sufficient to justify the department's actions in the circumstances.

The director shall consider and balance the previously mentioned four factors and may consult with department personnel and the department's representatives in the judicial review proceeding. The director shall expeditiously grant or deny the stay.

7.50(9) *Expedited cases—when applicable.* In case a protest is filed where the case is not of precedential value and the parties desire a prompt resolution of the dispute, the department and the protester may agree to have the case designated as an expedited case.

a. Agreement. The department and the protester shall execute an agreement to have the case treated as an expedited case. In this case, discovery is waived. The provisions of this agreement shall constitute a waiver of the rights set forth in Iowa Code chapter 17A for contested case proceedings. Within 30 days of written notice to the clerk of the hearings section for the department sent by the parties stating that an agreement to expedite the case has been executed, the clerk of the hearings section for the department must transfer the protest file to the division of administrative hearings.

b. Finality of decision. A decision entered in an expedited case proceeding shall not be reviewed by the director, state board of tax review, or any other court, and shall not be treated as a precedent for any other case.

c. Discontinuance of proceedings. Any time prior to a decision's being rendered, the taxpayer or the department may request that expedited case proceedings be discontinued if there are reasonable grounds to believe that the issues in dispute would be of precedential value.

d. Procedure. Upon return of an executed agreement for this procedure, the department shall within 14 days file its answer to the protest. The case shall be docketed for hearing as promptly as the presiding officer can reasonably hear the matter.

7.50(10) *Burden of proof.* The burden of proof with respect to assessments or denials of refunds in contested case proceedings is as follows:

a. The department must carry the burden of proof by clear and convincing evidence as to the issue of fraud with intent to evade tax.

b. The burden of proof is on the department for any tax periods for which the assessment was not made within six years after the return became due, excluding any extension of time for filing such return, except where the department's assessment is the result of the final disposition of a matter between the taxpayer and the Internal Revenue Service or where the taxpayer and the department signed a waiver of the statute of limitations to assess.

c. The burden of proof is on the department as to any new matter or affirmative defense raised by the department. "New matter" means an adjustment not set forth in the computation of the tax in the assessment or refund denial, as distinguished from a new reason for the assessment or refund denial. "Affirmative defense" is one resting on facts not necessary to support the taxpayer's case.

d. In all instances where the burden of proof is not expressly placed upon the department in this subrule, the burden of proof is upon the protester.

7.50(11) *Costs.* A prevailing taxpayer in a contested case proceeding related to the determination, collection, or refund of a tax, penalty, or interest may be awarded reasonable litigation costs by the department incurred subsequent to the issuance of the notice of assessment or refund denial based upon the following:

a. The reasonable expenses of expert witnesses.

b. The reasonable costs of studies, reports, and tests.

c. The reasonable fees of independent attorneys or independent accountants retained by the taxpayer. No such award is authorized for accountants or attorneys who represent themselves or who are employees of the taxpayer.

d. An award for reasonable litigation costs shall not exceed $25,000 per case.

e. No award shall be made for any portion of the proceeding which has been unreasonably protracted by the taxpayer.

f. For purposes of this subrule, "prevailing taxpayer" means a taxpayer who establishes that the position of the department in the contested case proceeding was not substantially justified and who has substantially prevailed with respect to the amount in controversy, or has substantially prevailed with respect to the most significant issue or set of issues presented. If the position of the department in issuance of the assessment or refund denial was not substantially justified and if the matter is resolved or conceded before the contested case proceeding is commenced, there cannot be an award for reasonable litigation costs.

g. The definition of "prevailing taxpayer" is taken from the definition of "prevailing party" in 26 U.S.C. §7430. Therefore, federal cases determining whether the Internal Revenue Service's position was substantially justified will be considered in the determination of whether a taxpayer is entitled to an award of reasonable litigation costs to the extent that 26 U.S.C. §7430 is consistent with Iowa Code section 421.60(4).

h. The taxpayer has the burden of establishing the unreasonableness of the department's position.

i. Once a contested case has commenced, a concession by the department of its position or a settlement of the case either prior to the evidentiary hearing or any order issued does not, per se, either authorize an award of reasonable litigation costs or preclude such award.

j. If the department relied upon information provided or action conducted by federal, state, or local officials or law enforcement agencies with respect to the tax imposed by Iowa Code chapter 453B, an award for reasonable litigation costs shall not be made in a contested case proceeding involving the determination, collection, or refund of that tax.

k. The taxpayer who seeks an award of reasonable litigation costs must specifically request such award in the protest or it will not be considered.

l. A request for an award of reasonable litigation costs shall be held in abeyance until the concession or settlement of the contested case proceeding, or the issuance of a proposed order in the contested case proceeding, unless the parties agree otherwise.

m. At the hearing held for the purpose of deciding whether an award for reasonable litigation costs should be awarded, consideration shall be given to the following points:

(1) Whether the department's position was substantially justified;

(2) Whether the protester is the prevailing taxpayer;

(3) The burden is upon protester to establish how the alleged reasonable litigation costs were incurred. This requires a detailed accounting of the nature of each cost, the amount of each cost, and to whom the cost was paid or owed;

(4) Whether alleged litigation costs are reasonable or necessary;

(5) Whether protester has met its burden of demonstrating all of these points.

7.50(12) *Interlocutory appeals.* Upon written request of a party or on the director's own motion, the director may review an interlocutory order of the presiding officer. In determining whether to do so, the director shall weigh the extent to which granting the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order by the director at the time of the review of the proposed decision of the presiding officer would provide an adequate remedy. Any request for interlocutory review must be filed within 14 days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.

Interlocutory appeals do not apply to licensing.

7.50(13) *Consolidation and severance.*

a. Consolidation. The presiding officer may consolidate any or all matters at issue in two or more contested case proceedings where:

(1) The matters at issue involve common parties or common questions of fact or law;

(2) Consolidation would expedite and simplify consideration of the issues involved; and

(3) Consolidation would not adversely affect the rights of any of the parties to those proceedings.

b. Severance. The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

Since stipulations are encouraged, it is expected and anticipated that the parties proceeding to a hearing will stipulate to evidence to the fullest extent to which complete or qualified agreement can be reached including all material facts that are not, or should not be, fairly in dispute.

Without the necessity of proceeding to an evidentiary hearing in a contested case, the parties may agree in writing to informally dispose of the case by stipulation, agreed settlement, consent order, or by another method agreed upon. If such informal disposition is utilized, the parties shall so indicate to the presiding officer that the case has been settled. Upon request, the presiding officer shall issue a closing order to reflect such a disposition. The contested case is terminated upon issuance of a closing order.

Unless otherwise precluded by law, the parties in a contested case proceeding may mutually agree to waive any provision under these sets of rules governing the contested case proceedings.

This rule is intended to implement Iowa Code sections 17A.15(3), 421.60, 422.57(1) and 452A.68.
[**ARC 9875B**, IAB 11/30/11, effective 1/4/12]

701—7.51(17A) Record and transcript. The record in a contested case shall include:

1. All pleadings, motions and rulings;
2. All evidence received or considered and all other submissions;
3. A statement of all matters officially noticed;
4. All questions and offers of proof, objections, and rulings thereon;
5. All proposed findings and exceptions;
6. All orders of the presiding officer; and
7. The order of the director on appeal or review.

Oral hearings regarding proceedings on appeal to or considered on motion of the director which are recorded by mechanical means shall not be transcribed for the record of such appeal or review unless a party, by written notice, or the director, orally or in writing, requests such transcription. Such a request must be filed with the clerk of the hearings section for the department who will be responsible for making the transcript. A transcription will be made only of that portion of the oral hearing relevant to the appeal or review, if so requested, and no objection is made by any other party to the proceeding or the director. Upon request, the department shall provide a copy of the whole or any portion of the record at cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party.

Parties who request that a hearing be recorded by certified shorthand reporters rather than by electronic means shall bear the cost of that recordation, unless otherwise provided by law.

Upon issuance of a proposed decision which leaves no issues open for further consideration or upon issuance of a closing order, the administrative hearings division shall promptly forward the record of a contested case proceeding to the director. However, the administrative hearings division may keep the tapes and any evidentiary proceeding in case a transcript of the proceeding is required and, if one is required, the administrative hearings division shall make the transcription and promptly forward the tapes and the transcription to the director.

701—7.52(17A) Rehearing. Any party to a contested case may file an application with the director for a rehearing in the contested case, stating the specific grounds therefor and the relief sought. The application must be filed within 20 days after the final order is issued. See subrule 7.50(7) as to when a proposed order becomes a final order. A copy of such application shall be timely mailed by the applicant to all parties in conformity with rule 701—7.53(17A). The director shall have 20 days from the filing of the application to grant or deny the rehearing. If the application is granted, a notice will be served on the parties stating the time and place of the rehearing. An application for rehearing shall be deemed denied if not granted by the director within 20 days after filing.

The application for rehearing which is filed shall contain a caption in the following form:

BEFORE THE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF _____ (state taxpayer's name and address and designate type of proceeding, e.g., income tax refund claim).	}	APPLICATION FOR REHEARING DOCKET NO._____

The application for rehearing shall substantially state in separate numbered paragraphs the following:

1. Clear and concise statements of the reasons for requesting a rehearing and each and every error which the party alleges to have been committed during the contested case proceedings;
2. Clear and concise statements of all relevant facts upon which the party relies;
3. Reference to any particular statute or statutes and any rule or rules involved;
4. The signature of the party or that of the party's representative, the address of the party or the party's representative, and the telephone number of the party or the party's representative.

No applications for rehearing shall be filed with or entertained by an administrative law judge.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202.

701—7.53(17A) Service. All papers or documents required by 701—Chapter 7 to be filed with the department or the presiding officer and served upon the opposing party or other person shall be served by ordinary mail unless another rule specifically refers to another method. All notices required by 701—Chapter 7 to be served on parties or persons by the department or presiding officer shall be served by ordinary mail unless another rule specifically refers to another method.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202.

701—7.54(17A) Ex parte communications and disqualification.

7.54(1) *Ex parte communication.* A party that has knowledge of a prohibited communication by any party or presiding officer should file a copy of the written prohibited communication or a written summary of the prohibited oral communication with the clerk of the hearings section for the department. The clerk of the hearings section for the department is to transfer the filed copy of the prohibited communication to the presiding officer.

a. Prohibited communications. Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the department or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating as defined in this rule, prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

b. "Ex parte" communication defined. Written, oral or other forms of communication are "ex parte" if made without notice and opportunity for all parties to participate.

c. How to avoid prohibited communications. To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate.

Notice of written communications shall be provided in compliance with rules in this division and may be supplemented by telephone, facsimile, electronic mail or other means of notification. Where permitted, oral communications may be initiated through conference telephone calls, including all parties or their representatives.

d. Joint presiding officers. Persons who jointly act as presiding officer in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

e. Advice to presiding officer. Persons may be present in deliberations or otherwise advise the presiding officer without notice or opportunity for parties to participate as long as they are not disqualified from participating in the making of a proposed or final decision under any provision of law and they comply with the rules in this division.

f. Procedural communications. Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines.

g. Disclosure of prohibited communications. A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication, shall be submitted for inclusion in the record under seal by protective order. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

h. Disclosure by presiding officer. Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

i. Sanction. The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule, including default, a decision against the offending party, censure, suspension, or revocation of the privilege to practice before the department or the administrative hearings division. Violation of ex parte communication prohibitions by department personnel or their representatives shall be reported to the clerk of the hearings section for the department for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

7.54(2) *Disqualification of a presiding officer.* Request for disqualification of a presiding officer must be filed in the form of a motion supported by an affidavit asserting an appropriate ground for disqualification. A substitute presiding officer may be appointed by the division of administrative hearings pursuant to 1998 Iowa Acts, chapter 1202, section 15, if the disqualified presiding officer is an administrative law judge. If the disqualified presiding officer is the director, the governor must appoint a substitute presiding officer.

a. Grounds for disqualification. A presiding officer or other person shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

(1) Has a personal bias or prejudice concerning a party or a representative of a party;

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

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

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

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

(6) Has a spouse or relative within the third degree of relationship that:

1. Is a party to the case, or an officer, director or trustee of a party;
2. Is a lawyer in the case;
3. Is known to have an interest that could be substantially affected by the outcome of the case; or
4. Is likely to be a material witness in the case; or

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

b. "Personally investigated" means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term "personally investigated" does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person's investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other department functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by 1998 Iowa Acts, chapter 1202, section 19(3), and these rules.

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

d. Motion asserting disqualification. If a party asserts disqualification on any appropriate ground, the party shall file a motion supported by an affidavit pursuant to 1998 Iowa Acts, chapter 1202, section 19(7). The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party. If, during the course of the hearing, a party first becomes aware of evidence of bias or other grounds for disqualification, the party may move for disqualification but must establish the grounds by the introduction of evidence into the record.

If the presiding officer determines that disqualification is appropriate, the presiding officer or other person shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal and seek a stay as provided under this division.

701—7.55(17A) Licenses.

7.55(1) *Denial of license, refusal to renew license.* When the department is required by constitution or statute to provide notice and an opportunity for an evidentiary hearing prior to the refusal or denial of a license, a notice, as prescribed in 701—7.47(17A), shall be served by the department upon the licensee or applicant. Prior to the refusal or denial of a license, the department shall give 30 days' written notice to the applicant or licensee in which to appear at a hearing to show cause why a license should not be refused or denied. In addition to the requirements of 701—7.47(17A) the notice shall contain a statement of facts or conduct and the provisions of law which warrant the denial of the license or the refusal to renew a license. If the licensee so desires, the licensee may file a petition as provided in subrule 7.55(3) with the presiding officer within 30 days prior to the hearing. The department may, in its discretion, file an answer to a petition filed by the licensee prior to the hearing. Thereafter, the rules contained in this division governing contested case proceedings shall apply.

When a licensee has made timely and sufficient application for the renewal of a license or a new license with reference to any activity of a continuing nature, the existing license does not expire until the application has been finally determined by the department, and in case the application is denied or the terms of the new license limited, until the last date for seeking judicial review of the department's order or a later date fixed by order of the department or the reviewing court. See 195—subrule 20.4(1) regarding gambling license applications.

7.55(2) *Revocation of license.* The department shall not revoke, suspend, annul or withdraw any license until written notice is served by personal service or restricted certified mail pursuant to 701—7.47(17A) within the time prescribed by the applicable statute and the licensee whose license is to be revoked, suspended, annulled or withdrawn, is given an opportunity to show at an evidentiary hearing conducted pursuant to the rules governing contested case proceedings in this chapter compliance with all lawful requirements for the retention of the license. However, in the case of the revocation, suspension, annulment, or withdrawal of a sales or use tax permit, written notice will be served pursuant to 701—7.47(17A) only if the permit holder requests that this be done following notification, by ordinary mail, of the director's intent to revoke, suspend, annul, or withdraw the permit. In addition to the requirements of 701—7.47(17A) the notice shall contain a statement of facts or conduct and the provisions of law which warrant the revocation, suspension, annulment, or withdrawal of the license. A licensee whose license may be revoked, suspended, annulled, or withdrawn, may file a petition as provided in subrule 7.55(3) with the clerk of the hearings section for the department prior to the hearing. The department may, in its discretion, file an answer to a petition filed by the licensee prior to the hearing. Thereafter, the rules contained in this division governing contested case proceedings shall apply.

Notwithstanding the above, if the department finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in an order to the licensee, summary suspension of a license shall be ordered pending proceedings for revocation as provided herein. These proceedings shall be promptly instituted and determined. When a summary suspension as provided herein is ordered, a notice of the time, place and nature of the evidentiary hearing shall be attached to the order.

7.55(3) *Petition.* When a person desires to file a petition as provided in subrules 7.55(1) and 7.55(2), the petition to be filed shall contain a caption in the following form:

BEFORE THE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF _____ (state taxpayer's name, and address and type of license).	}	PETITION DOCKET NO._____ (filled in by Department)

The petition shall substantially state in separate numbered paragraphs the following:

1. The full name and address of the petitioner;
2. Reference to the type of license and the relevant statutory authority;
3. Clear, concise and complete statements of all relevant facts showing why petitioner's license should not be revoked, refused, or denied;
4. Whether a similar license has previously been issued to or held by petitioner or revoked and if revoked the reasons therefor; and
5. The signature of the petitioner or petitioner's representative, the address of petitioner and of petitioner's representative, and the telephone number of petitioner or petitioner's representative.

701—7.56(17A) Declaratory order—in general. Any oral or written advice or opinion rendered to members of the public by department personnel not pursuant to a petition for declaratory order is not binding upon the department. However, department personnel, including field personnel, ordinarily will discuss substantive tax issues with members of the public or their representatives prior to the receipt

of a petition for a declaratory order, but such oral or written opinions or advice are not binding on the department. This should not be construed as preventing members of the public or their representatives from inquiring whether the department will issue a declaratory order on a particular question. In these cases, however, the name of the taxpayer shall be disclosed. The department will also discuss questions relating to certain procedural matters as, for example, submitting a request for a declaratory order or submitting a petition to initiate rule-making procedures. Members of the public may, of course, seek oral technical assistance from a departmental employee in regard to the proper preparation of a return or report required to be filed with the department. Such oral advice is advisory only and the department is not bound to recognize it in the examination of the return, report or records.

7.56(1) *Petition for declaratory order.* Any person may file a petition with the Clerk of the Hearings Section for the Department of Revenue, Fourth Floor, Hoover State Office Building, Des Moines, Iowa 50319, seeking a declaratory order as to the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the department. A petition is deemed filed when it is received by the clerk of the hearings section for the department. The clerk of the hearings section for the department shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the clerk of the hearings section for the department an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

DEPARTMENT OF REVENUE

Petition by (Name of Petitioner) for a Declaratory Order on (Cite provisions of law involved).	}	PETITION FOR DECLARATORY ORDER Docket No._____

The petition must provide the following information:

a. A clear and concise statement of all relevant facts on which the order is requested;

b. A citation and the relevant language of the specific statutes, rules, policies, decisions, or orders, whose applicability is questioned, and any other relevant law;

c. The questions petitioner wants answered, stated clearly and concisely;

d. The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers;

e. The reasons for requesting the declaratory order and disclosure of the petitioner's interest in the outcome;

f. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity;

g. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the questions presented in the petition;

h. Any request by petitioner for a meeting provided for by this rule; and

i. Whether the petitioner is presently under audit by the department.

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

7.56(2) *Notice of petition.* Within 15 days after receipt of a petition for a declaratory order, the clerk of the hearings section for the department shall give notice of the petition to all persons not served by the petitioner to whom notice is required by any provision of law. The clerk of the hearings section for the department may also give notice to any other persons.

7.56(3) *Intervention.*

a. Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 20 days of the filing of a petition for declaratory order, shall be allowed to intervene in a proceeding for a declaratory order.

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

c. A petition for intervention shall be filed with the Clerk of the Hearings Section for the Department of Revenue, Fourth Floor, Hoover State Office Building, Des Moines, Iowa 50319. Such a petition is deemed filed when it is received by the clerk of the hearings section for the department. The clerk of the hearings section for the department will provide the petitioner with a file-stamped copy of the petition for intervention if the petitioner provides an extra copy for this purpose. A petition for intervention must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

DEPARTMENT OF REVENUE

Petition by (Name of Original Petitioner) for a Declaratory Order on (Cite provisions of law cited in original Petition).	}	PETITION FOR INTERVENTION Docket No._____

The petition for intervention must provide the following information:

(1) Facts supporting the intervenor's standing and qualifications for intervention;

(2) The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers;

(3) Reasons for requesting intervention and disclosure of the intervenor's interest in the outcome;

(4) A statement indicating whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity;

(5) The names and addresses of any additional persons, or a description of any additional class of persons, known by the intervenor to be affected by, or interested in, the questions presented;

(6) Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding;

(7) Whether the intervenor is presently under audit by the department; and

(8) Consent of the intervenor to be bound by the declaratory order.

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

For a petition for intervention to be allowed, the petitioner must have consented to be bound by the declaratory order and the petitioner must have standing regarding the issues raised in the petition for declaratory order. The petition for intervention must not correct or raise any additional facts that are in the petition for declaratory order. To have standing, the intervenor must have a legally protectible and tangible interest at stake in the petition for declaratory order under consideration by the director for which the party wishes to petition to intervene. Black's Law Dictionary, Centennial Edition, p. 1405, citing, Guidry v. Roberts, 331 So. 44, 50 (La.App.). Based on Iowa case law, the department may refuse to entertain a petition from one whose rights will not be invaded or infringed. Bowers v. Bailey 237 Iowa 295, 21 N.W.2d 773 (1946). The department may, by rule, impose a requirement of standing upon those that seek a declaratory order at least to the extent of requiring that they be potentially aggrieved or adversely affected by the department action or failure to act. Bonfield, "The Iowa Administrative Procedure Act, Background, Construction, Applicability and Public Access to Agency Law, The Rule-making Process," 60 Iowa Law Review 731, 805 (1975). The department adopts this requirement of standing for those seeking a petition for a declaratory order and those seeking to intervene in a petition for a declaratory order.

An association or a representative group is not considered to be an entity qualifying for filing a petition requesting a declaratory order on behalf of all of the association or group members. Each member of an association may not be similarly situated or represented by the factual scenario set forth in such a petition.

If a party seeks to have an issue determined by declaratory order, but the facts are different from a petition for declaratory order that is currently under consideration by the director, the interested party should not petition as an intervenor in the petition for declaratory order currently under the director's consideration. Instead, the party should file a separate petition for a declaratory order and the petition should include all of the relevant facts. The director may deny a petition for intervention without denying the underlying petition for declaratory order that is involved.

7.56(4) *Briefs.* The petitioner or any intervenor may file a brief in support of the position urged. The department may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised in the petition.

7.56(5) *Inquiries.* Inquiries concerning the status of a declaratory order proceeding may be made to Administrator of the Compliance Division, Department of Revenue, Fourth Floor, Hoover State Office Building, Des Moines, Iowa 50319.

7.56(6) *Service and filing of petitions and other papers.*

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

b. Filing—when required. All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order, shall be filed with Clerk of the Hearings Section for the Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319. All petitions, briefs, or other papers that are required to be served upon a party shall be filed simultaneously with the department.

c. Method of service, time of filing, and proof of mailing. Method of service, time of filing, and proof of mailing shall be as provided in 701—7.41(17A) and 701—7.53(17A).

7.56(7) *Department consideration.* Upon request by petitioner in the petition, the department may schedule a brief and informal meeting between the original petitioner, all intervenors, and the department, a member of the department, or a member of the staff of the department, to discuss the questions raised. The department may solicit comments or information from any person on the questions raised. Also, comments or information on the questions raised may be submitted to the department by any person.

7.56(8) *Action on petition.*

a. Within the time allowed by 1998 Iowa Acts, chapter 1202, section 13(5), after receipt of a petition for a declaratory order, the director shall take action on the petition as required by 1998 Iowa Acts, chapter 1202, section 13(5).

b. The date of issuance of an order or of a refusal to issue an order is as defined in 701—7.37(17A).

7.56(9) *Refusal to issue order.*

a. The department shall not issue a declaratory order where prohibited by 1998 Iowa Acts, chapter 1202, section 13(1), and may refuse to issue a declaratory order on some or all questions raised for the following reasons:

(1) The petition does not substantially comply with the required form;

(2) The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the department to issue an order;

(3) The department does not have jurisdiction over the questions presented in the petition;

(4) The questions presented by the petition are also presented in a current rule making, contested case, or other department or judicial proceeding, that may definitively resolve them;

(5) The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter;

(6) The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order;

(7) There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances;

(8) The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct, in an effort to establish the effect of that conduct or to challenge a department decision already made;

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

(10) The petitioner requests the department to determine whether a statute is unconstitutional on its face; or

(11) The petition requests a declaratory order on an issue presently under investigation or audit or in rule-making proceedings or in litigation in a contested case or court proceedings.

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

c. Refusal to issue a declaratory order pursuant to this provision does not preclude the filing of a new petition that seeks to eliminate the grounds for the department's refusal to issue an order.

7.56(10) *Contents of declaratory order—effective date.* In addition to the order itself, a declaratory order must contain the date of its issuance, the name of petitioner and all intervenors, the specific statutes, rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion.

A declaratory order is effective on the date of issuance.

7.56(11) *Copies of orders.* A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

7.56(12) *Effect of a declaratory order.* A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. A declaratory order is binding on the department, the petitioner, and any intervenors. As to all other persons, a declaratory order serves only as precedent and is not binding on the department. The issuance of a declaratory order constitutes final department action on the petition. A declaratory order, once issued, will not be withdrawn at the request of the petitioner.

7.56(13) *Prejudice or no consent.* The department will not issue a declaratory order that would substantially prejudice the rights of a person who would be a necessary party and who does not consent in writing to the determination of the matter by a declaratory order proceeding.

701—7.57(17A) Department procedure for rule making.

7.57(1) The department hereby adopts and incorporates by reference the following Uniform Rules on Agency Procedure for Rule Making, which are printed in the first volume of the Iowa Administrative Code, with the additions, changes, and deletions to those rules listed below:

X.2(17A) Advice on possible rules before notice of proposed rule adoption.

X.4(1) Notice of proposed rule making—contents.

X.4(3) Copies of notices. In addition to the text of this subrule, the department adds that the payment for the subscription and the subscription term is one year.

X.5(17A) Public participation. In addition to the text of this rule, the department also adds that written submissions should be submitted to the coadministrator of the Compliance Division, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319. Also, any requests for special requirements concerning accessibility are to be made to the Clerk of the Hearings Section, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319, telephone (515)281-7081;

X.6(17A) Regulatory analysis. In addition to the text of this rule, the department also adds that small businesses or organizations of small businesses may register on the department's small business impact list by making a written application to the Administrator of the Compliance Division, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319;

X.7(17A,25B) Fiscal impact statement;

X.8(17A) Time and manner of rule adoption;

X.9(17A) Variance between adopted rule and published notice of proposed rule adoption; and

X.10(17A) Exemptions from public rule-making procedures. In addition to the text of this rule, the department also adds that exempt categories are generally limited to rules for nonsubstantive changes to a rule, such as rules for correcting grammar, spelling or punctuation in an existing or proposed rule.

X.11(17A) Concise statement of reasons. In addition to the text of this rule, the department also adds that a request for a concise statement of reasons for a rule must be submitted to the Administrator of the Compliance Division, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319.

X.12(1) Contents, style and form of rule—contents;

X.12(4) Contents, style and form—style and form;

X.14(17A) Filing of rules;

X.15(17A) Effectiveness of rules prior to publication;

X.16(17A) General statement of policy; and

X.17(17A) Review by agency of rules.

7.57(2) The department hereby states that the following cited Uniform Rules on Agency Procedure for Rule Making are not adopted by the department:

X.1(17A) Applicability;

X.3(17A) Public rule-making docket;

X.4(2) Notice of proposed rule making—incorporated by reference;

X.12(2) Contents, style, and form of rule—incorporation by reference;

X.12(3) Contents, style and form of rule—references to materials not published in full; and

X.13(17A) Agency rule-making record.

701—7.58(17A) Public inquiries on rule making and the rule-making records. The department maintains records of information obtained and all actions taken and criticisms received regarding any rule within the past five years. The department also keeps a record of the status of every rule within the rule-making procedure. Inquiries concerning the status of rule making may be made by contacting the Administrator of the Compliance Division, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319. For additional information regarding criticism of rules see 701—7.59(17A).

701—7.59(17A) Criticism of rules. The Administrator of the Compliance Division, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319, is designated as the office where interested persons may submit by electronic means or by mail criticisms, requests for waivers, or comments regarding a rule. A criticism of a specific rule must be more than a mere lack of understanding of a rule or a dislike regarding the rule. To constitute a criticism of a rule, the criticism must be in writing, indicate it is a criticism of a specific rule, and have a valid legal basis for support. All requests for waivers, comments, or criticisms received on any rule will be kept in a separate record for a period of five years by the department.

These rules are intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and Iowa Code section 421.60.

DIVISION III
WAIVER OR VARIANCE

701—7.60(78GA,HF2206) Waiver or variance of certain department rules. All discretionary rules or discretionary provisions in a rule over which the department has jurisdiction, in whole or in part, may be subject to waiver or variance. See subrules 7.60(3) and 7.60(4).

7.60(1) *Definitions.* The following terms apply to the interpretation and application of this rule:

"Discretionary rule" or *"discretionary provisions in a rule"* means rules or provisions in rules resulting from a delegation by the legislature to the department to create a binding rule to govern a given issue or area. The department is not interpreting any statutory provision of the law promulgated by the legislature in a discretionary rule. Instead, a discretionary rule is authorized by the legislature when the legislature has delegated the creation of binding rules to the department and the contents of

such rules are at the discretion of the department. A rule that contains both discretionary and interpretive provisions is deemed to be a discretionary rule to the extent of the discretionary provisions in the rule.

"Interpretive rules" or *"interpretive provisions in rules"* means rules or provisions in rules which define the meaning of a statute or other provision of law or precedent where the department does not possess the delegated authority to bind the courts to any extent with its definition.

"Waiver or variance" means an agency action which suspends, in whole or in part, the requirements or provisions of a rule as applied to an identified person on the basis of the particular circumstances of that person.

7.60(2) *Scope of rule.* This rule creates generally applicable standards and a generally applicable process for granting individual waivers or variances from the discretionary rules or discretionary provisions in rules adopted by the department in situations where no other specifically applicable law provides for waivers or variances. To the extent another more specific provision of law purports to govern the issuance of a waiver or variance from a particular rule, the more specific waiver or variance provision shall supersede this rule with respect to any waiver or variance from that rule.

The waiver or variance provisions set forth in this rule do not apply to rules over which the department does not have jurisdiction or when issuance of the waiver or variance would be inconsistent with any applicable statute, constitutional provision or other provision of law.

7.60(3) *Applicability of this rule.* This rule applies only to waiver or variance of those departmental rules that are within the exclusive rule-making authority of the department. This rule shall not apply to interpretive rules that merely interpret or construe the meaning of a statute, or other provision of law or precedent, if the department does not possess statutory authority to bind a court, to any extent, with its interpretation or construction. Thus, this waiver or variance rule applies to discretionary rules and discretionary provisions in rules, and not to interpretive rules.

The application of this rule is strictly limited to petitions for waiver or variance filed outside of a contested case proceeding. Petitions for waiver or variance from a discretionary rule or discretionary provisions in rules filed after the commencement of a contested case as provided in 701—7.47(17A) will be treated as an issue of the contested case to be determined by the presiding officer of the contested case.

7.60(4) *Authority to grant a waiver or variance.* The director may not issue a waiver or variance under this rule unless:

a. The legislature has delegated authority sufficient to justify the action; and

b. The waiver or variance is consistent with statutes and other provisions of law. No waiver or variance from any mandatory requirement imposed by statute may be granted under this rule.

7.60(5) *Criteria for waiver or variance.* The director may, in the director's sole discretion, issue an order in response to a petition, granting a waiver or variance from a discretionary rule or a discretionary provision in a rule adopted by the department, in whole or in part, as applied to the circumstances of a specified person, if the director finds that the waiver or variance is consistent with subrules 7.60(3) and 7.60(4), and if all of the following criteria are also met:

a. The waiver or variance would not prejudice the substantial legal rights of any person;

b. The rule or provisions of the rule are not specifically mandated by statute or another provision of law;

c. The application of the rule or rule provision would result in an undue hardship or injustice to the petitioner; and

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

7.60(6) *Director's discretion.* The final decision to grant or deny a waiver or variance shall be vested in the director of revenue. This decision shall be made at the sole discretion of the director based upon consideration of relevant facts.

7.60(7) *Burden of persuasion.* The burden of persuasion shall be on the petitioner to demonstrate by clear and convincing evidence that the director should exercise discretion to grant the petitioner a waiver or variance based upon the criteria contained in subrule 7.60(5).

7.60(8) *Contents of petition.* A petition for waiver or variance must be in the following format:

Iowa Department of Revenue

Name of Petitioner	*	Petition for
Address of Petitioner	*	Waiver
Type of Tax at Issue	*	Docket No._____

A petition for waiver or variance must contain all of the following, where applicable and known to the petitioner:

a. The name, address, telephone number, and case number or state identification number of the person or entity for whom a waiver or variance is being requested;

b. A description and citation of the specific rule or rule provisions from which a waiver or variance is being requested;

c. The specific waiver or variance requested, including a description of the precise scope and operative period for which the petitioner wants the waiver or variance to extend;

d. The relevant facts that the petitioner believes would justify a waiver or variance. This statement shall include a signed statement from the petitioner attesting to the accuracy of the facts represented in the petition, and a statement of reasons that the petitioner believes will justify a waiver or variance;

e. A complete history of any prior contacts between the petitioner and the department relating to the activity affected by the proposed waiver or variance, including audits, notices of assessment, refund claims, contested case hearings, or investigative reports relating to the activity within the last five years;

f. Any information known to the petitioner relating to the department's treatment of similar cases;

g. The name, address, and telephone number of any public agency or political subdivision which might be affected by the grant of a waiver or variance;

h. The name, address, and telephone number of any person or entity who would be adversely affected by the granting of the waiver or variance;

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

j. Signed releases of information authorizing persons with knowledge of relevant facts to furnish the department with information relating to the waiver or variance;

k. If the petitioner seeks to have identifying details deleted, which deletion is authorized by statute, such details must be listed with the statutory authority for the deletion; and

l. Signature by the petitioner at the conclusion of the petition attesting to the accuracy and truthfulness of the information set forth in the petition.

7.60(9) *Filing of petition.* A petition for waiver or variance must be filed with the clerk of the hearings section for the Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50309.

7.60(10) *Additional information.* Prior to issuing an order granting or denying a waiver or variance, the director may request additional information from the petitioner relating to the petition and surrounding circumstances. The director may, on the director's own motion, or at the petitioner's request, schedule a telephonic or in-person meeting between the petitioner or the petitioner's representative, or both, and the director to discuss the petition and surrounding circumstances.

7.60(11) *Notice of petition for waiver or variance.* The petitioner shall provide, within 30 days of filing the petition for waiver or variance, a notice consisting of a concise summary of the contents of the petition for waiver or variance and stating that the petition is pending. Such notice shall be mailed by the petitioner to all persons entitled to such notice. Such persons to whom notice must be mailed include, but are not limited to, the director and all parties to the petition for waiver or variance, or the parties' representatives. The petitioner must then file written notice with the clerk of the hearings section for the department (address indicated above) attesting that the notice has been mailed. The names, addresses and telephone numbers of the persons to whom the notices were mailed shall be included in the filed written notice. The department has the discretion to give such notice to persons other than those persons notified by the petitioner.

7.60(12) *Ruling on a petition for waiver or variance.* An order granting or denying a waiver or variance must conform to the following:

a. An order granting or denying a waiver or variance shall be in writing and shall contain a reference to the particular person and rule or rule provision to which the order pertains, a statement of the relevant facts and reasons upon which the action is based and a description of the narrow and precise scope and operative time period of a waiver or variance, if one is issued.

b. If a petition requested the deletion of identifying details, then the order must either redact the details prior to the placement of the order in the public record file referenced in subrule 7.60(17) or set forth the grounds for denying the deletion of identifying details as requested.

c. Conditions. The director may condition the grant of a waiver or variance on any conditions which the director deems to be reasonable and appropriate in order to protect the public health, safety and welfare.

7.60(13) *Time period for waiver or variance; extension.* Unless otherwise provided, an order granting a petition for waiver or variance will be effective for 12 months from the date the order granting the waiver or variance is issued. Renewal of a granted waiver or variance is not automatic. To renew the waiver or variance beyond the 12-month period, the petitioner must file a new petition requesting a waiver or variance. The renewal petition will be governed by the provisions in this rule and must be filed prior to the expiration date of the previously issued waiver or variance or extension of waiver or variance. Even if the order granting the waiver or variance was issued in a contested case proceeding, any request for an extension shall be filed with and acted upon by the director. However, renewal petitions must request an extension of a previously issued waiver or variance. Granting the extension of the waiver or variance is at the director's sole discretion and must be based upon whether the factors set out in subrules 7.60(4) and 7.60(5) remain valid.

7.60(14) *Time for ruling.* The director shall grant or deny a petition for waiver or variance as soon as practicable but, in any event, shall do so within 120 days of its receipt, unless the petitioner agrees in writing to a later date or the director indicates in a written order that it is impracticable to issue the order within the 120-day period.

7.60(15) *When deemed denied.* Failure of the director to grant or deny a waiver or variance within the 120-day or the extended time period shall be deemed a denial of that petition.

7.60(16) *Service of orders.* Within seven days of its issuance, any order issued under this rule shall be transmitted to the petitioner or the person to whom the order pertains, and to any other person entitled to such notice by any provision of law.

7.60(17) *Record keeping.* The department is required to maintain a record of all petitions for waiver or variance and rulings granting or denying petitions for waiver or variance.

a. Petitions for waiver or variance. The department shall maintain a record of all petitions for waiver or variance available for public inspection. Such records will be indexed and filed and made available for public inspection at the clerk of the hearings section for the department at the address previously set forth in subrule 7.60(9).

b. Report of orders granting or denying a waiver or variance. All orders granting or denying a waiver or variance shall be summarized in a semiannual report to be drafted by the department and submitted to the administrative rules coordinator and the administrative rules review committee.

7.60(18) *Cancellation of waiver or variance.* A waiver or variance issued pursuant to this rule may be withdrawn, canceled, or modified if, after appropriate notice, the director issues an order finding any of the following:

a. The person who obtained the waiver or variance order withheld or misrepresented material facts relevant to the propriety or desirability of the waiver or variance; or

b. The alternative means for ensuring that public health, safety, and welfare will be adequately protected after issuance of the waiver or variance order have been demonstrated to be insufficient, and no other means exist to protect the substantial legal rights of any person; or

c. The person who obtained the waiver or variance has failed to comply with all of the conditions in the waiver or variance order.

7.60(19) *Violations.* A violation of a condition in a waiver or variance order shall be treated as a violation of the particular rule or rule provision for which the waiver or variance was granted. As a result, the recipient of a waiver or variance under this rule who violates a condition of the waiver or variance may be subject to the same remedies or penalties as a person who violates the rule or rule provision at issue.

7.60(20) *Defense.* After an order granting a waiver or variance is issued, the order shall constitute a defense, within the terms and the specific facts indicated therein, for the person to whom the order pertains in any proceeding in which the rule in question is sought to be invoked, unless subrules 7.60(18) and 7.60(19) are applicable.

7.60(21) *Hearing and appeals.* Appeals from a decision granting or denying a waiver or variance in a contested case proceeding shall be in accordance with 701—Chapter 7 governing hearings and appeals from decisions in contested cases. These appeals shall be taken within 30 days of the issuance of the ruling granting or denying the waiver or variance request, unless a different time is provided by rule or statute, such as provided in the area of license revocation (see 701—7.55(17A)).

The provisions of Iowa Code sections 17A.10 to 17A.18A and the department rules 701—Chapter 7 regarding contested case proceedings shall apply to any petition for waiver or variance of a rule or provisions in a rule filed within a contested case proceeding. A petition for waiver or variance of a rule provision in a rule outside of a contested case proceeding will not be considered under the statutes or the department's rules relating to contested case proceedings. Instead, the director's decision on the petition for waiver or variance is considered to be "other agency action."

This rule is intended to implement 2000 Iowa Acts, House File 2206.

DIVISION IV
PETITION FOR RULE MAKING

701—7.61(17A) Petition for rule making.

7.61(1) *Form of petition.* Any person or agency may file a petition for rule making at the Office of the Director, Department of Revenue, Hoover State Office Building, Fourth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319. A petition is deemed filed when it is received by the director. The department will provide the petitioner with a file-stamped copy of the petition if the petitioner provides the department an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

DEPARTMENT OF REVENUE

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

The petition must provide the following information:

a. A statement of the specific rule-making action sought by the petitioner including the text or a summary of the contents of the proposed rule or amendment to a rule and, if it is a petition to amend or repeal a rule, a citation and the relevant language to the particular portion or portions of the rule proposed to be amended or repealed.

b. A citation to any law deemed relevant to the department's authority to take the action urged or to the desirability of that action.

c. A brief summary of petitioner's arguments in support of the action urged in the petition.

d. A brief summary of any data supporting the action urged in the petition.

e. The names and addresses of other persons, or a description of any class of persons, known by the petitioner to be affected by or interested in the proposed action which is the subject of the petition.

f. Any request by petitioner for a meeting.

g. Any other matters deemed relevant that are not covered by the above requirements.

7.61(2) *Form signed and dated.* The petition must be signed and dated by the petitioner or the petitioner's representative. It must also include the name, mailing address, telephone number and, if requested, the E-mail address of the petitioner and petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.

7.61(3) *Denial by department.* The department may deny a petition because it does not substantially conform to the required form or because all the required information has not been provided.

7.61(4) *Briefs.* The petitioner may attach a brief to the petition in support of the action urged in the petition. The department may request a brief from the petitioner or from any other person concerning the substance of the petition.

7.61(5) *Status of petition.* Inquiries concerning the status of a petition for rule making may be made to the Office of the Director, Department of Revenue, Hoover State Office Building, Fourth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319.

7.61(6) *Informal meeting.* If requested by petitioner in the petition, the department may schedule an informal meeting between the petitioner and the department, or a member of the staff of the department, to discuss the petition. The department may request that the petitioner submit additional information or argument concerning the petition. The department may also solicit comments from any person on the substance of the petition. Also, comments on the substance of the petition may be submitted to the department by any person.

7.61(7) *Action required.* Within 60 days after the filing of the petition, or within an extended period as agreed to by the petitioner, the department must, in writing, either: (a) deny the petition and notify petitioner of its action and the specific grounds for the denial; or (b) grant the petition and notify petitioner that it has instituted rule-making proceedings on the subject of the petition. Petitioner shall be deemed notified of the denial of the petition or granting of the petition on the date that the department mails or delivers the required notification to petitioner.

7.61(8) *New petition.* Denial of a petition because it does not substantially conform to the required form does not preclude the filing of a new petition on the same subject when the new petition contains the required information that was the basis for the original denial.

This rule is intended to implement Iowa Code chapter 17A.

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CHAPTER 8
FORMS AND COMMUNICATIONS
[Prior to 12/17/86, Revenue Department[730]]

701—8.1(17A) Definitions. For the purposes of these rules the following definitions apply, unless the context otherwise requires:

"Communication" means any method of transfer of data, information, or money by any conduit or mechanism.

"Department" means the Iowa department of revenue.

"Director" means the director of the department of revenue.

"Form" means any overall physical arrangement and general layout of communications, using any method of communication, related to tax or other administration and prescribed by the director or otherwise required by law.

"Person" means any individual, corporation, limited liability company, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

"Return" means any form required for tax administration from any person to the department.

This rule is intended to implement Iowa Code paragraph 17A.3(1)*"b."*

701—8.2(17A) Official forms. The department and the director have developed and provide or prescribe many official forms designed to help persons exercise their rights and discharge their duties under the tax laws and rules, to explain tax laws and rules, to assist in the administration of tax laws and rules, and to assist in general financial administration. Communications with the department, for which official forms have been created, shall be carried out using those forms or approved substitutes. Each direction of every instruction contained within or accompanying official forms shall be followed, and each question within or accompanying every form shall be answered as if the instructions and forms were contained in these rules.

Copies of all official forms, instructions and communication formats may be obtained from the Iowa Department of Revenue, Policy and Communications Division, Hoover State Office Building, P.O. Box 10457, Des Moines, Iowa 50306; by telephoning (800)367-3388 or (515)281-3114 (for large orders of forms: (800)532-1531); by faxing (515)242-6040 or on the department's Web site at www.iowa.gov/tax.

8.2(1) *Nature of official forms.* Most, but not all, official forms are on paper. As prescribed by the director, communication means other than paper documents may be used for official forms.

8.2(2) *Mailing addresses.* The following post office box numbers should be used when corresponding with the department. All addresses are completed: Des Moines, Iowa 50306.

Box Number	Addressee
1792	Individual Income Tax Returns
9187	Motor Vehicle Fuel Tax Returns
10306	Deposit Unit
10411	Withholding Tax Returns
10412	Sales and Use Tax Returns
10413	Franchise Tax Returns and Estimated Payments

Box Number	Addressee
10455	Insurance Premiums Tax Household Hazardous Materials Environmental Protection Charge
10456	Compliance Division Examination Section
10457	Policy and Communications Division
10458	Field Services
10459	Property Tax Rent Reimbursement Claims
10460	Internal Services Division Technology and Information Management Division
10465	Revenue Operations Division Customer Accounts Registration Services
10466	Individual Estimated Payments
10467	Fiduciary and Inheritance Tax
10468	Corporation Income Tax Returns and Estimated Payments
10469	Property Tax
10470	Withholding—Verified Summary of Payments Report
10471	Accounts Receivable
10472	Hearings Section

This rule is intended to implement Iowa Code paragraph 17A.3(1)*"b."*
[**ARC 9875B**, IAB 11/30/11, effective 1/4/12]

701—8.3(17A) Substitution of official forms. This rule is to provide guidance for the use of other than official forms, whether they are on paper, are computer-generated, or are created using other media for communication. Approval shall be obtained prior to use of computer forms, replacement forms, reproduced forms, facsimile forms, or any other forms not provided by the department. The director reserves the right to make changes to forms when needed without prior notification to users of forms. The director also reserves the right to require use of official forms in communications with the department concerning tax administration or other matters.

8.3(1) *Types of substitute forms.* Many types of forms may, upon approval, be substituted for official forms. Descriptions of a partial list follow.

a. Reproduced forms. Reproduction (photocopy reprinting) of Iowa tax forms may be accomplished without prior approval of the department provided the following conditions are met:

(1) There is no variation from the official copy or format provided by the department, including reduction and enlargement or other format specification.

(2) Reprinting, copying, or reproduction of the form is not prohibited by another rule within this chapter.

(3) Reprinting or reproduction of the form does not vary from criteria stated elsewhere in this chapter.

b. Replacement forms. Replacement forms are forms which are produced by imagery or otherwise replicated using the department official form as a model. These forms may include facsimiles of department forms that have been modified by the addition of line enlargements, copy deletion, or any other modifications.

c. Computer-generated forms. Computer-generated forms are forms that are created in their entirety, including layout, by the computer. These forms must be a facsimile of the official form that it is meant to replace.

d. Federal forms. Federal forms, or their alternates, do not require prior approval for use provided the form is approved for federal use and Iowa tax instructions or other administrative instructions authorize or require the use of federal forms in lieu of official Iowa forms.

e. Removable media and electronic reporting. Any removable media, such as compact discs, or any electronic transmission in other than official form requires prior approval of the department. No prior approval is necessary for submission of compact discs for certain information reporting when they are submitted in accordance with the department policy. To obtain additional information regarding the submitting of magnetic tapes, diskettes or other electronic reporting, please contact the Technology and Information Management Division, P.O. Box 10460, Des Moines, Iowa 50306.

8.3(2) *Approval of substitute forms.* Prior approval of substitute forms may be obtained by writing Technology and Information Management Division, P.O. Box 10460, Des Moines, Iowa 50306; by faxing (515)242-6040; or by a PDF submission via e-mail to IDRSubForms@iowa.gov. Fax communication or PDF submissions via e-mail to the department of approval requests are acceptable in limited circumstances. Normally, approval will be granted for use of substitute forms for one year only. Those forms listed on the substitute forms checklist should be submitted for approval. If doubt exists about the need for approval of a particular substitute form, the form should be submitted for consideration.

8.3(3) *Failure to obtain required approval.* Forms filed with the department that are not official or approved may be returned at the discretion of the director.

8.3(4) *Forms that may not be reproduced.* Certain forms supplied by the department shall not be duplicated or reproduced because of special processing requirements for the forms. These forms will normally have an optical scan line with special characters or print to ensure that automated processing equipment accurately credits the proper accounts. Exceptions to allow reproduction may occur on a limited basis with the consent of the department. The requestor must demonstrate compatibility with and meet all requirements and standards of the department to ensure proper and accurate processing of the form by the department. The department, at its option, may provide an explanation as to why a form is not acceptable, but is not required to do so. Forms that may not be reproduced, except as provided for above, include department-generated accounts receivable notices.

8.3(5) *General information.* The following general information is applicable to all reproduced, replacement, or computer-generated forms:

a. Paper. Paper must be of at least equal quality to stock used by the department for official forms. Carbon-bonded paper is prohibited for all forms. Colored paper should be used for all forms substituting for official paper forms unless paper used is of the identical color of an official paper form.

b. Ink and imaging material. Black ink or black imaging material should be used in the printing or duplication of all substitute forms on paper.

c. Size. Paper forms must be the same size as the official form.

d. Legibility. All forms must have a high standard of legibility.

e. Distinctive markings and symbols. Some official forms contain distinctive symbols. These symbols must be reproduced on other than official forms.

f. Labels. Preprinted labels furnished by the department should be affixed to returns submitted to the department.

g. Accuracy of reproduction. Forms submitted for approval should be a facsimile of the official form. No variation from the official form will be allowed for forms which are identified as returns.

This rule is intended to implement Iowa Code paragraph 17A.3(1)*"b."*

[**ARC 9875B**, IAB 11/30/11, effective 1/4/12]

701—8.4(17A) Description of forms. Forms prescribed by the director can be divided into those required for the administration of various taxes and those required for administrative systems other than tax-related.

8.4(1) *Tax forms.* Taxes administered by the department that require forms are listed in the following lettered paragraphs:

a. Corporate income return systems include forms designed by the department as well as forms used in federal tax administration. Approved substitute forms may be used for returns.

b. Corporate income tax field and office audit systems, related field collections systems, and the corporate tax error resolution system have forms designed by the department. Approved substitute forms may be used.

c. Franchise tax returns include forms designed by the department as well as forms used in federal tax administration. Approved substitute forms may be used for returns.

d. Franchise audit and collection systems have forms designed by the department. Approved substitute forms may be used.

e. Corporate and franchise estimated tax systems have forms designed by the department. Approved substitute forms may be used.

f. Individual and fiduciary income returns include forms designed by the department as well as forms used in federal tax administration. Approved substitute forms may be used for returns.

g. Individual and fiduciary income tax field and office audit systems and related field collections systems have forms designed by the department. Approved substitutes may be used.

h. New jobs tax credit system has forms designed by the department. Approved substitute forms may be used.

i. Individual income tax withholding payment voucher systems have forms designed by the department. Approved substitute forms may be used.

j. IA-W4 system, declaration of estimated tax, and withholding penalty waiver systems have forms designed by the department. Approved substitutes may be used.

k. Sales and use tax returns and payment voucher systems have forms designed by the department. Approved substitute forms may be used in limited situations.

l. Local option sales and services tax and hotel/motel tax systems have forms designed by the department. Approved substitute forms may be used in limited situations.

m. Field and office audit and collections systems for sales and use tax, sales tax refund examination system, industrial machinery, equipment, and computer refund systems, and sales and use tax penalty waiver systems have forms designed by the department. Approved substitute forms may be used.

n. Motor fuel tax returns systems have forms designed by the department. Approved substitute forms may be used.

o. Special fuel tax returns systems have forms designed by the department. Approved substitute forms may be used.

p. Motor fuel tax and special fuel tax error resolution systems and related field and office audit and collection systems have forms designed by the department. Approved substitute forms may be used.

q. Inheritance, generation skipping transfer, qualified use inheritance, and estate tax returns systems have forms designed by the department. Approved substitute forms may be used.

r. Inheritance, generation skipping transfer, qualified use inheritance and estate tax field and office audit systems, and related field collections systems have forms designed by the department. Approved substitute forms may be used.

s. Cigarette and tobacco tax systems with related office and field audit and field collection systems have forms designed by the department. Approved substitute forms may be used.

t. Property assessor and deputy assessor examination records systems have forms designed by the department. Approved substitute forms may be used.

u. Central property tax assessments system has forms designed by the department. Approved substitute forms may be used.

v. Elderly credit mobile home, Iowa disabled and senior citizen property tax, and special assessment credit systems have forms designed by the department. Approved substitute forms may be used.

w. Environmental protection charge systems have forms designed by the department. Approved substitute forms may be used.

x. Excise tax on unlawful dealing in certain substances system has forms designed by the department. Approved substitute forms may be used.

y. Taxpayer contact systems have forms designed by the department. Approved substitute forms may be used.

z. Federal and state exchange of information systems have forms designed by the department as well as others. Approved substitute forms may be used.

aa. Accounts receivable notices system has forms designed by the department. No substitute forms may be used.

bb. The department shall provide the taxpayer a statement of the rights of a taxpayer and obligations of the department during an audit, procedures by which a taxpayer may appeal an adverse decision of the department, and procedures which the department uses to enforce the tax laws. No substitute form may be used.

8.4(2) *Other forms.* Rescinded IAB 4/14/04, effective 5/19/04.

This rule is intended to implement Iowa Code paragraph 17A.3(1)*"b"* and sections 421.7 and 422.21.
[**ARC 9875B**, IAB 11/30/11, effective 1/4/12]

701—8.5(422) Electronic filing of Iowa income tax returns. Electronic filing allows individuals and businesses that meet department criteria to file their Iowa income tax returns electronically. All information is electronically transmitted. Nothing is submitted on paper unless specifically requested by the department. A taxpayer's electronic Iowa return will include the same information as if the taxpayer had filed a paper return.

There is no statutory requirement that taxpayers file their Iowa income tax returns electronically. Taxpayers also have the option to file by paper.

8.5(1) *Definitions.* For the purpose of this rule, the following definitions apply, unless the context otherwise requires:

"Acknowledgment" means a report generated by the department and sent electronically to a transmitter via the IRS indicating the department's acceptance or rejection of an electronic submission.

"Declaration for e-File Return form" means a taxpayer declaration form that authenticates the electronic tax return, authorizes its transmission, and consents to the financial transaction order as designated using the financial institution information provided.

"Department" means the Iowa department of revenue.

"Direct debit" means an order for electronic withdrawal of funds from a taxpayer's financial institution account for payment to the Iowa department of revenue.

"Direct deposit" means an order for electronic transfer of a refund into a taxpayer's financial institution account.

"E-file provider" means a firm that is assigned an Electronic Filing Identification Number (EFIN) by the IRS to assume any one or more of the following IRS e-file provider roles: electronic return originator, intermediate service provider, transmitter, software developer, or reporting agent.

"Electronic filing" means a paperless filing of the Iowa income tax return, order for financial transaction, or both by way of the IRS e-file program, also known as federal/state electronic filing (ELF/MeF).

"Electronic return originator (ERO)" means an authorized IRS e-file provider that originates the electronic submission by any one of the following methods: electronically sending an electronic tax

return to a Transmitter that will transmit the electronic tax return to the IRS, directly transmitting the electronic tax return to the IRS, or providing the electronic tax return to an Intermediate Service Provider for processing prior to transmission to the IRS.

"Intermediate service provider" means the firm that assists with processing submission information between the ERO (or the taxpayer in the case of online filing) and a Transmitter.

"Online filing" means the process for taxpayers to self-prepare returns by entering return data directly into commercially available software, software downloaded from an Internet site and prepared off-line, or through an online Internet site.

"Origination of an electronic return" means the action by an ERO of electronically sending the return directly to an Intermediate Service Provider, a Transmitter, or the IRS.

"Reporting agent" means a firm that originates the electronic submission of certain returns for its clients or transmits the returns to the IRS in accordance with the IRS electronic filing procedures, or both.

"Self-select PIN signature alternative" means the taxpayer electronically signs the return with a personal identification number (PIN). The PIN is any five numbers (except all zeros) that taxpayers choose to enter as their electronic signature.

"Software developer" means an approved IRS e-file provider that develops software according to IRS and Iowa specifications for the purposes of formatting electronic returns, transmitting electronic returns directly to the IRS, or both. A software developer may sell its software.

"Stockpiling" means collecting returns from taxpayers or from other e-file providers and waiting more than three calendar days after receiving the information necessary for transmission to transmit the returns to the department.

"Transmitter" means a firm that transmits electronic tax return information directly to the IRS and routes electronic acknowledgments from the IRS (and the states) to the firm originating the electronic return.

8.5(2) *Completion and documentation of the electronic return.*

a. All monetary amounts on the prepared return must be in whole dollars. The electronic submission must match the prepared return. The taxpayer(s) must declare the authenticity of the electronic return before it is transmitted. The department has adopted the self-select PIN signature alternative as implemented by the IRS. If the ERO elects not to use the taxpayer self-select PIN signature alternative, the Declaration for e-File Return form must be completed and signed by the preparer, ERO, and taxpayer(s). If the ERO makes changes to the electronic return after the Declaration for e-File Return form has been signed by the taxpayer(s), a new Declaration for e-File Return form must be completed and signed by the taxpayer(s) before the return is transmitted.

b. The ERO must provide the taxpayer a copy of all forms and information to be filed. The taxpayer and ERO must retain all tax documentation for three years. The Declaration for e-File Return form and accompanying schedules are to be furnished to the department only when specifically requested.

8.5(3) *Direct deposit and direct debit.*

a. Taxpayers designating direct deposit of the Iowa refund or direct debit of payment remitted to the department on electronically filed returns must provide proof of account ownership to the ERO. The department is not responsible for the misapplication of a direct deposit refund or direct debit payment caused by error, negligence, or wrongdoing on the part of the taxpayer, e-file provider, financial institution or any agent of the above.

b. Once the return has been transmitted, the financial order may not be altered. The department may, when processing procedures allow, grant a taxpayer's timely request to revoke the financial order. A direct deposit or direct debit order will be disregarded by the department if the electronic submission is rejected for any reason as indicated in the acknowledgment.

c. The department may, when processing procedures require, convert a direct deposit order to a paper check. If a refund is deposited into an incorrect bank account, the department will issue a paper refund check once the funds are returned by the financial institution.

d. Funds will be withdrawn from the account specified in the direct debit order no sooner than the date specified by the taxpayer. This date must occur no later than the due date when the due date

has not yet elapsed. This date must specify immediate payment when the due date has already elapsed. This date will be superseded by the electronic postmark date when the date occurs prior to the electronic postmark date. The direct debit payment within the electronic submission accepted by the department that is postmarked on or before the payment due date is considered timely, provided that the direct debit payment is honored by the financial institution.

8.5(4) *Software approval.* Software developers that want to develop electronic submission formatting software for e-filing Iowa returns shall register their respective software products annually with the department. The department publishes specifications, test packages, and testing procedures. Software must pass transmission tests before the department will approve it for electronic filing of Iowa income tax returns. The department will define the test period annually.

8.5(5) *ERO acceptance to participate.* Once accepted by the IRS as an ERO for a specific tax type, the ERO is automatically accepted to e-file Iowa returns of that tax type, provided that the department offers the tax type for e-file.

8.5(6) *Suspension of an e-file provider from participation in the Iowa electronic filing program.*

a. The department may immediately suspend, without notice, an e-file provider from the Iowa electronic filing program. In most cases, a suspension is effective as of the date of the letter informing the e-file provider of the suspension. Before suspending an e-file provider, the department may issue a warning letter describing specific corrective action required to correct deviations set forth in paragraph 8.5(6)*"b."* An e-file provider will be automatically prohibited from participating in the Iowa electronic filing program if denied participation in, or suspended from, the federal electronic filing program.

b. An e-file provider that is eligible to participate in the federal electronic filing program may be suspended from the Iowa electronic filing program if any of the following conditions occur. The list is for illustrative purposes only and is not deemed to be all-inclusive.

(1) Deterioration in the format of electronic returns transmitted.

(2) Unacceptable cumulative error or rejection rate or failure to correct errors resulting from the transmission of electronic returns.

(3) Untimely received, illegible, incomplete, missing, or unapproved substitute Declaration for e-File Return forms when requested by the department.

(4) Stockpiling returns at any time while participating in the Iowa electronic filing program.

(5) Failure on the part of the transmitter to retrieve acknowledgments within two working days of the department's providing them.

(6) Failure on the part of the transmitter to initiate the communication of acknowledgments to the ERO within two working days of the department's providing them.

(7) Significant complaints about the e-file provider.

(8) Failure on the part of the e-file provider to cooperate with the department's efforts to monitor e-file providers, investigate electronic filing abuse, and investigate the possible filing of fraudulent returns.

(9) Submitting the electronic return with information that is not identical to information on the Declaration for e-File Return form.

(10) Transmitting the electronic return with software not approved by the department for use in the Iowa electronic filing program for the given tax type and tax period.

(11) Failure on the part of the e-file provider to provide W-2s, 1099s, or out-of-state tax returns when requested by the department.

8.5(7) *Administrative procedure for denial of participation or suspension of participation.*

a. When a firm has requested participation in the Iowa electronic filing program but there is reason to deny the request, the department shall send a letter to the firm advising that entry into the program has been denied. When an e-file provider is a participant in the Iowa electronic filing program but is to be suspended from the program for any condition described in subrule 8.5(6), the department will send a letter to notify the e-file provider about its suspension from the program.

b. When the firm either disagrees with the denial of participation letter or the suspension from participation letter, the firm must file a written protest to the department within 60 days of the date of the denial letter or the suspension letter. The written protest must be filed pursuant to rule 701—7.41(17A).

During the administrative review process, the denial of the firm's participation in or the suspension of the firm from the Iowa electronic filing program shall remain in effect.

This rule is intended to implement Iowa Code sections 422.21 and 422.68.

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CHAPTER 42
ADJUSTMENTS TO COMPUTED TAX AND TAX CREDITS
[Prior to 12/17/86, Revenue Department[730]]

701—42.1(257,422) School district surtax. Iowa law provides for the implementation of an income surtax for increasing local school district budgets. The surtax must be approved by the voters of a school district in a special election or by a resolution of the board of directors of a school district. The surtax rate is determined by the department of management on the basis of the revenue to be raised by the surtax for the particular school district with the surtax.

The school district surtax is imposed on the income tax liabilities of all taxpayers residing in the school district on the last day of the taxpayers' tax years. For purposes of the school district surtax, income tax liability is the tax computed under Iowa Code section 422.5, less the nonrefundable credits against computed tax which are authorized in Iowa Code chapter 422, division II.

In a situation where an individual is residing in a school district with a surtax and the individual dies during the tax year, the individual will be considered to be subject to the surtax, since the individual was residing in the school district on the last day of the individual's tax year.

An individual serving in the Armed Forces of the United States who maintains permanent residence in an Iowa school district with a surtax is subject to the surtax regardless of whether the individual is physically residing in the school district on the last day of the tax year.

A person who is present in the school district on the last day of the tax year on a temporary basis due to annual leave or in transit between duty stations is not subject to the surtax.

This rule is intended to implement Iowa Code sections 257.21, 257.29, and 422.15.
[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.2(422D) Emergency medical services income surtax. Effective July 1, 1992, a county board of supervisors may offer for voter approval a local option income surtax, an ad valorem property tax, or a combination of the two taxes to generate revenues for emergency medical services. However, this rule pertains only to the local option income surtax for emergency medical services. If a majority of those voting in the election approve the emergency medical services income surtax, the income surtax will be imposed for tax years beginning on or after January 1 of the fiscal year in which the election is held. Thus, if an election is held in the 2007-2008 fiscal year (July 1, 2007, through June 30, 2008) and the income surtax is approved in the election, the income surtax will be imposed on 2008 returns for individuals filing on a calendar-year basis. In the case of individuals filing on a fiscal-year basis, the income surtax will be imposed on returns for tax years beginning in the 2008 fiscal year. If an emergency medical services income surtax is imposed for a county, it can be imposed only for a maximum period of five years. When the emergency medical income surtax is repealed because the five-year imposition has expired, the income surtax is repealed as of December 31 for tax years beginning on or after that date.

42.2(1) *The rate of the income surtax imposed for emergency medical services.* After the income surtax is approved by an election of county voters, the board of supervisors will set the rate of tax to be imposed, which can be expressed in tenths of 1 percent or hundredths of 1 percent but cannot exceed 1 percent. In addition, because the cumulative total of the percents of income surtax imposed on any taxpayer in the county cannot exceed 20 percent, the rate of an emergency medical services income surtax may be limited, if a school district income surtax has been approved previously by a school district in the county and the surtax rate exceeds 19 percent. Therefore, assuming that a school district in the county had previously approved an income surtax rate of 19.4 percent, the medical emergency income surtax rate would be limited to six-tenths of 1 percent. If a school district income surtax and emergency medical income surtax are approved on or about the same date and the cumulative total of the income surtaxes is greater than 20 percent, the income surtax approved on the earlier of the two dates will be allowed at the rate approved and the second income surtax approved will be limited accordingly so that the cumulative rate will not exceed 20 percent. If a school district income surtax and an emergency medical income surtax are approved on the same date with a proposed cumulative rate that exceeds 20 percent, each of the surtaxes will be reduced equally so that the cumulative surtax rate will not exceed 20 percent. Assuming that a school district in a particular county approves an income surtax of 20 percent

on November 4, 2008, and an emergency medical income surtax of 1 percent is approved on the same date, both surtaxes will be reduced by five-tenths of 1 percent so that the cumulative rate of the two income surtaxes does not exceed 20 percent. The department of management can provide information about any income surtaxes that have been approved for the school districts in the county.

42.2(2) *Imposing the emergency medical income surtax.* The emergency medical income surtax will be imposed on the state income tax liability on each individual residing in the county at the end of the individual's tax year, whether the individual's tax year ends at the end of the calendar year or fiscal year. For purposes of the emergency medical income surtax, an individual's income tax liability is the aggregate of the state income taxes determined in Iowa Code section 422.5 less the nonrefundable credits against computed income tax which are authorized in Iowa Code chapter 422, division II.

42.2(3) *Administering the emergency medical income surtax.* The director of revenue shall administer the emergency medical income surtax in the same way as other state individual tax laws are administered. All powers and requirements related to administering the state income tax law apply to the administration of the emergency medical income surtax including, but not limited to, the provisions of Iowa Code sections 422.4, 422.20 to 422.31, 422.68, 422.70, and 422.72 to 422.75. The county board of supervisors and county officials shall confer with the director for assistance in drafting the ordinance imposing the emergency medical income surtax. Certified copies of the ordinance shall be filed with the department of revenue and the department of management within 30 days after the emergency medical income surtax is approved.

42.2(4) *Accounting for the emergency medical income surtax and paying the surtax.* The department shall account for the emergency medical income surtax and any interest and penalties on the surtax so that there is a separate accounting for each county where the income surtax is imposed. The accounting shall be applicable to those individual income tax returns filed on or before November 1 of the calendar year following the tax year for which the tax is imposed. The emergency medical income surtax and any penalties and interest should be credited to a "local income surtax fund" established in the office of the state treasurer. On or before December 15 of the year after the tax year, the director of revenue shall certify to the state treasurer the income surtax and any interest and penalties collected from returns filed on or before November 1.

This rule is intended to implement Iowa Code chapter 422D.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.3(422) Exemption credits.

42.3(1) A single person shall deduct from the computed tax a personal exemption credit of $40. A single person is defined in 701—subrule 39.4(1).

42.3(2) A married person living with husband or wife at the close of the taxable year, or living with husband or wife at the time of the death of that spouse during the taxable year, shall, if a joint return is filed, deduct from the computed tax a personal exemption of $80. Where such spouse files a separate return, each spouse is entitled to deduct from the computed tax a personal exemption of $40. The personal exemption may not be divided between the spouses in any other proportion.

42.3(3) A taxpayer shall deduct from computed tax an exemption of $40 for each dependent. "Dependent" has the same meaning as provided by the Internal Revenue Code, and the same dependents shall be claimed for Iowa income tax purposes as the taxpayer is entitled to claim for federal income tax purposes. If each spouse furnished 50 percent of the support, the spouses must elect between them which spouse is to be entitled to claim the dependent. The dividing of dependent credits applies only to the number of dependents and not to the credit amount for a particular dependent.

42.3(4) A head of household as defined in 701—subrule 39.4(7) is allowed a personal exemption credit of $80.

42.3(5) A taxpayer who is 65 years of age on or before the first day following the end of the tax year is allowed an additional personal exemption credit of $20 in addition to any other credits allowed by this rule.

42.3(6) A taxpayer who is blind, as defined in Iowa Code section 422.12(1)*"e,"* is allowed a personal exemption credit of $20 in addition to any other credits allowed by this rule.

42.3(7) A nonresident taxpayer or a part-year resident taxpayer will be allowed to deduct personal exemption credits as if the nonresident taxpayer or part-year taxpayer was a resident for the entire year.

This rule is intended to implement Iowa Code section 422.12.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.4(422) Tuition and textbook credit for expenses incurred for dependents attending grades kindergarten through 12 in Iowa. Effective for tax years beginning on or after January 1, 1998, taxpayers who pay tuition and textbook expenses of dependents who attend grades kindergarten through 12 in an Iowa school may receive a tax credit of 25 percent of up to $1,000 of qualifying expenses for each dependent attending an elementary or secondary school located in Iowa. In order for the taxpayer to qualify for the tax credit for tuition and textbooks, the elementary school or secondary school that the dependent is attending must meet the standards for accreditation of public and nonpublic schools in Iowa provided in Iowa Code section 256.11. In addition, the school the dependent is attending must not be operated for profit and must adhere to the provisions of the United States Civil Rights Act of 1964, and the provisions of Iowa Code chapter 216, which is known as the Iowa civil rights Act of 1965. The following definitions and criteria apply to the determination of the tax credit for amounts paid by the taxpayer for tuition and textbooks for a dependent attending an elementary or secondary school in Iowa:

42.4(1) *Tuition.* For purposes of the tuition and textbook tax credit, "tuition" means any charge made by an elementary or secondary school for the expense of personnel, buildings, equipment and materials other than textbooks, and other expenses of elementary or secondary schools which relate to the teaching of only those subjects that are legally and commonly taught in public elementary or secondary schools in Iowa. "Tuition" includes charges by a qualified school for summer school classes or for private instruction of a child who is physically unable to attend classes at the site of the elementary or secondary school.

"Tuition" does not include charges or fees which relate to the teaching of religious tenets, doctrines, or worship in cases where the purpose of the teaching is to inculcate the religious tenets, doctrines, or worship. In addition, "tuition" does not include amounts paid to an individual or other entity for private instruction of a dependent who attends an elementary or secondary school in Iowa. Amounts paid to a school for meals, lodging, or clothing for a dependent do not qualify for the tax credit for tuition.

Amounts paid to an individual or organization for home schooling of a dependent or the teaching of a dependent outside of an elementary or secondary school may not be claimed for purposes of the tuition and textbook tax credit.

42.4(2) *Textbooks.* For purposes of the tuition and textbook tax credit, "textbooks" means books and other instructional materials used in elementary and secondary schools in Iowa to teach only those subjects legally and commonly taught in public elementary and secondary schools in Iowa. "Textbooks" includes fees or charges by the elementary or secondary school for required supplies or materials for classes in art, home economics, shop or similar courses. "Textbooks" also includes books and materials used for extracurricular activities, such as sporting events, musical events, dramatic events, speech activities, driver's education, or programs of a similar nature.

"Textbooks" does not include amounts paid for books or other instructional materials used in the teaching of religious tenets, doctrines, or worship, in cases where the purpose of the teaching is to inculcate the religious tenets, doctrine, or worship. "Textbooks" also does not include amounts paid for books or other instructional materials used in teaching a dependent subjects in the home or outside of an elementary or secondary school.

42.4(3) *Extracurricular activities.* For purposes of the tuition and textbook tax credit, amounts paid for dependents to participate in or to attend extracurricular activities may be claimed as part of the tuition and textbook tax credit. "Extracurricular activities" includes sporting events, musical events, dramatic events, speech activities, driver's education if provided at a school, and programs of a similar nature.

a. The following are specific examples of expenditures related to a dependent's participation in or attendance at extracurricular activities that may qualify for the tuition and textbook tax credit:

(1) Fees for participation in school sports activities.

(2) Fees for field trips.

(3) Rental fees for instruments for school bands or orchestras but not rental fees in rent-to-own contracts.

(4) Driver's education fees, if paid to a school.

(5) Cost of activity tickets or admission tickets to school sporting, music and dramatic events.

(6) Fees for events such as homecoming, winter formal, prom, or similar events.

(7) Rental of costumes for school plays.

(8) Purchase of costumes for school plays if the costumes are not suitable for street wear.

(9) Purchase of track shoes, football shoes, or other athletic shoes with cleats, spikes, or other features that are not suitable for street wear.

(10) Costs of tickets or other admission fees to attend banquets or buffets for school academic or athletic awards.

(11) Trumpet grease, woodwind reeds, guitar picks, violin strings and similar types of items for maintenance of instruments used in school bands or orchestras.

(12) Band booster club or athletic booster club dues, but only if dues are for the dependent attending the school and not the parent or adult.

(13) Rental of formal gown or tuxedo for school dance or other school event.

(14) Dues paid to school clubs or school-sponsored organizations such as chess club, photography club, debate club, or similar organizations.

(15) Amounts paid for music that will be used in school music programs, including vocal music programs.

(16) Fees paid for general materials for shop class, agriculture class, home economics class, or auto repair class and general fees for equivalent classes.

(17) Fees for a dependent's bus trips to attend school if paid to the school.

b. The following are specific examples of expenditures related to a dependent's participation in or attendance at extracurricular activities that will not qualify for the tuition and textbook credit.

(1) Purchase of a musical instrument used in a school band or orchestra.

(2) Purchase of basketball shoes or other athletic shoes that are readily adaptable to street wear.

(3) Amounts paid for special testing such as SAT or PSAT, and for Iowa talent search tests.

(4) Payments for senior trips, band trips, and other overnight school activity trips which involve payment for meals and lodging.

(5) Fees paid to K-12 schools for courses for college credit.

(6) Amounts paid for T-shirts, sweatshirts and similar clothing that is appropriate for street wear.

(7) Amounts paid for special programs at universities and colleges for high school students.

(8) Payment for private instrumental lessons, voice lessons or similar lessons.

(9) Amounts paid for a school yearbook, annual or class ring.

(10) Fees for special materials paid for shop class, agriculture class, auto repair class, home economics class and similar classes. For purposes of this paragraph, "special materials" means materials used for personal projects of the dependents, such as materials to make furniture for personal use, automobile parts for family automobiles and other materials for projects for personal or family benefit.

42.4(4) *Claiming the credit.* The credit can only be claimed by the spouse who claims the dependent credit on the Iowa tax return as described in subrule 42.3(3). For example, for divorced or separated parents, only the spouse who claims the dependent credit on the Iowa return can claim the tuition and textbook credit for tuition and textbook expenses for that dependent.

In cases where married taxpayers file separately on a combined return form, the tuition and textbook credit shall be allocated between the spouses in the ratio in which the dependent credit was claimed between the spouses.

EXAMPLE: A married couple has two dependent children and claimed a tuition and textbook credit of $500 related to both children on their 2011 Iowa return. The taxpayers filed separately on a combined Iowa return form for 2011. One spouse claimed both of the dependent credits on the Iowa return. The $500 tuition and textbook credit will be claimed by the spouse who claimed the dependent credits on the Iowa return.

EXAMPLE: A married couple has three dependent children and claimed a tuition and textbook credit of $600 related to all three children on their 2011 Iowa return. The taxpayers filed separately on a combined Iowa return form for 2011. One spouse claimed one dependent credit, and the other spouse claimed two dependent credits on the Iowa return. The spouse who claimed one dependent credit will claim $200 of the tuition and textbook credit, while the spouse who claimed two dependent credits will claim $400 of the tuition and textbook credit.

This rule is intended to implement Iowa Code section 422.12.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9820B**, IAB 11/2/11, effective 12/7/11]

701—42.5(422) Nonresident and part-year resident credit. For tax years beginning on or after January 1, 1982, an individual who is a nonresident of Iowa for the entire tax year, or an individual who is an Iowa resident for a portion of the tax year, is allowed a credit against the individual's Iowa income tax liability for the Iowa income tax on the portion of the individual's income which was earned outside Iowa while the person was a nonresident of Iowa. This credit is computed on Schedule IA 126, which is included in the Iowa individual income tax booklet. The following subrules clarify how the nonresident and part-year resident credit is computed for nonresidents of Iowa and taxpayers who are part-year residents of Iowa during the tax year.

42.5(1) *Nonresident/part-year resident credit for nonresidents of Iowa.* A nonresident of Iowa shall complete the Iowa individual return in the same way an Iowa resident completes the form by reporting the individual's total net income, including income earned outside Iowa, on the front of the IA 1040 return form. A nonresident individual is allowed the same deduction for federal income tax and the same itemized deductions as an Iowa resident taxpayer with identical deductions for these expenditures. Thus, a nonresident with a taxable income of $40,000 would have the same initial Iowa income tax liability as a resident taxpayer with a taxable income of $40,000 before the nonresident/part-year resident credit is computed.

The nonresident/part-year resident credit is computed on Schedule IA 126. The lines referred to in this subrule are from Schedule IA 126 and Form IA 1040 for the 2008 tax year. Similar lines on the schedule and form may apply for subsequent tax years. The individual's Iowa source net income from lines 1 through 25 of the schedule is totaled on line 26 of the schedule. If the nonresident's Iowa source net income is less than $1,000, the taxpayer is not subject to Iowa income tax and is not required to file an Iowa income tax return for the tax year. However, if the Iowa source net income amount is $1,000 or more, the Iowa source net income is then divided by the person's all source net income on line 27 of Schedule IA 126 to determine the percentage of the Iowa net income to all source net income. This Iowa income percentage is inserted on line 28 of the schedule, and this percentage is then subtracted from 100 percent to arrive at the nonresident/part-year resident credit percentage or the percentage of the individual's total income which was earned outside Iowa. The nonresident/part-year resident credit percentage is entered on line 29 of Schedule IA 126. The Iowa income tax on total income from line 43 of the IA 1040 is entered on line 30 of Schedule IA 126. The total of nonrefundable credits from line 49 of the IA 1040 is then shown on line 31 of Schedule IA 126. The amount on line 31 is subtracted from the amount on line 30 which results in the Iowa total tax after nonrefundable credits which is entered on line 32. This Iowa tax-after-credits amount is multiplied by the nonresident/part-year resident credit percentage from line 29 to compute the nonresident/part-year resident credit. The amount of the credit is inserted on line 33 of Schedule IA 126 and on line 51 of the IA 1040.

EXAMPLE A. A single resident of Nebraska had Iowa source net income of $15,000 in 2008 from wages earned from employment in Iowa. The rest of this person's income was attributable to sources outside Iowa. This nonresident of Iowa had an all source net income of $40,000 and a taxable income of $30,000 due to a federal tax deduction of $7,000 and itemized deductions of $3,000. The Iowa income percentage is computed by dividing the Iowa source net income of $15,000 by the taxpayer's all source net income of $40,000, which results in a percentage of 37.5. This percentage is subtracted from 100 percent which leaves a nonresident/part-year resident credit percentage of 62.5.

The Iowa tax from line 43 of the IA 1040 is $1,508. The total nonrefundable credit from line 49 is $40, which leaves a tax amount of $1,468 when the credit is subtracted from $1,508. When $1,468 is

multiplied by the nonresident/part-year resident credit percentage of 62.5, a nonresident credit of $918 is computed which is entered on line 33 of Schedule IA 126 as well as on line 51 of the IA 1040 for 2008.

EXAMPLE B. A California resident, who was married, had $20,000 of Iowa source income in 2008 from an Iowa farm. This individual had an additional $80,000 in income that was attributable to sources outside Iowa, but the individual's spouse had no income. The taxpayers had paid $18,000 in federal income tax in 2008 and had itemized deductions of $12,000 in 2008.

The taxpayers' taxable income on their joint Iowa return was $70,000. The taxpayers had an Iowa income tax liability of $4,583 after application of the personal exemption credits of $80. The taxpayers had an Iowa source income of $20,000 and an all source net income of $100,000. Therefore, the Iowa income percentage was 20. Subtracting the Iowa income percentage of 20 percent from 100 percent leaves a nonresident/part-year resident credit percentage of 80.

When the Iowa income tax liability of $4,583 is multiplied by 80 percent, this results in a nonresident/part-year resident credit of $3,666. This credit amount is entered on line 33 of the Schedule IA 126 and on line 51 of Form IA 1040.

42.5(2) *Nonresident/part-year resident credit for part-year residents of Iowa.* An individual who is a resident of Iowa for part of the tax year shall complete the front of the IA 1040 income tax return form as a resident taxpayer by showing the taxpayer's total income, including income earned outside Iowa, on the front of the IA 1040 return form. A part-year resident of Iowa is allowed the same federal tax deduction and itemized deductions as a resident taxpayer who has paid the same amount of federal income tax and has paid for the same deductions that can be claimed on Schedule A in the tax year. Therefore, a part-year resident would have the same initial Iowa income tax liability as an Iowa resident with the same taxable income before computation of the nonresident/part-year resident credit.

The nonresident/part-year resident credit for a part-year resident is computed on Schedule IA 126. The lines referred to in this subrule are from the IA 1040 income tax return form and the Schedule IA 126 for 2008. Similar lines may apply for tax years after 2008. The individual's Iowa source income is totaled on line 26 of Schedule IA 126 and includes all the individual's income received while the taxpayer was a resident of Iowa and all the Iowa source income received during the period of the tax year when the individual was a resident of a state other than Iowa. Iowa source income includes, but is not limited to, wages earned in Iowa while a resident of another state as well as income from Iowa farms and other Iowa businesses that was earned during the portion of the year that the taxpayer was a nonresident of Iowa. In the case of interest from a part-year resident's account at an Iowa financial institution, only interest earned during the period of the individual's Iowa residence is Iowa source income unless the account is for an Iowa business. If the part-year resident's account at a financial institution is for an Iowa business, all interest earned in the year by the part-year resident from the account is taxable to Iowa.

Income earned outside Iowa by the part-year resident during the portion of the year the individual was an Iowa resident is taxable to Iowa and is part of the individual's Iowa source income. To compute the nonresident/part-year resident credit for a part-year resident, the taxpayer's Iowa source income on Schedule IA 126 is totaled. If the Iowa source income is less than $1,000, the taxpayer is not subject to Iowa income tax and is not required to file an Iowa return. If the Iowa source income is $1,000 or more, it is divided by the taxpayer's all source net income on line 27 of Schedule IA 126. The percentage computed by this procedure is the Iowa income percentage and is entered on line 28 of the Schedule IA 126. The Iowa income percentage is then subtracted from 100 percent to arrive at the nonresident/part-year resident credit percentage which is entered on line 29 of Schedule IA 126. The Iowa tax from line 43 of the IA 1040 is then shown on line 30 of Schedule IA 126. The total of the Iowa nonrefundable credits from line 49 of the IA 1040 is entered on line 31 of Schedule IA 126 and is subtracted from the Iowa tax amount on line 30. The tax-after-credits amount on line 32 is next multiplied by the nonresident/part-year resident credit percentage from line 28. The amount calculated from this procedure is the nonresident/part-year resident credit which is shown on line 33 of Schedule IA 126 and on line 51 of Form IA 1040.

EXAMPLE A. A single individual was a resident of Nebraska for the first half of 2008 and moved to Iowa on July 1, 2008, to accept a job in Des Moines. This individual earned $20,000 from wages, $200 from interest, and $4,000 from a ranch in Nebraska from January 1, 2008, through June 30, 2008. In

the last half of 2008, this person had wages of $30,000, interest income of $300, and $4,000 from the Nebraska ranch. This part-year resident had federal income tax paid in 2008 of $11,000 and had itemized deductions of $3,000.

The part-year resident's all source net income was $58,500 and the Iowa source net income was $34,300, which includes the Iowa wages, the Nebraska ranch income of $4,000 earned during the individual's period of Iowa residence, as well as the interest income of $300 earned during that time of the tax year. The Iowa taxable income for the part-year resident for 2008 was $44,500, which included the federal income tax deduction of $11,000 and itemized deductions of $3,000. The individual's Iowa income percentage was 58.6 which was determined by dividing the Iowa source income of $34,300 by the all source income of $58,500. Subtracting the Iowa income percentage of 58.6 from 100 percent results in a nonresident/part-year resident credit percentage of 41.4. The Iowa tax on total income was $2,529 which was reduced to $2,489 after subtraction of the personal exemption credit of $40.

When $2,489 is multiplied by the nonresident/part-year resident percentage of 41.4, a nonresident/part-year resident credit of $1,030 is computed for this part-year resident.

EXAMPLE B. A single individual moved from Minnesota to Iowa on July 1, 2008. This person had received $5,000 in income from an Iowa farm in March of the tax year and another $10,000 from this farm in September of 2008. This person had $10,000 in wages from employment in Minnesota in the first half of the year and another $15,000 in wages from employment in Iowa in the last half of 2008. This person had $2,000 in interest from a Minnesota bank in the first half of the year and $2,000 in interest from an Iowa bank in the last six months of 2008. This taxpayer had $8,000 in federal income tax withheld from wages in 2008 and claimed the standard deduction on both the Iowa and federal income tax returns.

The part-year resident's all source income was $44,000 and the Iowa source income was $32,000 which consisted of $15,000 in wages, $2,000 in interest income, and $15,000 in income from the Iowa farm. Since the farm was in Iowa, the farm income received in the first half of 2008 was taxable to Iowa as well as the farm income received while the individual was an Iowa resident. The individual's Iowa taxable income was $34,250 which was computed after subtracting the federal income tax deduction of $8,000 and a standard deduction of $1,750. The taxpayer's Iowa income tax liability was $1,757 after subtraction of a personal exemption credit of $40.

The taxpayer's Iowa income percentage was 72.7 which was computed by dividing the Iowa source income of $32,000 by the all source income of $44,000. The nonresident/part-year resident credit percentage was 27.3 which was arrived at by subtracting the Iowa income percentage of 72.7 from 100 percent. The taxpayer's nonresident/part-year resident credit is $480. This was determined by multiplying the Iowa income tax liability after personal exemption credit amount of $1,757 by the nonresident/part-year resident percentage of 27.3.

This rule is intended to implement Iowa Code section 422.5.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.6(422) Out-of-state tax credits.

42.6(1) *General rule.* Iowa residents are allowed an out-of-state tax credit for taxes paid to another state or foreign country on income which is also reported on the taxpayer's Iowa return. The out-of-state tax credit is allowable only if the taxpayer files an Iowa resident income tax return.

If the Iowa resident is a partner, shareholder, member, or beneficiary of a partnership, S corporation, limited liability company, or trust which files a composite income tax return in another state on behalf of the partners, shareholders, members or beneficiaries, the out-of-state tax credit will be allowed for the Iowa resident. The Iowa resident must provide a schedule of the resident's share of the income tax paid to another state on a composite basis, and the out-of-state tax credit is limited based upon the calculation set forth in subrule 42.6(2).

However, if the partnership, S corporation, limited liability company or trust is directly subject to tax in another state and the tax is not directly imposed on the resident taxpayer, then the out-of-state tax credit is not allowed for the Iowa resident on the tax directly imposed on the partnership, S corporation, limited liability company, or trust. For example, if another state does not recognize the S corporation

election for state purposes and a corporation income tax is imposed directly on the S corporation, then the out-of-state tax credit is not allowed for the Iowa resident shareholder on the corporation income tax paid to the other state.

42.6(2) *Limitation of out-of-state tax credit.* If an Iowa resident taxpayer pays income tax to another state or foreign country on any of the taxpayer's income, the taxpayer is entitled to a net tax credit; that is, the taxpayer may deduct from the taxpayer's Iowa net tax (not from gross income) the amount of income tax actually paid to the other state or country, provided the amount deducted as a credit does not exceed the amount of Iowa net income tax on the same income which was taxed by the other state or foreign country.

42.6(3) *Computation of tax credit.*

a. The limitation on the tax credit must be computed according to the following formula: Gross income taxed by another state or foreign country that is also taxed by Iowa shall be divided by the total gross income of the Iowa resident taxpayer. This quotient, multiplied by the net Iowa tax as determined on the total gross income of the taxpayer as if entirely earned in Iowa, shall be the maximum tax credit against the Iowa net tax. This quotient shall be computed as a percentage with a minimum of one decimal place. However, if the income tax paid to the other state or foreign country on the gross income taxed by the other state or foreign country is less than the maximum tax credit against the Iowa tax, the out-of-state credit allowed against the Iowa tax may not exceed the income tax paid to the other state or foreign country. The income tax paid to the other state or foreign country is the net state or foreign income tax actually paid for the tax year on the income taxed by the other state or foreign country and not the state or foreign income tax paid during the tax year, such as state income tax or foreign income tax withheld from the income taxed by the other state or foreign country.

b. Out-of-state tax credit examples. An individual who is an Iowa resident for the entire tax year can claim an out-of-state tax credit against the person's Iowa income tax liability for any income tax paid to another state or foreign country for the tax year on any gross income received by the individual for the year which was derived from sources outside of Iowa to the extent this gross income is also subject to Iowa income tax.

However, in the case of an individual who is a part-year resident of Iowa for the tax year, that individual can only claim an out-of-state tax credit against the person's Iowa income tax liability for income tax paid to another state or foreign country on gross income derived from sources outside of Iowa during the period of the tax year that the individual was an Iowa resident and only to the extent this gross income derived from sources outside of Iowa was also subject to Iowa income tax.

The taxpayer's out-of-state credit is computed on Schedule IA 130 which is to be filed with the taxpayer's Iowa individual income tax return. The taxpayer's income tax return or other document of the other state or foreign country supporting the income tax paid to the other state or foreign country shall be filed with the individual's Iowa income tax return to support the out-of-state tax credit claimed.

EXAMPLE 1. Gene Miller was an Iowa resident for the entire year 2008. Mr. Miller lived in Council Bluffs and worked the entire year for a company in Omaha, Nebraska. Mr. Miller had wages of $30,000 and Nebraska income tax withheld of $1,000. He also had income of $10,000 from rental of an Iowa farm and another $10,000 in interest income from a personal savings account in an Iowa bank. The amount of Mr. Miller's gross income that was taxed by Nebraska (the other state or foreign country) was $30,000. His total gross income in 2008 was $50,000. Thus, 60 percent of his income was earned in Nebraska. Mr. Miller's Iowa tax on line 54 of Form IA 1040 was $917, which resulted in a potential out-of-state credit of 60 percent of the Iowa tax or $550 because 60 percent of Mr. Miller's income was earned outside Iowa and was taxed by Nebraska. However, Mr. Miller's income tax liability on the Nebraska income tax return was only $500. Thus, the out-of-state tax credit allowed was $500, because that was less than the potential out-of-state tax credit of $550.

EXAMPLE 2. Ben Smith was a part-year Iowa resident in 2008. He resided in Missouri for the first six months of the year until he moved to Keokuk, Iowa, on July 1. Mr. Smith was employed in Missouri for the entire year and had wages of $30,000 and had Missouri income tax liability of $1,000. Half of Mr. Smith's wages or $15,000 of the wages was earned during the time Mr. Smith was an Iowa resident. Mr. Smith also had $10,000 in farm rental income from farmland located in Iowa. The amount of gross

income taxed by Missouri while Mr. Smith was an Iowa resident was $15,000. Mr. Smith's gross income earned while an Iowa resident for the year was $25,000. Thus, 60 percent of the gross income was earned in the other state while Mr. Smith was an Iowa resident. Mr. Smith's Iowa income tax on line 54 of the IA 1040 was $1,292. This resulted in a potential out-of-state credit of $775 because 60 percent of the gross income was earned in Missouri during the period Mr. Smith was an Iowa resident. However, since 50 percent of the income earned in Missouri was earned while Mr. Smith was a resident of Iowa and the Missouri income tax liability for the year was $1,000, the out-of-state credit was $500 or 50 percent of the Missouri income tax liability. The out-of-state credit allowed was $500, because this was less than the Iowa income tax of $775 that was applicable to the gross income earned in Missouri during the period Mr. Smith was an Iowa resident.

42.6(4) *Proof of claim for tax credit.* The credit may be deducted from Iowa net income tax if written proof of such payment to another state or foreign country is furnished to the department. The department will accept any one of the following as proof of such payment:

a. A photocopy, or other similar reproduction, of either:

(1) The receipt issued by the other state or foreign country for payment of the tax, or

(2) The canceled check (both sides) with which the tax was paid to the other state or foreign country together with a statement of the amount and kind (whether wages, salaries, property or business) of total income on which such tax was paid.

b. A copy of the income tax return filed with the other state or foreign country which has been certified by the tax authority of that state or foreign country and showing thereon that the income tax assessed has been paid to them.

This rule is intended to implement Iowa Code section 422.8.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.7(422) Out-of-state tax credit for minimum tax.

42.7(1) *General rule.* Iowa residents are allowed an out-of-state tax credit for minimum taxes or income taxes paid to another state or foreign country on preference items derived from sources outside of Iowa. Part-year residents who pay minimum tax to another state or foreign country on preference items derived from sources outside Iowa will be allowed an out-of-state tax credit only to the extent that the minimum tax paid to the other state or foreign country relates to preference items that occurred during the period the taxpayer was an Iowa resident. Taxpayers who were nonresidents of Iowa for the entire tax year are not eligible for an out-of-state tax credit on their Iowa returns for minimum taxes paid to another state or foreign country on preference items.

If the Iowa resident is a partner, shareholder, member, or beneficiary of a partnership, S corporation, limited liability company, or trust which files a composite income tax return and pays minimum tax in another state on behalf of the partners, shareholders, members or beneficiaries, the out-of-state tax credit will be allowed for the Iowa resident. The Iowa resident must provide a schedule of the resident's share of the minimum tax paid to another state on a composite basis, and the out-of-state tax credit is limited based upon the calculation set forth in subrule 42.7(2).

However, if the partnership, S corporation, limited liability company, or trust is directly subject to minimum tax in another state and the minimum tax is not directly imposed on the resident taxpayer, then the out-of-state tax credit is not allowed for the Iowa resident on the minimum tax directly imposed on the partnership, S corporation, limited liability company, or trust. For example, if another state does not recognize the S corporation election for state tax purposes and a corporation income tax is imposed directly on the S corporation which includes minimum tax, then the out-of-state tax credit is not allowed for the Iowa resident shareholder on the corporation income tax, including minimum tax, paid to the other state.

42.7(2) *Limitation of out-of-state tax credit for minimum tax.* The limitation on the out-of-state tax credit for minimum tax is that the credit shall not exceed the Iowa minimum tax that would have been computed on the same preference items which were taxed by the other state or foreign country. The limitation may be determined according to the following formula: The total of preference items earned outside of Iowa and taxed by another state or foreign country shall be divided by the total of

preference items of the resident taxpayer. This quotient, multiplied by the state minimum tax on the total of preference items as if entirely earned in Iowa, shall be the maximum credit against the Iowa minimum tax. However, if the minimum tax imposed by the other state or foreign country is less than the minimum tax computed under the limitation formula, the out-of-state credit for minimum tax will not exceed the minimum tax imposed by the other state or foreign country.

No out-of-state credit will be allowed on the Iowa return for minimum tax paid to another state or foreign country to the extent that the minimum tax of the other state or foreign country is imposed on items of tax preference not subject to the Iowa minimum tax. In addition, no out-of-state credit will be allowed for minimum tax paid to another state or foreign country of capital gains or losses from distressed sales which are excluded from the Iowa minimum tax. Capital gains or losses from distressed sales are described in rule 701—40.27(422).

42.7(3) *Proof of claim for out-of-state tax credit for minimum tax.* The out-of-state credit for minimum tax may be claimed on the return of a taxpayer if proof of payment of minimum tax to the state or foreign country is included with the return. Documents needed for proof of payment are a photocopy of the minimum tax form of the state or country to which minimum tax was paid as well as instructions from the minimum tax form or other information which specifies how the minimum tax is imposed and what preference items are subject to the minimum tax of that state or foreign country.

In the case of audit by the department of a taxpayer claiming an out-of-state tax credit for minimum tax paid, the department may require additional proof of payment of the out-of-state tax credit. The department will accept any of the following documents as verification of payment of the minimum tax:

a. A photocopy, or other similar reproduction, of either:

(1) The receipt issued by the other state or foreign country for payment of the tax, including the minimum tax, or

(2) The canceled check (both sides) which was used for payment of the minimum tax to the other state or foreign country.

b. A copy of the return filed with the other state or foreign country which has been certified by the tax authority of that state or foreign country and which shows that the income tax, including the minimum tax, has been paid.

This rule is intended to implement Iowa Code section 422.8.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.8(422) Withholding and estimated tax credits. An employee from whose wages tax is withheld shall claim credit for the tax withheld on the employee's income tax return for the year during which the tax was withheld. Credit will be allowed only if a copy of the withholding statement is attached to the return. Taxpayers who have made estimated income tax payments shall claim credit for the estimated tax paid for the taxable year.

This rule is intended to implement Iowa Code section 422.16.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.9(422) Motor fuel credit. An individual, partnership, limited liability company, or S corporation may elect to receive an income tax credit in lieu of the motor fuel tax refund provided by Iowa Code chapter 452A. An individual, partnership, limited liability company, or S corporation which holds a motor fuel tax refund permit under Iowa Code section 452A.18 when it makes this election must cancel the permit within 30 days after the first day of the tax year. However, if the refund permit is not canceled within this period, the permit becomes invalid at the time the election to receive an income tax credit is made. The election will continue for subsequent tax years unless a new motor fuel tax refund permit is obtained.

The motor fuel income tax credit must be the amount of Iowa motor fuel tax paid on qualifying fuel purchases as determined by Iowa Code chapter 452A and Iowa Code section 422.110 less any state sales tax as determined by 701—subrule 231.2(2). The credit must be claimed on the tax return covering the tax year in which the motor fuel tax was paid. If the motor fuel credit results in an overpayment of income tax, the overpayment may be refunded or may be credited to income tax due in the subsequent tax year.

The motor fuel tax credits for fuel taxes paid by partnerships, limited liability companies, and S corporations are not claimed on returns filed for the partnerships, limited liability companies, and S corporations. Instead, the pro-rata shares of the motor fuel tax credits are allocated to the partners, members, and shareholders in the same ratio as incomes are allocated to the partners, members, and shareholders. A schedule must be attached to the individual's returns showing the distribution of gallons and the amount of credit claimed by each partner, member, or shareholder.

The partnership, limited liability company, or S corporation must attach to its return a schedule showing the allocation to each partner, member, or shareholder of the motor fuel purchased by the partnership, limited liability company, or S corporation which qualifies for the credit.

This rule is intended to implement Iowa Code sections 422.110 and 422.111.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.10(422) Alternative minimum tax credit for minimum tax paid in a prior tax year. Minimum tax paid in prior tax years commencing with tax years beginning on or after January 1, 1987, by a taxpayer can be claimed as a tax credit against the taxpayer's regular income tax liability in a subsequent tax year. Therefore, 1988 is the first tax year that the minimum tax credit is available, and the credit is based on the minimum tax paid by the taxpayer for 1987. The minimum tax credit may only be used against regular income tax for a tax year to the extent that the regular tax is greater than the minimum tax for the tax year. If the minimum tax credit is not used against the regular tax for a tax year, the remaining credit is carried over to the following tax year to be applied against the regular income tax liability for that period. The minimum tax credit is computed on Form IA 8801.

42.10(1) *Examples of computation of the minimum tax credit and carryover of the credit.*

EXAMPLE 1. The taxpayers reported $5,000 of minimum tax for 2007. For 2008, the taxpayers reported regular tax less credits of $8,000, and the minimum tax liability is $6,000. The minimum tax credit is $2,000 for 2008 because, although the taxpayers had an $8,000 regular tax liability, the credit is allowed only to the extent that the regular tax exceeds the minimum tax. Since only $2,000 of the carryover credit from 2007 was used, there is a $3,000 minimum tax carryover credit to 2009.

EXAMPLE 2. The taxpayers reported $2,500 of minimum tax for 2007. For 2008, the taxpayers reported regular tax less credits of $8,000, and the minimum tax liability is $5,000. The minimum tax credit is $2,500 for 2008 because, although the regular tax less credits exceeded the minimum tax by $3,000, the credit is allowed only to the extent of minimum tax paid for prior tax years. There is no minimum tax carryover credit to 2009.

42.10(2) *Minimum tax credit for nonresidents and part-year residents.* Nonresident and part-year resident taxpayers who paid Iowa minimum tax in tax years beginning on or after January 1, 1987, are eligible for the minimum tax credit to the extent that the minimum tax they paid was attributable to tax preferences and adjustments. Therefore, if a nonresident or part-year resident taxpayer had Iowa source tax preferences or adjustments, then all the minimum tax that was paid would qualify for the minimum tax credit.

The minimum tax credit for a tax year as computed above applies to the regular income tax liability less credits including the nonresident part-year credit to the extent this regular tax amount exceeds the minimum tax for the tax year. To the extent the credit is not used, the credit can be carried over to the next tax year.

This rule is intended to implement Iowa Code section 422.11B.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.11(15,422) Research activities credit. Effective for tax years beginning on or after January 1, 1985, taxpayers are allowed a credit equal to 6½ percent of the state's apportioned share of qualified expenditures for increasing research activities. Effective for tax years beginning on or after January 1, 1991, the Iowa research activities credit will be computed on the basis of the qualifying expenditures for increasing research activities as allowable under Section 41 of the Internal Revenue Code in effect on January 1, 1999. The state's apportioned share of the qualifying expenditures for increasing research activities is a percent equal to the ratio of qualified research expenditures in Iowa to the total qualified research expenditures. The Iowa research activities credit is made permanent for tax years beginning

on or after January 1, 1991, even though there may no longer be a research activities credit for federal income tax purposes.

42.11(1) Qualified expenditures in Iowa are:

a. Wages for qualified research services performed in Iowa.

b. Cost of supplies used in conducting qualified research in Iowa.

c. Rental or lease cost of personal property used in Iowa in conducting qualified research. Where personal property is used both within and without Iowa in conducting qualified research, the rental or lease cost must be prorated between Iowa and non-Iowa use by the ratio of days used in Iowa to total days used both within and without Iowa.

d. Sixty-five percent of contract expenses paid by a corporation to a qualified organization for basic research performed in Iowa.

42.11(2) Total qualified expenditures are:

a. Wages paid for qualified research services performed everywhere.

b. Cost of supplies used in conducting qualified research everywhere.

c. Rental or lease cost of personal property used in conducting qualified research everywhere.

d. Sixty-five percent of contract expenses paid by a corporation to a qualified organization for basic research performed everywhere.

"Qualifying expenditures for increasing research activities" is the smallest of the amount by which the qualified research expenses for the taxable year exceed the base period research expenses or 50 percent of the qualified research expenses for the taxable year.

A taxpayer may claim on the taxpayer's individual income tax return the pro-rata share of the credit for qualifying research expenditures incurred in Iowa by a partnership, subchapter S corporation, or estate or trust. The portion of the credit claimed by the individual must be in the same ratio as the individual's pro-rata share of the earnings of the partnership, subchapter S corporation, or estate or trust.

Any research credit in excess of the individual's tax liability, less the nonrefundable credits authorized in Iowa Code chapter 422, division II, may be refunded to the taxpayer or may be credited to the estimated tax of the taxpayer for the following year.

42.11(3) Research activities credit for tax years beginning in 2000. Effective for tax years beginning on or after January 1, 2000, the taxes imposed for individual income tax purposes will be reduced by a tax credit for increasing research activities in this state.

a. The credit equals the sum of the following:

(1) Six and one-half percent of the excess of qualified research expenses during the tax year over the base amount for the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities.

(2) Six and one-half percent of the basic research payments determined under Section 41(e)(1)(A) of the Internal Revenue Code during the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities. The state's apportioned share of the qualifying expenditures for increasing research activities is a percent equal to the ratio of qualified research expenditures in this state to total qualified research activities.

b. In lieu of the credit computed under paragraph 42.11(3)*"a,"* a taxpayer may elect to compute the credit amount for qualified research expenses incurred in this state in a manner consistent with the alternative incremental credit described in Section 41(c)(4) of the Internal Revenue Code for tax years beginning on or after January 1, 2000, but beginning before January 1, 2010. The taxpayer may make this election regardless of the method used by the taxpayer on the taxpayer's federal income tax return. The election made under this paragraph is for the tax year, and the taxpayer may use another method or this same method for any subsequent tax year. For purposes of this alternative incremental research credit computation, the credit percentages applicable to qualified research expenses described in clauses (i), (ii), and (iii) of Section 41(c)(4)(A) of the Internal Revenue Code are 1.65 percent, 2.20 percent, and 2.75 percent, respectively.

c. In lieu of the credit computed under paragraph 42.11(3)*"a,"* a taxpayer may elect to compute the credit amount for qualified research expenses incurred in this state in a manner consistent with the alternative simplified credit described in Section 41(c)(5) of the Internal Revenue Code for tax years

beginning on or after January 1, 2010. The taxpayer may make this election regardless of the method used by the taxpayer on the taxpayer's federal income tax return. The election made under this paragraph is for the tax year, and the taxpayer may use another method or this same method for any subsequent tax year.

For purposes of this alternative simplified research credit computation, the credit percentages applicable to qualified research expenses described in Section 41(c)(5)(A) and clause (ii) of Section 41(c)(5)(B) of the Internal Revenue Code are 4.55 percent and 1.95 percent, respectively.

d. For purposes of this subrule, the terms "base amount," "basic research payment," and "qualified research expense" mean the same as defined for the federal credit for increasing research activities under Section 41 of the Internal Revenue Code, except that, for purposes of the alternative incremental credit described in paragraph 42.11(3)*"b"* and the alternative simplified credit described in paragraph 42.11(3)*"c,"* such amounts are limited to research activities conducted within this state. For purposes of this subrule, "Internal Revenue Code" means the Internal Revenue Code in effect on January 1, 2011.

e. An individual may claim a research activities credit incurred by a partnership, S corporation, limited liability company, estate, or trust electing to have the income of the business entity taxed to the individual. The amount claimed by an individual from the business entity shall be based upon the pro-rata share of the individual's earnings from a partnership, S corporation, estate or trust. Any research credit in excess of the individual's tax liability, less the nonrefundable credits authorized in Iowa Code chapter 422, division II, may be refunded to the individual or may be credited to the individual's tax liability for the following tax year.

f. An eligible business approved under the new jobs and income program prior to July 1, 2005, is eligible for an additional research activities credit as described in 701—subrule 52.7(4). An eligible business approved under the enterprise zone program is eligible for an additional research activities credit as described in 701—subrules 52.7(5) and 52.7(6).

g. Tax years ending on or after July 1, 2005, but before July 1, 2009. For eligible businesses approved under the enterprise zone program and the high quality job creation program, research activities allowable for the Iowa research activities credit include expenses related to the development and deployment of innovative renewable energy generation components manufactured or assembled in Iowa. These expenses are not eligible for the federal credit for increasing research activities. These innovative renewable energy generation components do not include components with more than 200 megawatts in installed effective nameplate capacity. The research activities credit related to renewable energy generation components under the enterprise zone program and the high quality job creation program shall not exceed $1 million in the aggregate.

These expenses are available only for the additional research activities credit set forth in subrule 42.11(3), paragraph *"f,"* for businesses in enterprise zones and the additional research activities credit set forth in subrule 42.29(1) for businesses approved under the high quality job creation program. These expenses are not available for the research activities credit set forth in subrule 42.11(3), paragraphs *"a," "b"* and *"c."*

h. Tax years ending on or after July 1, 2009. For eligible businesses approved under the enterprise zone program, research activities allowable for the Iowa research activities credit include expenses related to the development and deployment of innovative renewable energy generation components manufactured or assembled in Iowa; such expenses related to the development and deployment of innovative renewable energy generation components are not eligible for the federal credit for increasing research activities.

(1) For purposes of this paragraph, innovative renewable energy generation components do not include components with more than 200 megawatts in installed effective nameplate capacity.

(2) The research activities credit related to renewable energy generation components under the enterprise zone program and the high quality jobs program described in subrule 42.42(1) shall not exceed $2 million for the fiscal year ending June 30, 2010, and $1 million for the fiscal year ending June 30, 2011.

(3) These expenses related to the development and deployment of innovative renewable energy generation components are applicable only to the additional research activities credit set forth in subrule

42.11(3), paragraph *"f,"* for businesses in enterprise zones and the additional research activities credit set forth in subrule 42.42(1) for businesses approved under the high quality jobs program, and are not applicable to the research activities credit set forth in subrule 42.11(3), paragraphs *"a," "b"* and *"c."*

42.11(4) Reporting of research activities credit claims. Beginning with research activities credit claims filed on or after July 1, 2009, the department shall issue an annual report to the general assembly of all research activities credit claims in excess of $500,000. The report, which is due by February 15 of each year, will contain the name of each claimant and the amount of the research activities credit for all claims filed during the previous calendar year in excess of $500,000.

This rule is intended to implement Iowa Code sections 15.335 and 422.10 as amended by 2011 Iowa Acts, Senate File 512.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 9820B**, IAB 11/2/11, effective 12/7/11]

701—42.12(422) New jobs credit. A tax credit is available to an individual who has entered into an agreement under Iowa Code chapter 260E and has increased employment by at least 10 percent.

42.12(1) *Definitions.*

a. The term "new jobs" means those jobs directly resulting from a project covered by an agreement authorized by Iowa Code chapter 260E (Iowa industrial new jobs training Act) but does not include jobs of recalled workers or replacement jobs or other jobs that formerly existed in the industry in this state.

b. The term "jobs directly related to new jobs" means those jobs which directly support the new jobs but do not include in-state employees transferred to a position which would be considered to be a job directly related to new jobs unless the transferred employee's vacant position is filled by a new employee. The burden of proof that a job is directly related to new jobs is on the taxpayer.

EXAMPLE A. A taxpayer who has entered into a chapter 260E agreement to train new employees for a new product line, transfers an in-state employee to be foreman of the new product line but does not fill the transferred employee's position. The new foreman's position would not be considered a job directly related to new jobs even though it directly supports the new jobs because the transferred employee's old position was not refilled.

EXAMPLE B. A taxpayer who has entered into a chapter 260E agreement to train new employees for a new product line transfers an in-state employee to be foreman of the new product line and fills the transferred employee's position with a new employee. The new foreman's position would be considered a job directly related to new jobs because it directly supports the new jobs and the transferred employee's old position was filled by a new employee.

c. The term "taxable wages" means those wages upon which an employer is required to contribute to the state unemployment fund as defined in Iowa Code subsection 96.19(37) for the year in which the taxpayer elects to take the new jobs tax credit. For fiscal year taxpayers, "taxable wages" shall not be greater than the maximum wage upon which an employer is required to contribute to the state unemployment fund for the calendar year in which the taxpayer's fiscal year begins.

d. The term "agreement" means an agreement entered into under Iowa Code chapter 260E after July 1, 1985, an amendment to that agreement, or an amendment to an agreement entered into before July 1, 1985, if the amendment sets forth the base employment level as of the date of the amendment. The term "agreement" also includes a preliminary agreement entered into under Iowa Code chapter 260E provided the preliminary agreement contains all the elements of a contract and includes the necessary elements and commitments relating to training programs and new jobs.

e. The term "base employment level" means the number of full-time jobs an industry employs at a plant site which is covered by an agreement under Iowa Code chapter 260E on the date of the agreement.

f. The term "project" means a training arrangement which is the subject of an agreement entered into under Iowa Code chapter 260E.

g. The term "industry" means a business engaged in interstate or intrastate commerce for the purpose of manufacturing, processing, or assembling products, conducting research and development, or providing services in interstate commerce, but excludes retail, health, and professional services. "Industry" does not include a business which closes or substantially reduces its operations in one area

of the state and relocates substantially the same operation in another area of the state. "Industry" is a business engaged in the above-listed activities rather than the generic definition encompassing all businesses in the state engaged in the same activities. For example, in the meat-packing business, an industry is considered to be a single corporate entity or operating division, rather than the entire meat-packing business in the state.

h. The term "new employees" means the same as new jobs or jobs directly related to new jobs.

i. The term "full-time job" means any of the following:

(1) An employment position requiring an average work week of 35 or more hours;

(2) An employment position for which compensation is paid on a salaried full-time basis without regard to hours worked; or

(3) An aggregation of any number of part-time or job-sharing employment positions which equal one full-time employment position. For purposes of this subrule, each part-time or job-sharing employment position shall be categorized with regard to the average number of hours worked each week as one-quarter, half, three-quarters, or full-time position, as set forth in the following table:

Average Number of Weekly Hours	**Category**
More than 0 but less than 15	¼
15 or more but less than 25	½
25 or more but less than 35	¾
35 or more	1 (full-time)

42.12(2) *How to compute the credit.* The credit is 6 percent of the taxable wages paid to employees in new jobs or jobs directly related to new jobs for the taxable year in which the taxpayer elects to take the credit.

EXAMPLE 1. A taxpayer enters into an agreement to increase employment by 20 new employees which is greater than 10 percent of the taxpayer's base employment level of 100 employees. In year one of the agreement, the taxpayer hires 20 new employees but elects not to take the credit in that year. In year two of the agreement, only 18 of the new employees hired in year one are still employed and the taxpayer elects to take the credit. The credit would be 6 percent of the taxable wages of the 18 remaining new employees. In year three of the agreement, the taxpayer hires two additional new employees under the agreement to replace the two employees that left in year two and elects to take the credit. The credit would be 6 percent of the taxable wages paid to the two replacement employees. In year four of the agreement, three of the employees for which a credit had been taken left employment and three additional employees were hired. No credit is available for these employees. A credit can only be taken one time for each new job or job directly related to a new job.

EXAMPLE 2. A taxpayer operating two plants in Iowa enters into a chapter 260E agreement to train new employees for a new product line at one of the taxpayer's plants. The base employment level on the date of the agreement at plant A is 300 and at plant B is 100. Under the agreement, 20 new employees will be trained for plant B which is greater than a 10 percent increase of the base employment level for plant B. In the year in which the taxpayer elects to take the credit, the employment level at plant A is 290 and at plant B is 120. The credit would be 6 percent of the wages of 10 new employees at plant B as 10 new jobs were created by the industry in the state. A credit for the remaining 10 employees can be taken if the employment level at plant A increases back to 300 during the period of time that the credit can be taken.

42.12(3) *When the credit can be taken.* The taxpayer may elect to take the credit in any tax year which either begins or ends during the period beginning with the date of the agreement and ending with the date by which the project is to be completed under the agreement. However, the taxpayer may not take the credit until the base employment level has been exceeded by at least 10 percent.

EXAMPLE: A taxpayer enters into an agreement to increase employment from a base employment level of 200 employees to 225 employees. In year one of the agreement, the taxpayer hires 20 new employees which is a 10 percent increase over the base employment level but elects not to take the credit. In year two of the agreement, two of the new employees leave employment. The taxpayer elects

to take the credit which would be 6 percent of the taxable wages of the 18 employees currently employed. In year three, the taxpayer hires 7 new employees and elects to take the credit. The credit would be 6 percent of the taxable wages of the 7 new employees.

A taxpayer may claim on the taxpayer's individual income tax return the pro-rata share of the Iowa new jobs credit from a partnership, subchapter S corporation, estate or trust. The portion of the credit claimed by the individual shall be in the same ratio as the individual's pro-rata share of the earnings of the partnership, subchapter S corporation, or estate or trust. All partners in a partnership, shareholders in a subchapter S corporation and beneficiaries in an estate or trust shall elect to take the Iowa new jobs credit the same year.

For tax years beginning prior to January 1, 2007, any Iowa new jobs credit in excess of the individual's tax liability less the credits authorized in Iowa Code sections 422.12 and 422.12B may be carried forward for ten years or until it is used, whichever is the earlier. For tax years beginning on or after January 1, 2007, any Iowa new jobs credit in excess of the individual's tax liability less the credits authorized in Iowa Code section 422.12 may be carried forward for ten years or until it is used, whichever is the earlier.

This rule is intended to implement Iowa Code section 422.11A.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.13(422) Earned income credit.

42.13(1) *Tax years beginning before January 1, 2007.* Effective for tax years beginning on or after January 1, 1990, an individual is allowed an Iowa earned income credit equal to a percentage of the earned income credit to which the taxpayer is entitled on the taxpayer's federal income tax return as authorized in Section 32 of the Internal Revenue Code. The Iowa earned income credit is nonrefundable; therefore, the credit may not exceed the remaining income tax liability of the taxpayer after the personal exemption credits and the other nonrefundable credits are deducted. The percentage of the earned income credit for tax years beginning in the 1990 calendar year is 5 percent. The percentage of the earned income credit for tax years beginning on or after January 1, 1991, is 6.5 percent.

For federal income tax purposes, the earned income credit is available for a low-income worker who maintains a household in the United States that is the principal place of abode of the worker and a child or children for more than one-half of the tax year or the worker must have provided a home for the entire tax year for a dependent parent. In addition, the worker must be (1) a married person who files a joint return and is entitled to a dependency exemption for a son or daughter, adopted child or stepchild; (2) a surviving spouse; or (3) an individual who qualifies as a head of household as described in Section 2(b) of the Internal Revenue Code. The federal earned income credit for a taxpayer is determined by computing the taxpayer's earned income on a worksheet provided in the federal income tax return instructions and determining the allowable credit from a table included in the instructions for the 1040 or 1040A. For purposes of the credit, a taxpayer's earned income includes wages, salaries, tips, or other compensation plus net income from self-employment.

In the case of married taxpayers who filed a joint federal return and who elected to file separate state returns or separately on the combined return form, the Iowa earned income credit is allocated between the spouses in the ratio that each spouse's earned income relates to the earned income of both spouses.

Nonresidents and part-year residents of Iowa are allowed the same earned income credits as resident taxpayers.

42.13(2) *Tax years beginning on or after January 1, 2007.* Effective for tax years beginning on or after January 1, 2007, an individual is allowed an Iowa earned income credit equal to 7 percent of the earned income credit to which the taxpayer is entitled on the taxpayer's federal income tax return as authorized in Section 32 of the Internal Revenue Code. The Iowa earned income credit is refundable; therefore, the credit may exceed the remaining income tax liability of the taxpayer after the personal exemption credits and other nonrefundable credits are deducted.

In the case of married taxpayers who filed a joint federal return and who elected to file separate state returns or separately on the combined return form, the Iowa earned income credit is allocated between the spouses in the ratio that each spouse's earned income relates to the earned income of both spouses.

Nonresidents or part-year residents of Iowa must determine the Iowa earned income tax credit in the ratio of their Iowa source net income to their total source net income. In addition, if nonresidents or part-year residents of Iowa are married and elect to file separate returns or separately on the combined return form, the Iowa earned income credit must be allocated between the spouses in the ratio of each spouse's Iowa source net income to the combined Iowa source net income.

EXAMPLE: A married couple lives in Omaha, Nebraska. One spouse worked in Iowa in 2007 and had wages and other income from Iowa sources of $12,000. That spouse had a federal adjusted gross income from all sources of $15,000. The other spouse had no Iowa source net income and had a federal adjusted gross income from all sources of $10,000. The taxpayers had a federal earned income credit of $2,800.

The federal earned income credit of $2,800 multiplied by 7 percent equals $196. The ratio of Iowa source net income of $12,000 divided by total source net income of $25,000 equals 48 percent. The Iowa earned income tax credit equals $196 multiplied by 48 percent, or $94.

This rule is intended to implement Iowa Code section 422.12B.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.14(15) Investment tax credit—new jobs and income program and enterprise zone program.

42.14(1) *General rule.* An investment tax credit of up to 10 percent of the new investment which is directly related to new jobs created by the location or expansion of an eligible business is available for businesses approved by the Iowa department of economic development under the new jobs and income program and the enterprise zone program. The new jobs and income program was repealed on July 1, 2005, and has been replaced with the high quality job creation program. See rule 701—42.29(15) for information on the investment tax credit under the high quality job creation program. Any investment tax credit earned by businesses approved under the new jobs and income program prior to July 1, 2005, remains valid and can be claimed on tax returns filed after July 1, 2005. The credit is available for machinery and equipment or improvements to real property placed in service after May 1, 1994. The credit shall be taken in the year the qualifying asset is placed in service. For business applications received by the Iowa department of economic development on or after July 1, 1999, purchases of real property made in conjunction with the location or expansion of an eligible business, the cost of land and any buildings and structures located on the land will be considered to be new investment which is directly related to new jobs for purposes of determining the amount of new investment upon which an investment tax credit may be taken. For projects approved on or after July 1, 2005, under the enterprise zone program, the investment tax credit will be amortized over a five-year period, as described in subrule 42.29(2).

For eligible businesses approved by the Iowa department of economic development on or after March 17, 2004, certain lease payments made by eligible businesses to a third-party developer will be considered to be new investment for purposes of computing the investment tax credit. The eligible business shall enter into a lease agreement with the third-party developer for a minimum of ten years. The investment tax credit is based on the annual base rent paid to a third-party developer by the eligible business for a period not to exceed ten years. The total costs of the annual base rent payments for the ten-year period cannot exceed the cost of the land and the third-party developer's cost to build or renovate the building used by the eligible business. The annual base rent is defined as the total lease payment less taxes, insurance and operating and maintenance expenses.

Any credit in excess of the tax liability for the tax year may be carried forward seven years or until used, whichever is the earlier.

If the business is a partnership, S corporation, limited liability company, or an estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount of the credit claimed by the individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

42.14(2) *Investment tax credit—value-added agricultural products or biotechnology-related processes.* For tax years beginning on or after July 1, 2001, an eligible business whose project primarily

involves the production of value-added agricultural products may elect to receive a refund for all or a portion of an unused investment tax credit. For tax years beginning on or after July 1, 2001, but before July 1, 2003, an eligible business includes a cooperative described in Section 521 of the Internal Revenue Code which is not required to file an Iowa corporation income tax return and whose project primarily involves the production of ethanol. For tax years beginning on or after July 1, 2003, an eligible business includes a cooperative described in Section 521 of the Internal Revenue Code which is not required to file an Iowa corporation income tax return. For tax years ending on or after July 1, 2005, an eligible business approved under the enterprise zone program whose project primarily involves biotechnology-related processes may elect to receive a refund for all or a portion of an unused investment tax credit.

Eligible businesses shall apply to the Iowa department of economic development for tax credit certificates between May 1 and May 15 of each fiscal year through the fiscal year ending June 30, 2009. The election to receive a refund of all or a portion of an unused investment tax credit is no longer available beginning with the fiscal year ending June 30, 2010. Only those businesses that have completed projects before the May 1 filing date may apply for a tax credit certificate. The Iowa department of economic development will not issue tax credit certificates for more than $4 million during a fiscal year for this program and eligible businesses described in subrule 42.29(2). If applications are received for more than $4 million, the applicants shall receive certificates for a prorated amount.

The Iowa department of economic development will issue tax credit certificates within a reasonable period of time. Tax credit certificates are valid for the tax year following project completion. The tax credit certificate must be attached to the tax return for the tax year during which the tax credit is claimed. The tax credit certificate shall not be transferred, except for a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return and whose project primarily involves the production of ethanol for tax years beginning on or after January 1, 2002, or for a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return for tax years beginning on or after July 1, 2003.

For value-added agricultural projects, for a cooperative that is not required to file an Iowa income tax return because it is exempt from federal income tax, the cooperative must submit a list of its members and the share of each member's interest in the cooperative. The Iowa department of economic development will issue a tax credit certificate to each member on the list.

See 701—subrule 52.10(4) for examples illustrating how this subrule is applied.

For tax years beginning on or after January 1, 2002, but before July 1, 2003, a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return and whose project primarily involves the production of ethanol may elect to transfer all or a portion of its tax credit to its members. For tax years beginning on or after July 1, 2003, a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return may elect to transfer all or a portion of its tax credit to its members. The amount of tax credit transferred and claimed by a member shall be based upon the pro-rata share of the member's earnings in the cooperative. The Iowa department of economic development will issue a tax credit certificate to each member of the cooperative to whom the credit was transferred provided that tax credit certificates which total no more than $4 million are issued during a fiscal year. The tax credit certificate must be attached to the tax return for the tax year during which the tax credit is claimed.

42.14(3) *Repayment of credits.* If an eligible business fails to maintain the requirements of the new jobs and income program or the enterprise zone program, the taxpayer may be required to repay all or a portion of the tax incentives taken on Iowa returns. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the tax credits may have expired, the department may proceed to collect the tax incentives forfeited by failure to maintain the requirements of the new jobs and income program or the enterprise zone program because this repayment is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability.

If the eligible business, within five years of purchase, sells, disposes of, razes, or otherwise renders unusable all or a part of the land, buildings, or other existing structures for which a tax credit was claimed

under this rule, the income tax liability of the eligible business for the year in which all or part of the property is sold, disposed of, razed, or otherwise rendered unusable shall be increased by one of the following amounts:

a. One hundred percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within one full year after being placed in service.

b. Eighty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within two full years after being placed in service.

c. Sixty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within three full years after being placed in service.

d. Forty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within four full years after being placed in service.

e. Twenty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within five full years after being placed in service.

This rule is intended to implement Iowa Code section 15.333 as amended by 2010 Iowa Acts, Senate File 2380.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—42.15(422) Child and dependent care credit. Effective for tax years beginning on or after January 1, 1990, there is a child and dependent care credit which is refundable to the extent the amount of the credit exceeds the taxpayer's income tax liability less other applicable income tax credits.

42.15(1) *Computation of the Iowa child and dependent care credit.* The Iowa child and dependent care credit is computed as a percentage of the child and dependent care credit which is allowed for federal income tax purposes under Section 21 of the Internal Revenue Code. The credit is computed so that taxpayers with lower adjusted gross incomes (net incomes in tax years beginning on or after January 1, 1991) are allowed higher percentages of their federal child care credit than taxpayers with higher adjusted gross incomes (net incomes). The following is a schedule showing the percentages of federal child and dependent care credits allowed on the taxpayers' Iowa returns on the basis of the federal adjusted gross incomes (or net incomes) of the taxpayers for tax years beginning on or after January 1, 1993.

*Federal Adjusted Gross Income (Net Income for Tax Years Beginning on or after January 1, 1993)	Percentage of Federal Child and Dependent Care Credit Allowed for 1993 through 2005 Iowa Returns	Percentage of Federal Credit Allowed for 2006 and Later Tax Years
Less than $10,000	75%	75%
$10,000 or more but less than $20,000	65%	65%
$20,000 or more but less than $25,000	55%	55%
$25,000 or more but less than $35,000	50%	50%
$35,000 or more but less than $40,000	40%	40%
$40,000 or more but less than $45,000	No Credit	30%
$45,000 or more	No Credit	No Credit

*Note that in the case of married taxpayers who have filed joint federal returns and elect to file separate returns or separately on the combined return form, the taxpayers must determine the child and dependent care credit by the schedule provided in this rule on the basis of the combined federal adjusted gross income of the taxpayers or their combined net income for tax years beginning on or after January 1, 1991. The credit determined from the schedule must be allocated between the married taxpayers in the proportion that each spouse's federal adjusted gross income relates to the combined federal adjusted gross income of the taxpayers or in the proportion that each spouse's net income relates to the combined net income of the taxpayers in the case of tax years beginning on or after January 1, 1991.

42.15(2) *Examples of computation of the Iowa child and dependent care credit.* The following are examples of computation of the child and dependent care credit and the allocation of the credit between spouses in situations where married taxpayers have filed joint federal returns and are filing separate Iowa

returns or separately on the combined return form. For tax years beginning on or after January 1, 1991, the taxpayers' net incomes are used to compute the Iowa child and dependent care credit and allocate the credit between spouses in situations where the taxpayers file separate Iowa returns or separately on the combined return form.

EXAMPLE A. A married couple has filed a joint federal return on which they showed a federal adjusted gross income of $40,000 or a combined net income of $40,000 on their state return for the tax year beginning January 1, 2007. Both spouses were employed. They had a federal child and dependent care credit of $600 which related to expenses incurred for care of their two small children. One of the spouses had a federal adjusted gross income of $30,000 or a net income of $30,000 and the second spouse had a federal adjusted gross income of $10,000 or a net income of $10,000.

The taxpayers' Iowa child and dependent care credit was $180 since they were entitled to an Iowa child and dependent care credit of 30 percent of their federal credit of $600. If the taxpayers elect to file separate Iowa returns, the $180 credit would be allocated between the spouses on the basis of each spouse's net income to the combined net income of both spouses as shown below:

$$\$180 \times \frac{\$30{,}000}{\$40{,}000} = \$135$$ child and dependent care credit for spouse with $30,000 net income for 2007

$$\$180 \times \frac{\$10{,}000}{\$40{,}000} = \$45$$ child and dependent care credit for spouse with $10,000 net income for 2007

EXAMPLE B. A married couple filed a joint federal return for 2007 and filed their 2007 Iowa return using the married filing separately on the combined return form filing status. Both spouses were employed. They had a federal child and dependent care credit of $800 which related to expenses incurred for care of their children. One spouse had a net income of $25,000 and the other spouse had a net income of $12,500.

The taxpayers' Iowa child and dependent care credit was $320, since they were entitled to an Iowa credit of 40 percent of their federal credit of $800. The $320 credit is allocated between the spouses on the basis of each spouse's net income as it relates to the combined net income of both spouses as shown below:

$$\$320 \times \frac{\$25{,}000}{\$37{,}500} = \$213$$ child and dependent care credit for spouse with $25,000 net income for 2007

$$\$320 \times \frac{\$12{,}500}{\$37{,}500} = \$107$$ child and dependent care credit for spouse with $12,500 net income for 2007

42.15(3) *Computation of the Iowa child and dependent care credit for nonresidents and part-year residents.* Nonresidents and part-year residents who have incomes from Iowa sources in the tax year may claim child and dependent care credits on their Iowa returns. To compute the amount of child and dependent care credit that can be claimed on the Iowa return by a nonresident or part-year resident, the following formula shall be used:

$$\text{Federal child and dependent care credit} \times \text{Percentage of federal child and dependent credit allowed on Iowa return from table in subrule 42.15(1)} \times \frac{\text{*Iowa net income}}{\text{Federal adjusted gross income or all source net income}}$$

*Iowa net income for purposes of determining the child care credit that can be claimed on the Iowa return by a nonresident or part-year resident taxpayer is the total of the Iowa source incomes less the Iowa source adjustments to income on line 26 of the Form IA 126.

In cases where married taxpayers are nonresidents or part-year residents of Iowa and are filing separate Iowa returns or separately on the combined return form, the child and dependent care credit allowable on the Iowa return should be allocated between the spouses in the ratio of the Iowa net income of each spouse to the combined Iowa net income of the taxpayers.

42.15(4) *Example of computation of the Iowa child and dependent care credit for nonresidents and part-year residents.* The following is an example of the computation of the Iowa child and dependent care credit for nonresidents and part-year residents.

A married couple lives in Omaha, Nebraska. One of the spouses worked in Iowa and had wages and other income from Iowa sources or an Iowa net income of $15,000. That spouse had an all source net income of $18,000. The second spouse had an Iowa net income of $10,000 and an all source net income of $12,000. The taxpayers had a federal child and dependent care credit of $800 which related to expenses incurred for the care of their two young children. The taxpayers' Iowa child and dependent care credit is calculated below for the 2007 tax year:

Federal child and dependent care credit		Percentage of federal child and dependent credit allowed on Iowa return		Iowa net income / All source net income		
$800	×	50%	=	$400 ×	$\frac{\$25,000}{\$30,000}$ =	$333

The $333 credit is allocated between the spouses as shown below for the 2007 tax year:

$333 × $\frac{\$10,000}{\$25,000}$ = $133 for spouse with Iowa source net income of $10,000

$333 × $\frac{\$15,000}{\$25,000}$ = $200 for spouse with Iowa source net income of $15,000

This rule is intended to implement Iowa Code section 422.12C.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.16(422) Franchise tax credit. For tax years beginning on or after January 1, 1997, a shareholder in a financial institution, as defined in Section 581 of the Internal Revenue Code, which has elected to have its income taxed directly to the shareholders may take a tax credit equal to the shareholder's pro-rata share of the Iowa franchise tax paid by the financial institution.

For tax years beginning on or after July 1, 2004, a member of a financial institution organized as a limited liability company that is taxed as a partnership for federal income tax purposes which has elected to have its income taxed directly to its members may take a tax credit equal to the member's pro-rata share of the Iowa franchise tax paid by the financial institution.

The credit must be computed by recomputing the amount of tax computed under Iowa Code section 422.5 by reducing the shareholder's or member's taxable income by the shareholder's or member's pro-rata share of the items of income and expenses of the financial institution and subtracting the credits allowed in Iowa Code sections 422.12 and 422.12B for tax years beginning prior to January 1, 2007. The recomputed tax must be subtracted from the amount of tax computed under Iowa Code section 422.5 reduced by the credits allowed in Iowa Code sections 422.12 and 422.12B for tax years beginning prior to January 1, 2007. For tax years beginning on or after January 1, 2007, only the credits allowed in Iowa Code section 422.12 are reduced in computing the franchise tax credit.

The resulting amount, not to exceed the shareholder's or member's pro-rata share of the franchise tax paid by the financial institution, is the amount of tax credit allowed the shareholder or member.

This rule is intended to implement Iowa Code section 422.11.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.17(15E) Eligible housing business tax credit. An individual who qualifies as an eligible housing business may receive a tax credit of up to 10 percent of the new investment which is directly related to the building or rehabilitating of homes in an enterprise zone. The tax credit may be taken on the tax return for the tax year in which the home is ready for occupancy.

An eligible housing business is one which meets the criteria in Iowa Code section 15E.193B.

42.17(1) *Computation of credit.* New investment which is directly related to the building or rehabilitating of homes includes but is not limited to the following costs: land, surveying, architectural services, building permits, inspections, interest on a construction loan, building materials, roofing, plumbing materials, electrical materials, amounts paid to subcontractors for labor and materials provided, concrete, labor, landscaping, appliances normally provided with a new home, heating and cooling equipment, millwork, drywall and drywall materials, nails, bolts, screws, and floor coverings.

New investment does not include the machinery, equipment, or hand or power tools necessary to build or rehabilitate homes.

A taxpayer may claim on the taxpayer's individual income tax return the pro-rata share of the Iowa eligible housing business tax credit from a partnership, S corporation, limited liability company, estate, or trust. The portion of the credit claimed by the individual shall be in the same ratio as the individual's pro-rata share of the earnings of the partnership, S corporation, limited liability company, or estate or trust, except for projects beginning on or after July 1, 2005, which used low-income housing tax credits authorized under Section 42 of the Internal Revenue Code to assist in the financing of the housing development. For these projects, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder.

For tax years beginning prior to January 1, 2007, any Iowa eligible housing business tax credit in excess of the individual's tax liability, less the credits authorized in Iowa Code sections 422.12 and 422.12B, may be carried forward for seven years or until it is used, whichever is the earlier. For tax years beginning on or after January 1, 2007, any Iowa eligible housing business tax credit in excess of the individual's tax liability less the credits authorized in Iowa Code section 422.12 may be carried forward for seven years or until it is used, whichever is the earlier.

If the eligible housing business fails to maintain the requirements of Iowa Code section 15E.193B, the taxpayer, in order to be an eligible housing business, may be required to repay all or a part of the tax incentives the taxpayer received. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the income tax credit may have expired, the department may proceed to collect the tax incentives forfeited by failure to maintain the requirements of Iowa Code section 15E.193B. This repayment is required because it is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability.

Prior to January 1, 2001, the tax credit cannot exceed 10 percent of $120,000 for each home or individual unit in a multiple dwelling unit building. Effective January 1, 2001, the tax credit cannot exceed 10 percent of $140,000 for each home or individual unit in a multiple dwelling unit building.

Effective for tax periods beginning on or after January 1, 2003, the taxpayer must receive a tax credit certificate from the Iowa department of economic development to claim the eligible housing business tax credit. The tax credit certificate shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the date the project was completed, the amount of the eligible housing business tax credit and the tax year for which the credit may be claimed. In addition, the tax credit certificate shall include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 42.17(2). The tax credit certificate must be attached to the income tax return for the tax period in which the home is ready for occupancy. The administrative rules for the eligible housing business tax credit for the Iowa department of economic development may be found under 261—Chapter 59.

42.17(2) *Transfer of the eligible housing business tax credit.* For tax periods beginning on or after January 1, 2003, the eligible housing business tax credit certificates may be transferred to any person or entity if low-income housing tax credits authorized under Section 42 of the Internal Revenue Code are used to assist in the financing of the housing development. In addition, the eligible housing business tax credit certificates may be transferred to any person or entity for projects beginning on or after July 1, 2005, if the housing development is located in a brownfield site as defined in Iowa Code section 15.291, or if the housing development is located in a blighted area as defined in Iowa Code section 403.17. No more than $3 million of tax credits for housing developments located in brownfield sites or blighted areas may be transferred in a calendar year, with no more than $1.5 million being transferred for any one eligible housing business in a calendar year.

Within 90 days of transfer of the tax credit certificate for transfers prior to July 1, 2006, the transferee must submit the transferred tax credit certificate to the Iowa department of economic development, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. For transfers on or after July 1, 2006, the transferee must submit the transferred tax credit certificate to the department of revenue. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee for transfers prior to July 1, 2006, the Iowa department of economic development will issue a replacement tax credit certificate to the transferee. For transfers on or after July 1, 2006, the department of revenue will issue the replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company or S corporation, the transferee shall provide a list of the partners, members or shareholders and information on how the housing business tax credit should be divided among the partners, members or shareholders. The transferee shall also provide the tax identification numbers and addresses of the partners, members or shareholders. The replacement tax credit certificate must contain the same information that was on the original certificate and must have the same expiration date as the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax period for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credits shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

This rule is intended to implement Iowa Code section 15E.193B.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.18(422) Assistive device tax credit. Effective for tax years beginning on or after January 1, 2000, a taxpayer that is a small business that purchases, rents, or modifies an assistive device or makes workplace modifications for an individual with a disability who is employed or will be employed by the taxpayer may qualify for an assistive device tax credit, subject to the availability of the credit. The assistive device credit is equal to 50 percent of the first $5,000 paid during the tax year by the small business for the purchase, rental, or modification of an assistive device or for making workplace modifications. Any credit in excess of the tax liability may be refunded or applied to the taxpayer's tax liability for the following tax year. If the taxpayer elects to take the assistive device tax credit, the taxpayer shall not deduct for Iowa income tax purposes any amount of the cost of an assistive device or workplace modification that is deductible for federal income tax purposes. A small business will not be eligible for the assistive device credit if the device is provided for an owner of the small business unless the owner is a bona fide employee of the small business.

42.18(1) *Submitting applications for the credit.* A small business that wishes to receive the assistive device tax credit must submit an application for the credit to the Iowa department of economic development and provide other information and documents requested by the Iowa department of economic development. If the taxpayer meets the criteria for qualification for the credit, the Iowa department of economic development will issue the taxpayer a certificate of entitlement for the credit. However, the aggregate amount of assistive device tax credits that may be granted by the Iowa department of economic development to all small businesses during a fiscal year cannot exceed $500,000. The certificate of entitlement for the assistive device credit shall include the taxpayer's

name, the taxpayer's address, the taxpayer's tax identification number, the estimated amount of the tax credit, the date on which the taxpayer's application was approved, the date when it is anticipated that the assistive device project will be completed and a space on the application where the taxpayer shall enter the date that the assistive device project was completed. The certificate of entitlement will not be considered to be valid for purposes of claiming the assistive device credit on the taxpayer's Iowa income tax return until the taxpayer has completed the assistive device project and has entered the completion date on the certificate of entitlement form. The tax year of the small business in which the assistive device project is completed is the tax year for which the assistive device credit may be claimed. For example, in a case where taxpayer A received a certificate of entitlement for an assistive device credit on September 15, 2007, and completed the assistive device workplace modification project on January 15, 2008, taxpayer A could claim the assistive device credit on taxpayer A's 2008 Iowa return, assuming that taxpayer A is filing returns on a calendar-year basis.

The department of revenue will not allow the assistive device credit on a taxpayer's return if the certificate of entitlement or a legible copy of the certificate is not attached to the taxpayer's income tax return. If the taxpayer has been granted a certificate of entitlement and the taxpayer is a partnership, limited liability company, S corporation, estate, or trust, where the income of the taxpayer is taxed to the individual owner(s) of the business entity, the taxpayer must provide a copy of the certificate to each of the owners with a statement showing how the credit is to be allocated among the individual owners of the business entity. An individual owner shall attach a copy of the certificate of entitlement and the statement of allocation of the assistive device credit to the individual's state income tax return.

42.18(2) *Definitions.* The following definitions are applicable to this rule:

"Assistive device" means any item, piece of equipment, or product system which is used to increase, maintain, or improve the functional capabilities of an individual with a disability in the workplace or on the job. "Assistive device" does not mean any medical device, surgical device, or organ implanted or transplanted into or attached directly to an individual. "Assistive device" does not include any device for which a certificate of title is issued by the state department of transportation, but does include any item, piece of equipment, or product system otherwise meeting the definition of "assistive device" that is incorporated, attached, or included as a modification in or to such a device issued a certificate of title.

"Business entity" means partnership, limited liability company, S corporation, estate, or trust, where the income of the business is taxed to each of the individual owners of the business, whether the individual owner is a partner, member, shareholder, or beneficiary.

"Disability" means the same as defined in Iowa Code section 15.102. Therefore, "disability" means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of the individual, a record of physical or mental impairment that substantially limits one or more of the major life activities of the individual, or being regarded as an individual with a physical or mental impairment that substantially limits one or more of the major life activities of the individual. "Disability" does not include any of the following:

1. Homosexuality or bisexuality.
2. Transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders, or other sexual behavior disorders.
3. Compulsive gambling, kleptomania, or pyromania.
4. Psychoactive substance abuse disorders resulting from current illegal use of drugs.
5. Alcoholism.

"Employee" means an individual who is employed by the small business and who meets the criteria in Treasury Regulation § 31.3401(c)-1(b), which is the definition of an employee for federal income tax withholding purposes. An individual who receives self-employment income from the small business shall not be considered an employee of the small business for purposes of this rule.

"Small business" means that the business either had gross receipts in the tax year before the current tax year of $3 million or less or employed not more than 14 full-time employees during the tax year prior to the current tax year.

"Workplace modifications" means physical alterations to the office, factory, or other work environment where the disabled employee is working or will work.

42.18(3) *Allocation of assistive tax credit to owners of a business entity.* If the taxpayer that was entitled to an assistive device credit is a business entity, the business entity shall allocate the allowable credit to each of the individual owners of the entity on the basis of each owner's pro-rata share of the earnings of the entity to the total earnings of the entity. Therefore, if a partnership has an assistive device credit of $2,500 for a tax year and one partner of the partnership receives 25 percent of the earnings of the partnership, that partner would receive an assistive device credit for the tax year of $625 or 25 percent of the total assistive device credit of the partnership.

42.18(4) *Repeal of credit.* The assistive device credit is repealed on July 1, 2009.

This rule is intended to implement Iowa Code section 422.11E.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.19(404A,422) Historic preservation and cultural and entertainment district tax credit. A historic preservation and cultural and entertainment district tax credit, subject to the availability of the credit, may be claimed against a taxpayer's Iowa individual income tax liability for 25 percent of the qualified costs of rehabilitation of property to the extent the costs were incurred on or after July 1, 2000, for approved rehabilitation projects of eligible property in Iowa. The administrative rules for the historic preservation and cultural and entertainment district tax credit for the historical division of the department of cultural affairs may be found under 223—Chapter 48.

42.19(1) *Eligible properties for the historic preservation and cultural and entertainment district tax credit.* The following types of property are eligible for the historic preservation and cultural and entertainment district tax credit:

a. Property verified as listed on the National Register of Historic Places or eligible for such listing.

b. Property designated as of historic significance to a district listed in the National Register of Historic Places or eligible for such designation.

c. Property or district designated a local landmark by a city or county ordinance.

d. Any barn constructed prior to 1937.

42.19(2) *Application and review process for the historic preservation and cultural and entertainment district tax credit.*

a. Taxpayers who want to claim an income tax credit for completing a historic preservation and cultural and entertainment district project must submit an application for approval of the project. The application forms for the historic preservation and cultural and entertainment district tax credit may be requested from the State Tax Credit Program Manager, State Historic Preservation Office, Department of Cultural Affairs, 600 E. Locust, Des Moines, Iowa 50319-0290. The telephone number for this office is (515)281-4137. Applications for the credit will be accepted by the state historic preservation office on or after July 1, 2000, until such time as all the available credits allocated for each fiscal year are encumbered. For fiscal years beginning on or after July 1, 2000, $2.4 million shall be appropriated for historic preservation and cultural and entertainment district tax credits for each year. For the fiscal years beginning July 1, 2005, and July 1, 2006, an additional $4 million of tax credits is appropriated for projects located in cultural and entertainment districts which are certified by the department of cultural affairs. If less than $4 million of tax credits is appropriated during a fiscal year, the remaining amount shall be applied to reserved tax credits for projects not located in cultural and entertainment districts in the order of original reservation by the department of cultural affairs. For the fiscal year beginning July 1, 2007, $10 million in historic preservation and cultural and entertainment district tax credits is available. For the fiscal year beginning July 1, 2008, $15 million in historic preservation and cultural and entertainment district tax credits is available. For the fiscal year beginning July 1, 2009, through the fiscal year beginning July 1, 2011, $50 million in historic preservation and cultural and entertainment district tax credits is available. The allocation of the $50 million of credits for the fiscal year beginning July 1, 2009, through the fiscal year beginning July 1, 2011, is set forth in rule 223—48.7(303,404A). For fiscal years beginning on or after July 1, 2012, $45 million in historic preservation and cultural and entertainment district tax credits is available. Tax credits shall not be reserved by the department of cultural affairs for more than three years except for tax credits issued for contracts entered into prior to July 1, 2007.

b. For the state fiscal year beginning on July 1, 2009, $20 million of the credits may be claimed on tax returns beginning on or after January 1, 2009, and $30 million of the credits may be claimed on tax returns beginning on or after January 1, 2010. For the state fiscal year beginning July 1, 2010, $20 million of the credits may be claimed on tax returns beginning on or after January 1, 2010, and $30 million of tax credits may be claimed on tax returns beginning on or after January 1, 2011. For the state fiscal year beginning July 1, 2011, $20 million of the credits may be claimed on tax returns beginning on or after January 1, 2011, and $30 million of tax credits may be claimed on tax returns beginning on or after January 1, 2012.

c. Applicants for the historic preservation and cultural and entertainment district tax credit must include all information and documentation requested on the application forms for the credit in order for the application to be processed.

d. The state historic preservation office (SHPO) shall establish selection criteria and standards for rehabilitation projects involving eligible property. The approval process shall not exceed 90 days from the date the application is received by SHPO. To the extent possible, the standards used by SHPO shall be consistent with the standards of the United States Secretary of the Interior for rehabilitation of eligible property.

e. Once SHPO approves a particular historic preservation and cultural and entertainment district tax credit project application, the office will encumber an estimated historic preservation and cultural and entertainment district tax credit under the name of the applicant(s) for the year the project is approved.

42.19(3) *Computation of the amount of the historic preservation and cultural and entertainment district tax credit.* The amount of the historic preservation and cultural and entertainment district tax credit is 25 percent of the qualified rehabilitation costs made to an eligible property in a project. Qualified rehabilitation costs are those rehabilitation costs approved by SHPO for a project for a particular taxpayer to the extent those rehabilitation costs are actually expended by that taxpayer.

In the case of commercial property, qualified rehabilitation costs must equal at least 50 percent of the assessed value of the property, excluding the value of the land, prior to rehabilitation. In the case of residential property or barns, the qualified rehabilitation costs must equal at least $25,000 or 25 percent of the assessed value, excluding the value of the land, prior to the rehabilitation, whichever amount is less. In computing the tax credit, the only costs which may be included are the qualified rehabilitation costs incurred commencing from the date on which the first qualified rehabilitation cost is incurred and ending with the end of the taxable year in which the property is placed in service. The rehabilitation period may include dates that precede approval of a project, provided that any qualified rehabilitation costs incurred prior to the date of approval of the project are qualified rehabilitation costs.

For purposes of the historic preservation and cultural and entertainment district tax credit, qualified rehabilitation costs include those costs properly included in the basis of the eligible property for income tax purposes. Costs treated as expenses and deducted in the year paid or incurred and amounts that are otherwise not added to the basis of the property for income tax purposes are not qualified rehabilitation costs. Amounts incurred for architectural and engineering fees, site survey fees, legal expenses, insurance premiums, development fees, and other construction-related costs are qualified rehabilitation costs to the extent they are added to the basis of the eligible property for tax purposes. Costs of sidewalks, parking lots, and landscaping do not constitute qualified rehabilitation costs. Any rehabilitation costs used in the computation of the historic preservation and cultural and entertainment district tax credit are not added to the basis of the property for Iowa income tax purposes if the rehabilitation costs were incurred in a tax year beginning on or after January 1, 2000, but prior to January 1, 2001. Any rehabilitation costs incurred in a tax year beginning on or after January 1, 2001, are added to the basis of the rehabilitated property for income tax purposes except those rehabilitation expenses that are equal to the amount of the computed historic preservation and cultural and entertainment district tax credit for the tax year.

For example, the basis of a commercial building in a historic district was $500,000, excluding the value of the land, before the rehabilitation project. During a project to rehabilitate this building, $600,000 in rehabilitation costs were expended to complete the project and $500,000 of those rehabilitation costs were qualified rehabilitation costs which were eligible for the historic preservation and cultural and

entertainment district tax credit of $125,000. Therefore, the basis of the building for Iowa income tax purposes was $975,000, since the qualified rehabilitation costs of $125,000, which are equal to the amount of the historic preservation and cultural and entertainment district tax credit for the tax year, are not added to the basis of the rehabilitated property. The basis of the building for federal income tax purposes was $1,100,000. However, for tax years beginning only in the 2000 calendar year, the basis of the building for Iowa income tax purposes would have been $600,000, since for those tax periods, any qualified rehabilitation expenses used to compute the historic preservation and cultural and entertainment district tax credit for the tax year could not be added to the basis of the property. It should be noted that this example does not consider any possible reduced basis for the building for federal income tax purposes due to the rehabilitation investment credit provided in Section 47 of the Internal Revenue Code. If the building in this example were eligible for the federal rehabilitation credit provided in Section 47 of the Internal Revenue Code, the basis of the building for Iowa tax purposes would be reduced accordingly by the same amount as the reduction required for federal tax purposes.

42.19(4) *Completion of the historic preservation and cultural and entertainment district project and claiming the historic preservation and cultural and entertainment district tax credit on the Iowa return.* After the taxpayer completes an authorized rehabilitation project, the taxpayer must be issued a certificate of completion of the project from the state historic preservation office of the department of cultural affairs. After verifying the taxpayer's eligibility for the historic preservation and cultural and entertainment district tax credit, the state historic preservation office shall issue a historic preservation and cultural and entertainment district tax credit certificate, which shall be attached to the taxpayer's income tax return for the tax year in which the rehabilitation project is completed or the year the credit was reserved, whichever is the later. For example, if a project was completed in 2008 and the credit was reserved for the state fiscal year ending June 30, 2010, the credit can be claimed on the 2009 calendar year return that is due on April 30, 2010. The tax credit certificate shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the address or location of the rehabilitation project, the date the project was completed, the year the tax credit was reserved and the amount of the historic preservation and cultural and entertainment district tax credit. In addition, the tax credit certificate shall include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 42.19(6). In addition, if the taxpayer is a partnership, limited liability company, estate or trust, where the tax credit is allocated to the owners or beneficiaries of the entity, a list of the owners or beneficiaries and the amount of credit allocated to each owner or beneficiary shall be provided with the certificate. The tax credit certificate shall be attached to the income tax return for the period in which the project was completed. If the amount of the historic preservation and cultural and entertainment district tax credit exceeds the taxpayer's income tax liability for the tax year for which the credit applies, the taxpayer is entitled to a refund of the excess portion of the credit at a discounted value for tax periods ending prior to July 1, 2007. However, the refund cannot exceed 75 percent of the allowable tax credit. The refund of the tax credit shall be computed on the basis of the following table:

Annual Interest Rate	Five-Year Present Value/Dollar Compounded Annually
5%	$.784
6%	$.747
7%	$.713
8%	$.681
9%	$.650
10%	$.621
11%	$.594
12%	$.567

13%	$.543
14%	$.519
15%	$.497
16%	$.476
17%	$.456
18%	$.437

EXAMPLE: The following is an example to show how the table can be used to compute a refund for a taxpayer. An individual has a historic preservation and cultural and entertainment district tax credit of $800,000 for a project completed in 2001. The individual had an income tax liability prior to the credit of $300,000 on the 2001 return, which leaves an excess credit of $500,000. The annual interest rate for tax refunds issued by the department of revenue in the 2001 calendar year is 11 percent. Therefore, to compute the five-year present value of the $500,000 excess credit, $500,000 is multiplied by the compound factor for 11 percent of .594 in the table, which results in a refund of $297,000.

For tax years ending on or after July 1, 2007, any historic preservation and cultural and entertainment district tax credit in excess of the taxpayer's tax liability is fully refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

42.19(5) *Allocation of historic preservation and cultural and entertainment district tax credits to the individual owners of the entity.* When the taxpayer that has earned a historic preservation and cultural and entertainment district tax credit is a partnership, limited liability company, S corporation, estate or trust where the individual owners of the business entity are taxed on the income of the entity, the historic preservation and cultural and entertainment district tax credit shall be allocated to the individual owners. The business entity shall allocate the historic preservation and cultural and entertainment district tax credit to each individual owner on the same pro-rata basis as the earnings of the business are allocated to the owners for projects beginning prior to July 1, 2005. For example, if a partner of a partnership received 25 percent of the earnings or income of the partnership for the tax year in which the partnership had earned a historic preservation and cultural and entertainment district tax credit, 25 percent of the credit would be allocated to this partner.

For projects beginning on or after July 1, 2005, which used low-income housing credits authorized under Section 42 of the Internal Revenue Code to assist in the financing of the rehabilitation project, the credit does not have to be allocated based on the pro-rata share of earnings of the partnership, limited liability company or S corporation. For these projects, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder.

42.19(6) *Transfer of the historic preservation and cultural and entertainment district tax credit.* For tax periods beginning on or after January 1, 2003, the historic preservation and cultural and entertainment district tax credit certificates may be transferred to any person or entity. A tax credit certificate of less than $1,000 shall not be transferable.

Within 90 days of transfer of the tax credit certificate for transfers prior to July 1, 2006, the transferee must submit the transferred tax credit certificate to the state historic preservation office of the department of cultural affairs, along with a statement which contains the transferee's name, address and tax identification number and amount of the tax credit being transferred. For transfers on or after July 1, 2006, the transferee must submit the transferred tax credit certificate to the department of revenue. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee for transfers prior to July 1, 2006, the state historic preservation office shall issue a replacement tax credit certificate to the transferee. For transfers on or after July 1, 2006, the department of revenue will issue the replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company or S corporation, the transferee shall provide a list of the partners, members or shareholders and information on how the historic preservation and cultural and entertainment district tax credit should be divided among the partners, members or shareholders. The transferee shall also

provide the tax identification numbers and addresses of the partners, members or shareholders. The replacement tax credit certificate must contain the same information that was on the original certificate and must have the same expiration date as the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax period for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

If the historic preservation and cultural and entertainment district tax credit of the transferee exceeds the tax liability shown on the transferee's return, the refund shall be discounted as described in subrule 42.19(4) for tax years ending prior to July 1, 2007, just as the refund would have been discounted on the Iowa income tax return of the taxpayer. For tax years ending on or after July 1, 2007, any historic preservation and cultural and entertainment district tax credit of the transferee in excess of the transferee's tax liability is fully refundable.

This rule is intended to implement Iowa Code chapter 404A as amended by 2011 Iowa Acts, Senate Files 517 and 521, and Iowa Code section 422.11D.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—42.20(422) Ethanol blended gasoline tax credit. Effective for tax years beginning on or after January 1, 2002, a retail gasoline dealer may claim an ethanol blended gasoline tax credit against that individual's individual income tax liability. The taxpayer must operate at least one retail motor fuel site at which more than 60 percent of the total gallons of gasoline sold and dispensed through one or more motor fuel pumps by the taxpayer in the tax year is ethanol blended gasoline. The tax credit shall be calculated separately for each retail motor fuel site operated by the taxpayer. The amount of the credit for each eligible retail motor fuel site is two and one-half cents multiplied by the total number of gallons of ethanol blended gasoline sold and dispensed through all motor fuel pumps located at that retail motor fuel site during the tax year in excess of 60 percent of all gasoline sold and dispensed through motor fuel pumps at that retail motor fuel site during the tax year.

For taxpayers having a fiscal year ending in 2002, the tax credit is available for each eligible retail motor fuel site based on the total number of gallons of ethanol blended gasoline sold and dispensed through all motor fuel pumps located at the taxpayer's retail motor fuel site from January 1, 2002, until the end of the taxpayer's fiscal year. Assuming a tax period that began on July 1, 2001, and ended on June 30, 2002, the taxpayer would be eligible for the tax credit based on the gallons of ethanol blended gasoline sold from January 1, 2002, through June 30, 2002. For taxpayers having a fiscal year ending in 2002, a claim for refund to claim the ethanol blended gasoline tax credit must be filed before October 1, 2003, even though the statute of limitations for refund set forth in 701—subrule 43.3(8) has not yet expired.

EXAMPLE 1: A taxpayer sold 100,000 gallons of gasoline at the taxpayer's retail motor fuel site during the tax year, 70,000 gallons of which was ethanol blended gasoline. The taxpayer is eligible for the credit since more than 60 percent of the total gallons sold was ethanol blended gasoline. The number of gallons in excess of 60 percent of all gasoline sold is 70,000 less 60,000, or 10,000 gallons. Two and one-half cents multiplied by 10,000 equals a $250 credit available.

The credit may be calculated on Form IA 6478. The credit must be calculated separately for each retail motor fuel site operated by the taxpayer. Therefore, if the taxpayer operates more than one retail motor fuel site, it is possible that one retail motor fuel site may be eligible for the credit while another retail motor fuel site may not. The credit may be taken only for those retail motor fuel sites for which more than 60 percent of gasoline sales involves ethanol blended gasoline.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

Starting with the 2006 calendar tax year, a taxpayer may claim the ethanol blended gasoline tax credit even if the taxpayer also claims the E-85 gasoline promotion tax credit provided in rule 701—42.31(422) for the same tax year for the same ethanol gallons.

EXAMPLE 2: A taxpayer sold 200,000 gallons of gasoline at a retail motor fuel site in 2006, of which 160,000 gallons was ethanol blended gasoline. Of these 160,000 gallons, 1,000 gallons was E-85 gasoline. Taxpayer is entitled to claim the ethanol blended gasoline tax credit of two and one-half cents multiplied by 40,000 gallons, since this amount constitutes the gallons in excess of 60 percent of the total gasoline gallons sold. Taxpayer may also claim the E-85 gasoline promotion tax credit on the 1,000 gallons of E-85 gasoline sold.

42.20(1) *Definitions.* The following definitions are applicable to this rule:

"Ethanol blended gasoline" means the same as defined in Iowa Code section 214A.1.

"Gasoline" means any liquid product prepared, advertised, offered for sale or sold for use as, or commonly and commercially used as, motor fuel for use in a spark-ignition, internal combustion engine, and which meets the specifications provided in Iowa Code section 214A.2.

"Motor fuel pump" means a pump, meter, or similar commercial weighing and measuring device used to measure and dispense motor fuel for sale on a retail basis.

"Retail dealer" means a person engaged in the business of storing and dispensing motor fuel from a motor fuel pump for sale on a retail basis, regardless of whether the motor fuel pump is located at a retail motor fuel site including a permanent or mobile location.

"Retail motor fuel site" means a geographic location in Iowa where a retail dealer sells and dispenses motor fuel on a retail basis. For example, tank wagons are considered retail motor fuel sites.

"Sell" means to sell on a retail basis.

42.20(2) *Allocation of credit to owners of a business entity.* If the taxpayer that was entitled to the ethanol blended gasoline tax credit is a partnership, limited liability company, S corporation, estate, or trust, the business entity shall allocate the allowable credit to each of the individual owners of the entity on the basis of each owner's pro-rata share of the earnings of the entity to the total earnings of the entity. Therefore, if a partnership has an ethanol blended gasoline tax credit of $3,000 and one partner of the partnership receives 25 percent of the earnings of the partnership, that partner would receive an ethanol blended gasoline tax credit for the tax year of $750 or 25 percent of the total ethanol blended gasoline tax credit of the partnership.

42.20(3) *Repeal of ethanol blended gasoline tax credit.* The ethanol blended gasoline tax credit is repealed on January 1, 2009. However, the tax credit is available for taxpayers whose fiscal year ends after December 31, 2008, for those ethanol gallons sold beginning on the first day of the taxpayer's fiscal year until December 31, 2008. The ethanol promotion tax credit described in rule 701—42.37(15,422) is available beginning January 1, 2009, for retail dealers of gasoline.

See 701—subrule 52.19(3) for an example illustrating how this subrule is applied.

This rule is intended to implement Iowa Code section 422.11C.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.21(15E) Eligible development business investment tax credit. Effective for tax years beginning on or after January 1, 2001, a business which qualifies as an eligible development business may receive a tax credit of up to 10 percent of the new investment which is directly related to the construction, expansion or rehabilitation of building space to be used for manufacturing, processing, cold storage, distribution, or office facilities.

An eligible development business must be approved by the Iowa department of economic development prior to March 17, 2004, and meet the qualifications of Iowa Code section 15E.193C. Effective March 17, 2004, the eligible development business program is repealed.

New investment includes the purchase price of land and the cost of improvements made to real property. The tax credit may be claimed by an eligible development business in the tax year in which the construction, expansion or rehabilitation is completed.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following seven years or until used, whichever is the earlier.

If the business is a partnership, S corporation, limited liability company, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

If the eligible development business fails to meet and maintain any one of the requirements to be an eligible business, the business shall be subject to repayment of all or a portion of the amount of tax incentives received. For example, if within five years of project completion the development business sells or leases any space to any retail business, the development business shall proportionally repay the value of the investment credit. The proportion of the investment credit that would be due for repayment by an eligible development business for selling or leasing space to a retail business would be determined by dividing the square footage of building space occupied by the retail business by the square footage of the total building space.

An eligible business which is not a development business and which operates in an enterprise zone cannot claim an investment tax credit if the property is owned, or was previously owned, by an approved development business that has already received an investment tax credit. An eligible business which is not a development business can claim an investment tax credit only on additional new improvements made to real property that was not included in the development business's approved application for the investment tax credit.

This rule is intended to implement Iowa Code section 15E.193C.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.22(15E,422) Venture capital credits.

42.22(1) *Investment tax credit for an equity investment in a qualifying business or community-based seed capital fund.* See rule 123—2.1(15E) for the discussion of the investment tax credit for an equity investment in a qualifying business or community-based seed capital fund, along with the issuance of tax credit certificates by the Iowa capital investment board.

The department of revenue will be notified by the Iowa capital investment board when the tax credit certificates are issued. The tax credit certificate must be attached to the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

For equity investments made in a community-based seed capital fund or equity investments made in a qualifying business on or after January 1, 2004, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

For equity investments made in a qualifying business prior to January 1, 2004, only direct investments made by an individual are eligible for the investment tax credit. Individuals receiving income from a revocable trust's investment in a qualifying business are eligible for the investment tax credit for the portion of the revocable trust's equity investment in a qualifying business.

42.22(2) *Investment tax credit for an equity investment in a venture capital fund.* See rule 123—3.1(15E) for the discussion of the investment tax credit for an equity investment in a venture capital fund, along with the issuance of tax credit certificates by the Iowa capital investment board. This credit is repealed for investments in venture capital funds made after July 1, 2010.

The department of revenue will be notified by the Iowa capital investment board when the tax credit certificates are issued. The tax credit certificate must be attached to the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

For equity investments made in a venture capital fund, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust

electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

42.22(3) *Contingent tax credit for investments in Iowa fund of funds.* See rule 123—4.1(15E) for the discussion of the contingent tax credit available for investments made in the Iowa fund of funds organized by the Iowa capital investment corporation. Tax credit certificates related to the contingent tax credits will be issued by the Iowa capital investment board.

The department of revenue will be notified by the Iowa capital investment board when these tax credit certificates are issued and, if applicable, when they are redeemed. If the tax credit certificate is redeemed, the certificate must be attached to the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate.

If the tax credit certificate is redeemed, any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following seven years or until used, whichever is the earlier.

If the tax credit certificate is redeemed, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

This rule is intended to implement Iowa Code sections 15E.43, 15E.66, and 422.11F and sections 15E.51 and 422.11G as amended by 2010 Iowa Acts, Senate File 2380.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—42.23(15) New capital investment program tax credits. Effective for tax periods beginning on or after January 1, 2003, a business which qualifies under the new capital investment program is eligible to receive tax credits. An eligible business under the new capital investment program must be approved by the Iowa department of economic development and meet the qualifications of 2003 Iowa Acts, chapter 125, section 4. The new capital investment program was repealed on July 1, 2005, and has been replaced with the high quality job creation program. See rule 701—42.29(15) for information on the tax credits available under the high quality job creation program. Any tax credits earned by businesses approved under the new capital investment program prior to July 1, 2005, remain valid and can be claimed on tax returns filed after July 1, 2005.

42.23(1) *Research activities credit.* A business approved under the new capital investment program is eligible for an additional research activities credit as described in 701—subrule 52.7(5). This credit for increasing research activities is in lieu of the research activities credit described in subrule 42.11(3).

42.23(2) *Investment tax credit.*

a. General rule. An eligible business can claim an investment tax credit equal to a percentage of the new investment directly related to new jobs created by the location or expansion of an eligible business. The percentage is equal to the amount provided in paragraph *"b."* New investment directly related to new jobs created by the location or expansion of an eligible business includes the following:

(1) The cost of machinery and equipment, as defined in Iowa Code section 427A.1(1), paragraphs *"e"* and *"j,"* purchased for use in the operation of the eligible business. The purchase price shall be depreciated in accordance with generally accepted accounting principles.

(2) The purchase price of real property and any buildings and structures located on the real property.

(3) The cost of improvements made to real property which is used in the operation of the eligible business.

For eligible businesses approved by the Iowa department of economic development on or after March 17, 2004, certain lease payments made by eligible businesses to a third-party developer will be considered to be new investment for purposes of computing the investment tax credit. The eligible business shall enter into a lease agreement with the third-party developer for a minimum of five years. The investment tax credit is based on the annual base rent paid to a third-party developer by the eligible business for a period not to exceed ten years. The total costs of the annual base rent payments for the ten-year period cannot exceed the cost of the land and the third-party developer's cost to build or renovate the building

used by the eligible business. The annual base rent is defined as the total lease payment less taxes, insurance and operating and maintenance expenses.

Any credit in excess of the tax liability for the tax period may be carried forward seven years or until used, whichever is the earlier.

If the business is a partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount of the credit claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust.

b. Tax credit percentage. The amount of tax credit claimed shall be based on the number of high quality jobs created as determined by the Iowa department of economic development:

(1) If no high quality jobs are created but economic activity within Iowa is advanced, the eligible business may claim a tax credit of up to 1 percent of the new investment.

(2) If 1 to 5 high quality jobs are created, the eligible business may claim a tax credit of up to 2 percent of the new investment.

(3) If 6 to 10 high quality jobs are created, the eligible business may claim a tax credit of up to 3 percent of the new investment.

(4) If 11 to 15 high quality jobs are created, the eligible business may claim a tax credit of up to 4 percent of the new investment.

(5) If 16 or more high quality jobs are created, the eligible business may claim a tax credit of up to 5 percent of the new investment.

c. Investment tax credit—value-added agricultural products or biotechnology-related processes. An eligible business whose project primarily involves the production of value-added agricultural products or uses biotechnology-related processes may elect to receive a refund for all or a portion of an unused investment tax credit. An eligible business includes a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol.

Eligible businesses that elect to receive a refund shall apply to the Iowa department of economic development for tax credit certificates between May 1 and May 15 of each fiscal year through the fiscal year ending June 30, 2009. The election to receive a refund of all or a portion of an unused investment tax credit is no longer available beginning with the fiscal year ending June 30, 2010. Only those businesses that have completed projects before the May 1 filing date may apply for a tax credit certificate. The Iowa department of economic development shall not issue tax credit certificates for more than $4 million during a fiscal year to eligible businesses for this program and eligible businesses described in subrule 42.14(2). If applications are received for more than $4 million, the applicants shall receive certificates for a prorated amount.

The Iowa department of economic development shall issue tax credit certificates within a reasonable period of time. Tax credit certificates are valid for the tax year following project completion. The tax credit certificate must be attached to the tax return for the tax year during which the tax credit is claimed. The tax credit certificate shall not be transferred, except for a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol, as provided in subrule 42.14(2). For value-added agricultural projects involving ethanol, the cooperative must submit a list of its members and the share of each member's interest in the cooperative. The Iowa department of economic development shall issue a tax credit certificate to each member on the list.

d. Repayment of benefits. If an eligible business fails to maintain the requirements of the new capital investment program, the taxpayer may be required to repay all or a portion of the tax incentives taken on Iowa returns. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the tax credits may have expired, the department may proceed to collect the tax incentives forfeited by failure to maintain the requirements of the new capital investment program. This repayment is required because it is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability.

An eligible business in the new capital investment program may also be required to repay all or a portion of the tax incentives received on Iowa returns if the eligible business experiences a layoff of employees in Iowa or closes any of its facilities in Iowa.

If, within five years of purchase, the eligible business sells, disposes of, razes, or otherwise renders unusable all or a part of the land, buildings, or other existing structures for which a tax credit was claimed under this subrule, the income tax liability of the eligible business shall be increased by one of the following amounts:

(1) One hundred percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within one full year after being placed in service.

(2) Eighty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within two full years after being placed in service.

(3) Sixty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within three full years after being placed in service.

(4) Forty percent of the tax credit claimed if the property ceases to be eligible for the tax credit within four full years after being placed in service.

(5) Twenty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within five full years after being placed in service.

This rule is intended to implement Iowa Code section 15.333 as amended by 2010 Iowa Acts, Senate File 2380, and sections 15.335 and 15.381 to 15.387.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—42.24(15E,422) Endow Iowa tax credit. Effective for tax years beginning on or after January 1, 2003, a taxpayer who makes an endowment gift to an endow Iowa qualified community foundation may qualify for an endow Iowa tax credit, subject to the availability of the credit. For tax years beginning on or after January 1, 2003, but before January 1, 2010, the credit is equal to 20 percent of a taxpayer's endowment gift to an endow Iowa qualified community foundation approved by the Iowa department of economic development. For tax years beginning on or after January 1, 2010, the credit is equal to 25 percent of a taxpayer's endowment gift to an endow Iowa qualified community foundation approved by the Iowa department of economic development. For tax years beginning on or after January 1, 2010, a taxpayer cannot claim a deduction for charitable contributions under Section 170 of the Internal Revenue Code for the amount of the contribution for which the tax credit is claimed for Iowa tax purposes. The administrative rules for the endow Iowa tax credit for the Iowa department of economic development may be found under 261—Chapter 47.

The total amount of endow Iowa tax credits available is $2 million in the aggregate for the 2003 and 2004 calendar years. The total amount of endow Iowa tax credits is $2 million annually for the 2005-2007 calendar years, and $200,000 of these tax credits on an annual basis is reserved for endowment gifts of $30,000 or less. The maximum amount of tax credit granted to a single taxpayer shall not exceed $100,000 for the 2003-2007 calendar years. The total amount of endow Iowa tax credits annually for the 2008 and 2009 calendar years is $2 million plus a percentage of the tax imposed on the adjusted gross receipts from gambling games in accordance with Iowa Code section 99F.11(3). The total amount of endow Iowa tax credits annually for 2010 is $2.7 million plus a percentage of the tax imposed on the adjusted gross receipts from gambling games in accordance with Iowa Code section 99F.11(3). The total amount of endow Iowa tax credits annually for 2011 and subsequent calendar years is $3.5 million plus a percentage of the tax imposed on the adjusted gross receipts from gambling games in accordance with Iowa Code section 99F.11(3). The maximum amount of tax credit granted to a single taxpayer shall not exceed 5 percent of the total endow Iowa tax credit amount authorized for 2008 and subsequent years. For example, the total amount of endow Iowa tax credits authorized for the 2011 calendar year is $4,551,813, so the maximum amount of tax credit authorized to a single taxpayer is $227,590.65 ($4,551,813 times 5 percent). The endow Iowa tax credit cannot be transferred to any other taxpayer.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

If a taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 15E.305 as amended by 2011 Iowa Acts, Senate File 302, and section 422.11H.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—42.25(422) Soy-based cutting tool oil tax credit. Effective for tax periods ending after June 30, 2005, and beginning before January 1, 2007, a manufacturer may claim a soy-based cutting tool oil tax credit. A manufacturer, as defined in Iowa Code section 428.20, may claim the credit equal to the costs incurred during the tax year for the purchase and replacement costs relating to the transition from using nonsoy-based cutting tool oil to using soy-based cutting tool oil.

All of the following conditions must be met to qualify for the tax credit:

1. The costs must be incurred after June 30, 2005, and before January 1, 2007.
2. The costs must be incurred in the first 12 months of the transition from using nonsoy-based cutting tool oil to using soy-based cutting tool oil.
3. The soy-based cutting tool oil must contain at least 51 percent soy-based products.
4. The costs of the purchase and replacement must not exceed $2 per gallon of soy-based cutting tool oil used in the transition.
5. The number of gallons used in the transition cannot exceed 2,000 gallons.
6. The manufacturer shall not deduct for Iowa income tax purposes the costs incurred in the transition to using soy-based cutting tool oil which are deductible for federal tax purposes.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

If a taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 422.11I.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.26(15I,422) Wage-benefits tax credit. Effective for tax years ending on or after June 9, 2006, a wage-benefits tax credit equal to a percentage of the annual wages and benefits paid for a qualified new job created by the location or expansion of the business in Iowa is available for qualified businesses.

42.26(1) *Definitions.* The following definitions are applicable to this rule:

"Average county wage" means the annualized average hourly wage calculated by the Iowa department of economic development using the most current four quarters of wage and employment information as provided in the Quarterly Covered Wage and Employment Data report provided by the department of workforce development. Agricultural/mining and governmental employment categories are deleted in compiling the wage information.

"Benefits" means all of the following:

1. Medical and dental insurance plans.
2. Pension and profit-sharing plans.
3. Child care services.
4. Life insurance coverage.
5. Vision insurance plan.
6. Disability coverage.

"Department" means the Iowa department of revenue.

"Full-time" means the equivalent of employment of one person:

1. For 8 hours per day for a five-day, 40-hour workweek for 52 weeks per year, including paid holidays, vacations, and other paid leave, or

2. The number of hours or days per week, including paid holidays, vacations, and other paid leave, currently established by schedule, custom or otherwise, as constituting a week of full-time work for the kind of service an individual performs for an employing unit.

"Grow Iowa values fund" means the grow Iowa values fund created in Iowa Code Supplement section 15G.108.

"Nonqualified new job" means any one of the following:

1. A job previously filled by the same employee in Iowa.
2. A job that was relocated from another location in Iowa.
3. A job that is created as a result of a consolidation, merger, or restructuring of a business entity if the job does not represent a new job in Iowa.

"Qualified new job" or *"job creation"* means a job that meets all of the following criteria:

1. Is a new full-time job that has not existed in the business in Iowa within the previous 12 months.
2. Is filled by a new employee for at least 12 months.
3. Is filled by a resident of the state of Iowa.
4. Is not created as a result of a change in ownership.
5. Was created on or after June 9, 2005.

"Retail business" means a business which sells its product directly to a consumer.

"Retained qualified new job" or *"job retention"* means the continued employment, after the first 12 months of employment, of the same employee in a qualified new job for another 12 months.

"Service business" means a business which is not engaged in the sale of tangible personal property, and which provides services to a local consumer market and does not have a significant proportion of its sales coming from outside Iowa.

42.26(2) *Calculation of credit.* A business which is not a retail or service business may claim the wage-benefits tax credit which is determined as follows:

a. If the annual wages and benefits for the qualified new job equal less than 130 percent of the average county wage, the credit is 0 percent of the annual wage and benefits paid.

b. If the annual wages and benefits for the qualified new job equal at least 130 percent but less than 160 percent of the average county wage, the credit is 5 percent of the annual wage and benefits paid for each qualified new job.

c. If the annual wages and benefits for the qualified new job equal at least 160 percent of the average county wage, the credit is 10 percent of the annual wage and benefits paid for each qualified new job.

If the business is a partnership, S corporation, limited liability company, or estate or trust electing to have the income taxed directly to the individual, an individual may claim the tax credit. The amount claimed by the individual shall be based upon the pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

42.26(3) *Application for the tax credit; tax credit certificate; amount of tax credit available.*

a. In order to claim the wage-benefits tax credit, the business must submit an application to the department along with information on the qualified new job or retained qualified new job. The application cannot be submitted until the end of the twelfth month after the qualified job was filled. For example, if the new job was created on June 9, 2005, the application cannot be submitted until June 9, 2006. The following information must be submitted in the application:

(1) Name, address and federal identification number of the business.

(2) A description of the activities of the business. If applicable, the proportion of the sales of the business which come from outside Iowa shall be included.

(3) The amount of wages and benefits paid to each employee for each new job for the previous 12 months.

(4) A computation of the amount of credit being requested.

(5) The address and state of residence of each new employee.

(6) The date that the qualified new job was filled.

(7) An indication of whether the job is a qualified new job or a retained qualified new job for which an application was filed for a previous year.

(8) The type of tax for which the credit will be applied.

(9) If the business is a partnership, S corporation, limited liability company, or estate or trust, a schedule of the partners, shareholders, members or beneficiaries. This schedule shall include the names, addresses and federal identification numbers of the partners, shareholders, members or beneficiaries, along with their percentage of the pro-rata share of earnings of the partnership, S corporation, limited liability company, or estate or trust.

b. Upon receipt of the application, the department has 45 days either to approve or deny the application. If the department does not act on the application within 45 days, the application is deemed approved. If the department denies the application, the business may appeal the decision to the Iowa economic development board within 30 days of the notice of denial.

c. If the application is approved, or if the Iowa economic development board approves the application that was previously denied by the department, a tax credit certificate will be issued by the department to the business, subject to the availability of the amount of credits that may be issued. The tax credit certificate shall contain the name, address and tax identification number of the business (or individual, estate or trust, if applicable), the date of the qualified new job(s), the wage and benefits paid for each job(s) for the 12-month period, the amount of the credit, the tax period for which the credit may be applied, and the type of tax for which the credit will be applied.

d. The tax credit certificates that are issued in a fiscal year cannot exceed $10 million for the fiscal year ending June 30, 2007, and shall not exceed $4 million for the fiscal years ending June 30, 2008, through June 30, 2011. The tax credit certificates are issued on a first-come, first-served basis. Therefore, if tax credit certificates have already been issued for the $10 million limit for the fiscal year ending June 30, 2007, any applications for tax credit certificates received after the $10 million limit has been reached will be denied. Similarly, if tax credit certificates have already been issued for the $4 million limit for the fiscal years ending June 30, 2008, through June 30, 2011, any applications for tax credit certificates received after the $4 million limit has been reached will be denied. If a business failed to receive all or a part of the tax credit due to the $10 million or $4 million limitation, the business may reapply for the tax credit for the retained new job for a subsequent tax period.

e. A business which qualifies for the tax credit for the fiscal year ending June 30, 2007, is eligible to receive the tax credit certificate for each of the fiscal years ending June 30, 2008, through June 30, 2011, subject to the $4 million limit for tax credits for the fiscal years ending June 30, 2008, through June 30, 2011, if the business retains the qualified new job during each of the fiscal years ending June 30, 2008, through June 30, 2011. The business must reapply by June 30 of each fiscal year for the tax credit, and the percentage of the wages and benefits allowed for the credit set forth in subrule 42.26(2) for the first year is applicable for each subsequent period. Preference will be given in issuing tax credit certificates for those businesses that retain qualified new jobs, and preference will be given in the order in which applications were filed for the fiscal year ending June 30, 2007. Therefore, those businesses which received the first $4 million of tax credits for the year ending June 30, 2007, in which the qualified jobs were created will automatically receive a tax credit for the fiscal years ending June 30, 2008, through June 30, 2011, as long as the qualified jobs are retained and an application is completed.

f. For the fiscal years ending June 30, 2008, through June 30, 2011, if credits become available because the jobs were not retained by businesses which received the first $4 million of credits for the year ending June 30, 2007, an application which was originally denied will be considered in the order in which the application was received for the fiscal year ending June 30, 2007.

EXAMPLE: Wage-benefits tax credits of $4 million are issued for the fiscal year ending June 30, 2007, relating to applications filed between July 1, 2006, and March 31, 2007. For the next fiscal year ending June 30, 2008, the same businesses that received the $4 million in wage-benefits tax credits filed applications totaling $3 million for the retained jobs for which the application for the prior year was filed on or before March 31, 2007. The first $3 million of the available $4 million will be allowed to these same businesses. The remaining $1 million that is still available for the fiscal year ending June 30, 2008,

will be allowed for those retained jobs for which applications for the prior year were filed starting on April 1, 2007, until the remaining $1 million in tax credits is issued.

g. A business may apply in writing to the Iowa economic development board for a waiver of the average wage and benefit requirement. If a waiver is granted, the business must provide the department with the waiver and it must be attached to the application.

h. A business may receive other federal, state, and local incentives and tax credits in addition to the wage-benefits tax credit. However, a business that receives a wage-benefits tax credit cannot receive tax incentives under the high quality job creation program set forth in Iowa Code chapter 15 or moneys from the grow Iowa values fund.

42.26(4) *Examples.* The following noninclusive examples illustrate how this rule applies:

EXAMPLE 1: Business A operates a grocery store and hires five new employees, each of whom will earn wages and benefits in excess of 130 percent of the average county wage. Business A would not qualify for the wage-benefits tax credit because Business A is a retail business.

EXAMPLE 2: Business B operates an accounting firm and hires two new accountants, each of whom will earn wages and benefits in excess of 160 percent of the average county wage. The accounting firm provides services to clients wholly within Iowa. Business B would not qualify for the wage-benefits tax credit because it is a service business. The majority of its sales are generated from within the state of Iowa and thus Business B, because it is a service business, is not eligible for the credit.

EXAMPLE 3: Business C operates a software development business and hires two new programmers, each of whom will earn wages and benefits in excess of 160 percent of the average county wage. Over 50 percent of the customers of Business C are located outside Iowa. Business C would qualify for the wage-benefits tax credit because a majority of its sales are coming from outside the state, even though Business C is engaged in the performance of services.

EXAMPLE 4: Business D is a manufacturer that hires a new employee in Clayton County, Iowa, on July 8, 2005. The average county wage for Clayton County for the third quarter of 2005 is $11.86 per hour. If the average county wage per hour for Clayton County is $11.95 for the fourth quarter of 2005, $12.05 for the first quarter of 2006, and $12.14 for the second quarter of 2006, the annualized average county wage for this 12-month period is $12.00 per hour. This wage equates to an average annual wage of $24,960 ($12.00 × 40 hours × 52 weeks). In order for Business D to qualify for the 5 percent wage-benefits tax credit, the new employee must receive wages and benefits totaling $32,448 (130 percent of $24,960) for the 12-month period from July 8, 2005, through July 7, 2006. In order for Business D to qualify for the 10 percent wage-benefits tax credit, the new employee must receive wages and benefits totaling $39,936 (160 percent of $24,960) for the 12-month period from July 8, 2005, through July 7, 2006.

EXAMPLE 5: Business E is a manufacturer that hires three new employees in Grundy County, Iowa, on July 1, 2005. If the average county wage for the 12-month period from July 1, 2005, through June 30, 2006, is $13.75 per hour in Grundy County, this wage equates to an average county wage of $28,600. The wages and benefits for each of these three new employees is $40,000 for the period from July 1, 2005, through June 30, 2006, which is 140 percent of the average county wage. Business E is entitled to a wage-benefits tax credit of $2,000 for each employee ($40,000 × 5 percent), for a total wage-benefits tax credit of $6,000. If Business E files on a calendar-year basis, the $6,000 wage-benefits tax credit can be claimed on the tax return for the period ending December 31, 2006.

EXAMPLE 6: Business F is a manufacturer that hires ten new employees on July 1, 2005, and qualifies for the wage-benefits tax credit because the wages and benefits paid exceed 130 percent of the average county wage. Business F receives a wage-benefits tax credit in July 2006 for these ten employees, which can be used on the tax return for the period ending December 31, 2006. On August 31, 2006, two of the employees leave the business and are replaced by two new employees. Business F is entitled to a wage-benefits tax credit for only eight employees in July 2007 because only eight employees continued employment for the subsequent 12 months in a job which meets the definition of a retained qualified new job. Business F cannot request a wage-benefits tax credit for the two employees hired on August 31, 2006. Business F cannot request the wage-benefits tax credit because these two full-time jobs existed

in the business within the previous 12 months in Iowa, and these jobs do not meet the definition of a qualified new job or retained qualified new job.

EXAMPLE 7: Business G is a manufacturer that hires ten new employees on July 1, 2005, and qualifies for the wage-benefits tax credit because the wages and benefits paid exceed 130 percent of the average county wage. Business G receives a wage-benefits tax credit in July 2006 for these ten employees equal to 5 percent of the wages and benefits paid. On October 1, 2006, Business G hires an additional five employees, each of whom receives wages and benefits in excess of 130 percent of the average county wage. Business G can apply for the wage-benefits tax credit on October 1, 2007, for these five employees, since these employees have now been employed for 12 months. However, the credit may not be allowed if more than $4 million of retained job tax credits have been issued for the fiscal year ending June 30, 2008.

EXAMPLE 8: Assume the same facts as Example 6, except that the $10 million limit of tax credits has already been met for the fiscal year ending June 30, 2007, and Business F hired five new employees on August 31, 2006. Business F can apply for the wage-benefits tax credit for the three employees on August 31, 2007, a number which is above the ten full-time jobs originally created, but Business F may not receive the tax credit if more than $4 million of retained job tax credits have been issued for the fiscal year ending June 30, 2008.

EXAMPLE 9: Assume the same facts as Example 7, except that the ten employees hired on July 1, 2005, by Business G received wages and benefits equal to 155 percent of the average county wage, and the five employees hired on October 1, 2006, by Business G received wages equal to 161 percent of the average county wage. Business G can apply for the tax credit on October 1, 2007, equal to 10 percent of the wages and benefits paid for the employees hired on October 1, 2006. On July 1, 2007, Business G can reapply for the tax credit equal to 5 percent of the wages and benefits paid only for the ten employees originally hired on July 1, 2005, even if the wages and benefits for these ten employees exceed 160 percent of the average county wage for the period from July 1, 2006, through June 30, 2007.

42.26(5) *Repeal of the wage-benefits tax credit.* The wage-benefits tax credit is repealed effective July 1, 2008. However, the wage-benefits tax credit is still available through the fiscal year ending June 30, 2011, as provided in subrule 42.26(3), paragraphs *"d," "e,"* and *"f."* A business is not entitled to a wage-benefits tax credit for a qualified new job created on or after July 1, 2008.

This rule is intended to implement Iowa Code chapter 15I and section 422.11L.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.27(422,476B) Wind energy production tax credit. Effective for tax years beginning on or after July 1, 2006, an owner of a qualified wind energy production facility that has been approved by the Iowa utilities board may claim a wind energy production tax credit for qualified electricity sold by the owner or used for on-site consumption against a taxpayer's Iowa individual income tax liability. The administrative rules for the certification of eligibility for the wind energy production tax credit for the Iowa utilities board may be found in rule 199—15.18(476B).

42.27(1) *Application and review process for the wind energy production tax credit.* An owner of a wind energy production facility must be approved by the Iowa utilities board in order to qualify for the wind energy production tax credit. The facility must be an electrical production facility that produces electricity from wind, that is located in Iowa, and that is placed in service on or after July 1, 2005, but before July 1, 2012. For applications filed on or after March 1, 2008, a facility must consist of one or more wind turbines which have a combined nameplate generating capacity of at least 2 megawatts and no more than 30 megawatts. For applications filed on or after July 1, 2009, by a private college or university, community college, institution under the control of the state board of regents, public or accredited nonpublic elementary and secondary school, or public hospital as defined in Iowa Code section 249J.3, the facility must have a combined nameplate generating capacity of no less than ¾ of a megawatt.

The maximum amount of nameplate generating capacity for all qualified wind energy production facilities cannot exceed 50 megawatts. An owner shall not own more than two qualified facilities. A facility that is not operational within 18 months after issuance of the approval from the Iowa utilities board will no longer be considered a qualified facility. However, a facility that is not operational within

18 months due to the unavailability of necessary equipment shall be granted an additional 12 months to become operational.

An owner of the qualified facility must apply to the Iowa utilities board for the wind energy production tax credit. The application for the tax credit must be filed no later than 30 days after the close of the tax year for which the credit is applied. The information to be included in the application is set forth in 199—subrule 15.20(1).

42.27(2) *Computation of the credit.* The wind energy production credit equals one cent multiplied by the number of kilowatt-hours of qualified electricity sold or used for on-site consumption by the owner during the tax year. For the first tax year in which the credit is applied, the kilowatt-hours of qualified electricity sold may exceed 12 months.

EXAMPLE: A qualified facility was placed in service on April 1, 2006, and the taxpayer files on a calendar-year basis. The first year for which the credit can be claimed is the period ending December 31, 2007, since that is the first tax year that began on or after July 1, 2006. The credit for the 2007 tax year can include electricity sold between April 1, 2006, and December 31, 2007.

The credit is not allowed for any kilowatt-hours of electricity sold to a related person. The definition of "related person" uses the same criteria set forth in Section 45(e)(4) of the Internal Revenue Code relating to the federal renewable electricity production credit. Persons shall be treated as related to each other if such persons are treated as a single employer under Treasury Regulation § 1.52-1. In the case of a corporation that is a member of an affiliated group of corporations filing a federal consolidated return, such corporation shall be treated as selling electricity to an unrelated person if such electricity is sold to the person by another member of the affiliated group.

The utilities board will notify the department of the number of kilowatt-hours of electricity sold by the qualified facility or generated and used on site by the qualified facility during the tax year. The department will calculate the credit and issue a tax credit certificate to the owner. The tax credit certificate will include the taxpayer's name, address and federal identification number, the tax type for which the credit will be claimed, the amount of the credit and the tax year for which the credit may be claimed. In addition, the tax credit certificate will include a place for the name and tax identification number of a transferee and the amount of the tax credit certificate, as provided in subrule 42.27(3). If the department refuses to issue the tax credit certificate, the taxpayer shall be notified in writing and the taxpayer will have 60 days from the date of denial to file a protest in accordance with rule 701—7.41(17A). The department will not issue a tax credit certificate if the facility is not operational within 18 months after approval was given by the utilities board, unless a 12-month extension is granted by the utilities board as provided in subrule 42.27(1).

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on the partner's, member's, shareholder's or beneficiary's pro-rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust, except when the taxpayer is eligible to receive renewable electricity production tax credits authorized under Section 45 of the Internal Revenue Code. In cases where the taxpayer is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder. In addition, if a taxpayer is a partnership, limited liability company, S corporation, or estate or trust that is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the taxpayer may distribute the tax credit to an equity holder or beneficiary as a liquidating distribution, or portion thereof, of an equity holder's interest in the partnership, limited liability company or S corporation, or the beneficiary's interest in the estate or trust.

The credit can be allowed for a ten-year period beginning on the date the qualified facility was originally placed in service. For example, if a facility was placed in service on April 1, 2006, the credit can be claimed for kilowatt-hours of electricity sold between April 1, 2006, and March 31, 2016.

To claim the tax credit, the taxpayer must attach the tax credit certificate to the tax return for the tax year set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for seven years or until it is used, whichever is the earlier.

42.27(3) *Transfer of the wind energy production tax credit certificate.* The wind energy production tax credit certificate may be transferred to any person or entity.

Within 30 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the wind energy production tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year and the same expiration date as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

This rule is intended to implement Iowa Code section 422.11J and Iowa Code chapter 476B as amended by 2011 Iowa Acts, House File 672.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—42.28(422,476C) Renewable energy tax credit. Effective for tax years beginning on or after July 1, 2006, a purchaser or producer of renewable energy whose facility has been approved by the Iowa utilities board may claim a renewable energy tax credit for qualified renewable energy against a taxpayer's Iowa individual income tax liability. The administrative rules for the certification of eligibility for the renewable energy tax credit for the Iowa utilities board may be found in rule 199—15.19(476C).

42.28(1) *Application and review process for the renewable energy tax credit.* A producer or purchaser of a renewable energy facility must be approved by the Iowa utilities board in order to qualify for the renewable energy credit. The eligible renewable energy facility can be a wind energy conversion facility, biogas recovery facility, biomass conversion facility, methane gas recovery facility, solar energy conversion facility or refuse conversion facility. The facility must be located in Iowa and placed in service on or after July 1, 2005, and before January 1, 2015.

The maximum amount of nameplate generating capacity of all wind energy conversion facilities cannot exceed 363 megawatts. The maximum amount of energy production capacity for biogas recovery facilities, biomass conversion facilities, methane gas recovery facilities, solar energy conversion facilities and refuse conversion facilities cannot exceed a combined output of 53 megawatts of nameplate generating capacity and 167 billion British thermal units of heat for a commercial purpose. A facility that is not operational within 30 months after issuance of approval from the utilities board will no longer be considered a qualified facility. However, if the facility is a wind energy conversion property and is not operational within 18 months due to the unavailability of necessary equipment, the facility may apply for a 12-month extension of the 30-month limit. Extensions can be renewed for succeeding 12-month periods if the facility applies for the extension prior to expiration of the current extension period. A producer of renewable energy, who is the person who owns the renewable energy facility, cannot own more than two eligible renewable energy facilities. A person that has an equity interest equal to or greater than 51 percent in an eligible renewable energy facility cannot have an equity interest greater than 10 percent in any other renewable energy facility.

A producer or purchaser of a renewable energy facility must apply to the utilities board for the renewable energy tax credit. The application for the tax credit must be filed no later than 30 days after the close of the tax year for which the credit is applied. The information to be included in the application is set forth in 199—subrule 15.21(1).

42.28(2) *Computation of the credit.* The renewable energy tax credit equals 1½ cents per kilowatt-hour of electricity, or 44 cents per 1000 standard cubic feet of hydrogen fuel, or $4.50 per 1 million British thermal units of methane gas or other biogas used to generate electricity, or $4.50 per 1 million British thermal units of heat for a commercial purpose generated by and purchased from an eligible renewable energy facility or used for on-site consumption by the producer during the tax year. For the first tax year in which the credit is applied, the kilowatt-hours, standard cubic feet or British thermal units generated by and purchased from the facility or used for on-site consumption by the producer may exceed 12 months.

EXAMPLE: A qualified wind energy production facility was placed in service on April 1, 2006, and the taxpayer files on a calendar-year basis. The first year for which the credit can be claimed is the year ending December 31, 2007, since that is the first tax year that began on or after July 1, 2006. The credit for the 2007 tax year can include electricity generated and purchased or used for on-site consumption by the producer between April 1, 2006, and December 31, 2007.

The credit is not allowed for any kilowatt-hours, standard cubic feet or British thermal units that are purchased from an eligible facility by a related person. Persons shall be treated as related to each other if either person owns an 80 percent or more equity interest in the other person.

The utilities board will notify the department of the number of kilowatt-hours, standard cubic feet or British thermal units that are generated and purchased from an eligible facility or used for on-site consumption by the producer during the tax year. The department will calculate the credit and issue a tax credit certificate to the purchaser or producer. The tax credit certificate will include the taxpayer's name, address and federal identification number, the tax type for which the credit will be claimed, the amount of the credit and the tax year for which the credit may be claimed. In addition, the tax credit certificate will include a place for the name and tax identification number of a transferee and the amount of the tax credit certificate, as provided in subrule 42.28(3). If the department refuses to issue the tax credit certificate, the taxpayer shall be notified in writing and the taxpayer will have 60 days from the date of denial to file a protest in accordance with rule 701—7.41(17A). The department will not issue a tax credit certificate if the facility is not operational within 30 months after approval was given by the utilities board, unless a 12-month extension is granted by the utilities board as provided in subrule 42.28(1). In addition, the department will not issue a tax credit certificate to any person who received a wind energy production tax credit in accordance with Iowa Code chapter 476B.

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on the partner's, member's, shareholder's or beneficiary's pro-rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust, except when the taxpayer is eligible to receive renewable electricity production tax credits authorized under Section 45 of the Internal Revenue Code. In cases where the taxpayer is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder. In addition, if a taxpayer is a partnership, limited liability company, S corporation, or estate or trust that is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the taxpayer may distribute the tax credit to an equity holder or beneficiary as a liquidating distribution, or portion thereof, of an equity holder's interest in the partnership, limited liability company or S corporation, or the beneficiary's interest in the estate or trust.

The credit can be allowed for a ten-year period beginning on the date the qualified facility was originally placed in service. For example, if a renewable energy facility was placed in service on April 1, 2006, the credit can be claimed for kilowatt-hours, standard cubic feet or British thermal units generated and purchased or used for on-site consumption by the producer between April 1, 2006, and March 31,

2016. Tax credit certificates cannot be issued for renewable energy purchased or produced for on-site consumption after December 31, 2024.

To claim the tax credit, the taxpayer must attach the tax credit certificate to the tax return for the tax period set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for seven years or until it is used, whichever is the earlier.

42.28(3) *Transfer of the renewable energy tax credit certificate.* The renewable energy tax credit certificate may be transferred once to any person or entity. A decision between a producer and purchaser of renewable energy regarding who may claim the tax credit is not considered a transfer.

Within 30 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the renewable energy tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year and the same expiration date as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

42.28(4) *Small wind innovation zones.* Effective for tax years beginning on or after January 1, 2009, an owner of a small wind energy system operating within a small wind innovation zone which has been approved by the Iowa utilities board is eligible for the renewable energy tax credit. The administrative rules of the Iowa utilities board for the certification of eligibility for owners of small wind energy systems operating within a small wind innovation zone may be found in rule 199—15.22(476).

This rule is intended to implement Iowa Code section 422.11J and Iowa Code chapter 476C as amended by 2011 Iowa Acts, House File 672.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—42.29(15) High quality job creation program. Effective for tax periods ending on or after July 1, 2005, for programs approved on or after July 1, 2005, but before July 1, 2009, a business which qualifies under the high quality job creation program is eligible to receive tax credits. The high quality job creation program replaces the new jobs and income program and the new capital investment program. An eligible business under the high quality job creation program must be approved by the Iowa department of economic development and meet the qualifications of Iowa Code section 15.329. The administrative rules for the high quality job creation program for the Iowa department of economic development may be found at 261—Chapter 68.

The high quality job creation program was repealed on July 1, 2009, and has been replaced with the high quality jobs program. See rule 701—42.42(15) for information on the investment tax credit and additional research activities credit under the high quality jobs program. Any investment tax credit and additional research activities credit earned by businesses approved under the high quality job creation program prior to July 1, 2009, remains valid and can be claimed on tax returns filed after July 1, 2009.

42.29(1) *Research activities credit.* An eligible business approved under the high quality job creation program is eligible for an additional research activities credit as described in 701—subrule 52.7(4).

Research activities allowable for the Iowa research activities credit include expenses related to the development and deployment of innovative renewable energy generation components manufactured or

assembled in Iowa; such expenses related to the development and deployment of innovative renewable energy generation components are not eligible for the federal credit for increasing research activities. For purposes of this subrule, innovative renewable energy generation components do not include components with more than 200 megawatts in installed effective nameplate generating capacity. The research activities credit related to renewable energy generation components under the high quality job creation program and the enterprise zone program shall not exceed $1 million in the aggregate.

These expenses related to the development and deployment of innovative renewable energy generation components are applicable only to the additional research activities credit set forth in this subrule and are not applicable to the research activities credit set forth in subrule 42.11(3), paragraphs *"a"* and *"b."* The research activities credit is subject to the threshold amounts of qualifying investment set forth in Iowa department of economic development 261—subrule 68.4(7).

42.29(2) *Investment tax credit.*

a. General rule. An eligible business can claim an investment tax credit equal to a percentage of the new investment directly related to new jobs created by the location or expansion of an eligible business. The percentage is equal to the amount provided in Iowa department of economic development 261—subrule 68.4(7). New investment directly related to new jobs created by the location or expansion of an eligible business includes the following:

(1) The cost of machinery and equipment, as defined in Iowa Code section 427A.1(1), paragraphs *"e"* and *"j,"* purchased for use in the operation of the eligible business. The purchase price shall be depreciated in accordance with generally accepted accounting principles.

(2) The purchase price of real property and any buildings and structures located on the real property.

(3) The cost of improvements made to real property which is used in the operation of the eligible business.

In addition, certain lease payments made by eligible businesses to a third-party developer will be considered to be new investment for purposes of computing the investment tax credit. The eligible business shall enter into a lease agreement with the third-party developer for a minimum of five years. The investment tax credit is based on the annual base rent paid to a third-party developer by the eligible business for a period not to exceed ten years. The total costs of the annual base rent payments for the ten-year period cannot exceed the cost of the land and the third-party developer's cost to build or renovate the building used by the eligible business. The annual base rent is defined as the total lease payment less taxes, insurance and operating and maintenance expenses.

The investment tax credit can be claimed in the tax year in which the qualifying assets are placed in service. The investment tax credit will be amortized over a five-year period. Any credit in excess of the tax liability for the tax period may be carried forward seven years or until used, whichever is the earlier.

EXAMPLE: An eligible business which files tax returns on a calendar-year basis earned $100,000 of investment tax credits for new investment made in 2006. The business can claim $20,000 of investment tax credits for each of the years from 2006 through 2010. The $20,000 of investment tax credit that can be claimed in 2006 can be carried forward to the 2007-2013 tax years if the entire credit cannot be claimed on the 2006 return. Similarly, the $20,000 investment tax credit that can be claimed in 2007 can be carried forward to the 2008-2014 tax years if the entire credit cannot be claimed on the 2007 return.

If the business is a partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount of the credit claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust electing to have the income taxed directly to an individual.

b. Investment tax credit—value-added agricultural products or biotechnology-related processes. An eligible business whose project primarily involves the production of value-added agricultural products or uses biotechnology-related processes may elect to receive a refund for all or a portion of an unused investment tax credit. An eligible business includes a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol.

Eligible businesses that elect to receive a refund shall apply to the Iowa department of economic development for tax credit certificates between May 1 and May 15 of each fiscal year through the fiscal year ending June 30, 2009. The election to receive a refund of all or a portion of an unused investment tax credit is no longer available beginning with the fiscal year ending June 30, 2010. Only those businesses that have completed projects before the May 1 filing date may apply for a tax credit certificate. The Iowa department of economic development shall not issue tax credit certificates for more than $4 million during a fiscal year to eligible businesses for this program and the enterprise zone program described in subrule 42.14(2). If applications are received for more than $4 million, the applicants shall receive certificates for a prorated amount.

The Iowa department of economic development shall issue tax credit certificates within a reasonable period of time. Tax credit certificates are valid for the tax year following project completion. The tax credit certificate must be attached to the tax return for the tax year during which the tax credit is claimed. The tax credit certificate shall not be transferred, except for a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol, as provided in subrule 42.14(2). For value-added agricultural projects involving ethanol, the cooperative must submit a list of its members and the share of each member's interest in the cooperative. The Iowa department of economic development shall issue a tax credit certificate to each member on the list.

c. Repayment of benefits. If an eligible business fails to maintain the requirements of the high quality job creation program, the taxpayer may be required to repay all or a portion of the tax incentives taken on Iowa returns. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the tax credits may have expired, the department may proceed to collect the tax incentives forfeited by failure of the eligible business to maintain the requirements of the high quality job creation program because the repayment is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability.

An eligible business in the high quality job creation program may also be required to repay all or a portion of the tax incentives received on Iowa returns if the eligible business experiences a layoff of employees in Iowa or closes any of its facilities in Iowa.

If, within five years of purchase, the eligible business sells, disposes of, razes, or otherwise renders unusable all or a part of the land, buildings, or other existing structures for which a tax credit was claimed under this subrule, the income tax liability of the eligible business shall be increased by one of the following amounts:

(1) One hundred percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within one full year after being placed in service.

(2) Eighty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within two full years after being placed in service.

(3) Sixty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within three full years after being placed in service.

(4) Forty percent of the tax credit claimed if the property ceases to be eligible for the tax credit within four full years after being placed in service.

(5) Twenty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within five full years after being placed in service.

42.29(3) *Determination of tax credit amounts.* The amount of tax credit claimed under the high quality job creation program shall be based on the number of high quality jobs created and the amount of qualifying investment made as determined by the Iowa department of economic development.

a. If the high quality jobs have a starting wage, including benefits, equal to or greater than 130 percent of the average county wage but less than 160 percent of the average county wage, see Iowa department of economic development 261—paragraph 68.4(7)*"a"* for the amount of tax credits that may be claimed.

b. If the high quality jobs have a starting wage, including benefits, equal to or greater than 160 percent of the average county wage, see Iowa department of economic development 261—paragraph 68.4(7)*"b"* for the amount of tax credits that may be claimed.

c. An eligible business approved under the high quality job creation program is not eligible for the wage-benefits tax credit set forth in rule 701—42.26(15I,422).

This rule is intended to implement Iowa Code sections 15.326 to 15.337.
[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—42.30(15E,422) Economic development region revolving fund tax credit. Effective for tax years ending on or after July 1, 2005, but beginning before January 1, 2010, a taxpayer who makes a contribution to an economic development region revolving fund may claim a tax credit, subject to the availability of the credit. The tax credit is equal to 20 percent of a taxpayer's contribution to the economic development region revolving fund approved by the Iowa department of economic development. The administrative rules for the economic development region revolving fund tax credit for the Iowa department of economic development may be found at 261—Chapter 32. The tax credit is repealed for tax years beginning on or after January 1, 2010.

The total amount of economic development region revolving fund tax credits available shall not exceed $2 million per fiscal year. The tax credit shall not be carried back to a tax year prior to the year in which the taxpayer redeems the credit. The economic development region revolving fund tax credit is not transferable to any other taxpayer.

Any tax credit in excess of the tax liability for the tax year may be credited to the tax liability for the following ten years or until used, whichever is the earlier.

If a taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code sections 15E.232 and 422.11K as amended by 2010 Iowa Acts, Senate File 2380.
[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—42.31(422) Early childhood development tax credit. Effective for tax years beginning on or after January 1, 2006, taxpayers may claim a tax credit equal to 25 percent of the first $1,000 of expenses paid to others for early childhood development for each dependent three to five years of age. The credit is available only to taxpayers whose net income is less than $45,000. If a taxpayer claims the early childhood development tax credit, the taxpayer cannot claim the child and dependent care credit described in rule 701—42.15(422). The early childhood development tax credit is refundable to the extent that the credit exceeds the taxpayer's income tax liability. For the tax year beginning in the 2006 calendar year only, amounts paid for early childhood development expenses in November and December of 2005 shall be considered paid in 2006 for purposes of computing the credit.

For married taxpayers who elect to file separately on a combined form or elect to file separate returns for Iowa tax purposes, the combined income of the taxpayers must be less than $45,000 to be eligible for the credit. If the combined income is less than $45,000, the early childhood development tax credit shall be prorated to each spouse in the proportion that each spouse's respective net income bears to the total combined income.

42.31(1) *Expenses eligible for the credit.* The following expenses qualify for the early childhood development tax credit, to the extent they are paid during the time period that a dependent is either three, four or five years of age:

a. Expenses for services provided by a preschool, as defined in Iowa Code section 237A.1. The preschool may only provide services for periods of time not exceeding three hours per day.

b. Books that improve child development, including textbooks, music books, art books, teacher editions and reading books.

c. Expenses paid for instructional materials required to be used in a child development or educational lesson activity. These materials include, but are not limited to, paper, notebooks, pencils, and art supplies. In addition, software and toys which are directly and primarily used for educational or learning purposes are considered instructional materials.

d. Expenses paid for lesson plans and curricula.

e. Expenses paid for child development and educational activities outside the home. These activities include, but are not limited to, drama, art, music and museum activities, including the entrance fees for such activities.

42.31(2) *Expenses not eligible for the credit.* The following expenses do not qualify for the early childhood development tax credit:

a. Any expenses paid to a preschool once a dependent reaches the age of six.

b. Expenses relating to food, lodging, membership fees, or other nonacademic expenses relating to child development and educational activities outside the home.

c. Expenses related to services, materials, or activities for the teaching of religious tenets, doctrines, or worship, in cases where the purpose of the teaching is to inculcate the religious tenets, doctrines, or worship.

This rule is intended to implement Iowa Code section 422.12C.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.32(422) School tuition organization tax credit. Effective for the tax year beginning on or after January 1, 2006, but beginning before January 1, 2007, a school tuition organization tax credit is available which is equal to 65 percent of the amount of the voluntary cash contributions made by a taxpayer to a school tuition organization. For tax years beginning on or after January 1, 2007, the school tuition organization tax credit is available which is equal to 65 percent of the amount of voluntary cash or noncash contributions made by a taxpayer to a school tuition organization. There are numerous federal revenue regulations, rulings, court cases and other provisions relating to the determination of the value of a noncash contribution, and these are equally applicable to the determination of the amount of a school tuition organization tax credit for tax years beginning on or after January 1, 2007.

42.32(1) *Definitions.* The following definitions are applicable to this rule:

"Certified enrollment" means the enrollment at schools served by school tuition organizations as of October 1, or the first Monday in October if October 1 falls on a Saturday or Sunday, of the appropriate year.

"Contribution" means a voluntary cash or noncash contribution to a school tuition organization that is not used for the direct benefit of any dependent of the taxpayer or any other student designated by the taxpayer.

"Eligible student" means a student residing in Iowa who is a member of a household whose total annual income during the calendar year prior to the school year in which the student receives a tuition grant from a school tuition organization does not exceed an amount equal to three times the most recently published federal poverty guidelines in the Federal Register by the United States Department of Health and Human Services.

"Qualified school" means a nonpublic elementary or secondary school in Iowa which is accredited under Iowa Code section 256.11, including a prekindergarten program for students who are five years of age by September 15 of the appropriate year, and adheres to the provisions of the federal Civil Rights Act of 1964 and Iowa Code chapter 216, and which is represented by only one school tuition organization.

"School tuition organization" means a charitable organization in Iowa that is exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code and that does all of the following:

1. Allocates at least 90 percent of its annual revenue in tuition grants for children to allow them to attend a qualified school of their parents' choice.
2. Awards tuition grants only to children who reside in Iowa.
3. Provides tuition grants to students without limiting availability to students of only one school.
4. Provides tuition grants only to eligible students.
5. Prepares an annual financial statement certified by a public accounting firm.

"Tuition grant" means a grant to a student to cover all or part of the student's tuition at a qualified school.

42.32(2) *Initial registration.* In order for contributions to a school tuition organization to qualify for the credit, the school tuition organization must initially register with the department. The following information must be provided with this initial registration:

a. Verification from the Internal Revenue Service that Section 501(c)(3) status was granted and that the school tuition organization is exempt from federal income tax.

b. A list of all qualified schools that the school tuition organization serves.

c. The names and addresses of all the members of the board of directors of the school tuition organization.

Once the school tuition organization is registered with the department, it is not required to subsequently register unless there is a change in the qualified schools that the organization serves. The school tuition organization must notify the department in writing of any changes in the qualified schools it serves.

42.32(3) *Participation forms.* Each qualified school that is served by a school tuition organization must annually submit a participation form to the department by November 1. The following information must be provided with this participation form:

a. The certified enrollment of the qualified school as of October 1, or the first Monday in October if October 1 falls on a Saturday or Sunday.

b. The name of the school tuition organization that represents the qualified school.

For the tax year beginning in the 2006 calendar year only, each qualified school served by a school tuition organization must submit to the department a participation form postmarked on or before August 1, 2006, which provides the certified enrollment as of the third Friday of September 2005, along with the name of the school tuition organization that represents the qualified school.

42.32(4) *Authorization to issue tax credit certificates.*

a. By December 1 of each year, the department will authorize school tuition organizations to issue tax credit certificates for the following tax year. For the tax year beginning in the 2006 calendar year only, the department, by September 1, 2006, will authorize school tuition organizations to issue tax credit certificates for the 2006 calendar year only. The total amount of tax credit certificates that may be authorized is $2.5 million for the 2006 calendar year, $5 million for the 2007 calendar year, $7.5 million for the 2008 through 2011 calendar years, and $8.75 million for 2012 and subsequent calendar years.

b. The amount of authorized tax credit certificates for each school tuition organization is determined by dividing the total amount of tax credit available by the total certified enrollment of all qualified participating schools. This result, which is the per-student tax credit, is then multiplied by the certified enrollment of each school tuition organization to determine the tax credit authorized to each school tuition organization.

EXAMPLE: For determining the authorized tax credits for the 2008 calendar year, if the certified enrollment of each qualified school in Iowa, as provided to the department by November 1, 2007, was 37,500, the per-student tax credit would be $200 ($7.5 million divided by 37,500). If a school tuition organization located in Scott County represents four qualified schools with a certified enrollment of 1,400 students, the school tuition organization would be authorized to issue $280,000 ($200 times 1,400) of tax credit certificates for the 2008 calendar year. The department would notify this school tuition organization by December 1, 2007, of the authorization to issue $280,000 of tax credit certificates for the 2008 calendar year. This authorization would allow the school tuition organization to solicit contributions totaling $430,769 ($280,000 divided by 65%) during the 2008 calendar year which would be eligible for the tax credit.

42.32(5) *Issuance of tax credit certificates.* The school tuition organization shall issue tax credit certificates to each taxpayer who made a cash or noncash contribution to the school tuition organization. The tax credit certificate, which will be designed by the department, will contain the name, address and tax identification number of the taxpayer, the amount and date that the contribution was made, the amount of the credit, the tax year that the credit may be applied, the school tuition organization to which the contribution was made, and the tax credit certificate number.

42.32(6) *Claiming the tax credit.* The taxpayer must attach the tax credit certificate to the tax return for which the credit is claimed. Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

a. The taxpayer may not claim an itemized deduction for charitable contributions for Iowa income tax purposes for the amount of the contribution made to the school tuition organization.

b. Married taxpayers who file separate returns or file separately on a combined return must allocate the school tuition organization tax credit to each spouse in the proportion that each spouse's respective net income bears to the total combined net income. Nonresidents or part-year residents of Iowa must determine the school tuition organization tax credit in the ratio of their Iowa source net income to their total source net income. In addition, if nonresidents or part-year residents of Iowa are married and elect to file separate returns or to file separately on a combined return, the school tuition organization tax credit must be allocated between the spouses in the ratio of each spouse's Iowa source net income to the combined Iowa source net income.

42.32(7) *Reporting requirements.* Each school tuition organization that issues tax credit certificates must report to the department, postmarked by January 12 of each tax year, the following information:

a. The names and addresses of all the members of the board of directors of the school tuition organization, along with the name of the chairperson of the board.

b. The total number and dollar value of contributions received by the school tuition organization for the previous tax year.

c. The total number and dollar value of tax credit certificates issued by the school tuition organization for the previous tax year.

d. A list of each taxpayer who received a tax credit certificate for the previous tax year, including the amount of the contribution and the amount of tax credit issued to each taxpayer for the previous tax year. This list should also include the tax identification number of the taxpayer and the tax credit certificate number for each certificate.

e. The total number of children utilizing tuition grants for the school year in progress as of January 12, along with the total dollar value of the tuition grants.

f. The name and address of each qualified school represented by the school tuition organization at which tuition grants are being utilized for the school year in progress.

g. The number of tuition grant students and the total dollar value of tuition grants being utilized for the school year in progress at each qualified school served by the school tuition organization.

This rule is intended to implement Iowa Code section 422.11S as amended by 2011 Iowa Acts, Senate File 533.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—42.33(422) E-85 gasoline promotion tax credit. Effective for tax years beginning on or after January 1, 2006, a retail dealer of gasoline may claim an E-85 gasoline promotion tax credit. "E-85 gasoline" means ethanol blended gasoline formulated with a minimum percentage of between 70 percent and 85 percent of volume of ethanol, if the formulation meets the standards provided in Iowa Code section 214A.2. For purposes of this rule, tank wagon sales are considered retail sales. The credit is calculated on Form IA 135. The credit is calculated by multiplying the total number of E-85 gallons sold by the retail dealer during the tax year by the following designated rates:

Calendar years 2006, 2007 and 2008	25 cents
Calendar years 2009 and 2010	20 cents
Calendar year 2011	10 cents
Calendar years 2012 through 2017	16 cents

A taxpayer may claim the E-85 gasoline promotion tax credit even if the taxpayer also claims the ethanol blended gasoline tax credit provided in rule 701—42.20(422) for gallons sold prior to January 1, 2009, or the ethanol promotion tax credit provided in rule 701—42.39(422) for gallons sold on or after January 1, 2009, for the same tax year for the same ethanol gallons.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

EXAMPLE: A taxpayer operated one retail motor fuel site in 2008 and sold 200,000 gallons of gasoline, of which 160,000 gallons was ethanol blended gasoline. Of these 160,000 gallons, 1,000 gallons was E-85 gasoline. Taxpayer may claim the E-85 gasoline promotion tax credit on the 1,000

gallons of E-85 gasoline sold during 2008. Taxpayer is also entitled to claim the ethanol blended gasoline tax credit of two and one-half cents multiplied by 40,000 gallons, since this constitutes the gallons in excess of 60 percent of the total gasoline gallons sold for the 2008 tax year.

42.33(1) *Fiscal year filers.* For taxpayers whose tax year is not on a calendar-year basis, the taxpayer may compute the tax credit on the gallons of E-85 gasoline sold during the year using the designated rates as shown above. Because the tax credit is repealed on January 1, 2018, a taxpayer whose tax year ends prior to December 31, 2017, may continue to claim the tax credit in the following tax year for any E-85 gallons sold through December 31, 2017. For a retail dealer whose tax year is not on a calendar-year basis and who did not claim the E-85 credit on the previous return, the dealer may claim the credit for the current tax year for the period beginning on January 1 of the previous tax year until the last day of the previous tax year.

See 701—subrule 52.30(1) for examples illustrating how this subrule is applied.

42.33(2) *Allocation of credit to owners of a business entity.* If a taxpayer claiming the E-85 ethanol promotion tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 422.11O as amended by 2011 Iowa Acts, Senate File 531.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9821B**, IAB 11/2/11, effective 12/7/11]

701—42.34(422) Biodiesel blended fuel tax credit. Effective for tax years beginning on or after January 1, 2006, a retail dealer of biodiesel blended fuel may claim a biodiesel blended fuel tax credit. "Biodiesel blended fuel" means a blend of biodiesel with petroleum-based diesel fuel which meets the standards provided in Iowa Code section 214A.2. The biodiesel blended fuel must be formulated with a minimum percentage of 2 percent by volume of biodiesel, if the formulation meets the standards provided by Iowa Code section 214A.2, to qualify for the tax credit for gallons sold on or after January 1, 2006, but before January 1, 2013. For gallons sold on or after January 1, 2013, but before January 1, 2018, the biodiesel blended fuel must be formulated with a minimum percentage of 5 percent by volume of biodiesel, if the formulation meets the standards provided by Iowa Code section 214A.2, to qualify for the tax credit. In addition, of the total gallons of diesel fuel sold by the retail dealer, 50 percent or more must be biodiesel blended fuel to be eligible for the tax credit for tax years beginning prior to January 1, 2009. For tax years beginning on or after January 1, 2009, but before January 1, 2012, the biodiesel blended fuel tax credit is calculated separately for each retail motor fuel site for which 50 percent or more of the total gallons of diesel fuel sold at the motor fuel site was biodiesel blended fuel. For tax years beginning on or after January 1, 2012, the requirement that 50 percent of all diesel fuel gallons sold be biodiesel gallons to be eligible for the tax credit is eliminated.

The tax credit equals three cents multiplied by the qualifying number of biodiesel blended fuel gallons sold by the taxpayer during the tax year for gallons sold through December 31, 2011. For gallons sold during the 2012 calendar year, the tax credit equals the sum of two cents multiplied by the qualifying number of biodiesel blended fuel gallons that have a minimum percentage of 2 percent by volume of biodiesel but less than 5 percent by volume of biodiesel and four and one-half cents multiplied by the qualifying number of biodiesel blended fuel gallons that have a minimum percentage of 5 percent by volume of biodiesel. For gallons sold during the 2013 to 2017 calendar years, the tax credit equals four and one-half cents multiplied by the qualifying number of biodiesel blended fuel gallons that have a minimum percentage of 5 percent by volume of biodiesel. In determining the minimum percentage by volume of biodiesel, the department will take into account reasonable variances due to testing and other limitations. For purposes of this rule, tank wagon sales are considered retail sales. The credit is calculated on Form IA 8864.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

EXAMPLE: A taxpayer operated four retail motor fuel sites during 2008 and sold a combined total at all four sites of 100,000 gallons of diesel fuel, of which 55,000 gallons was biodiesel blended fuel containing a minimum percentage of 2 percent by volume of biodiesel. Because 50 percent or more of the diesel fuel sold was biodiesel blended fuel, the taxpayer may claim the biodiesel blended fuel tax credit totaling $1,650, which is 55,000 gallons multiplied by three cents.

EXAMPLE: A taxpayer operated two retail motor fuel sites during 2008, and each site sold 40,000 gallons of diesel fuel. One site sold 25,000 gallons of biodiesel blended fuel, and the other site sold 10,000 gallons of biodiesel blended fuel. The taxpayer would not be eligible for the biodiesel blended fuel tax credit because only 35,000 gallons of the total 80,000 gallons, or 43.75 percent of the total diesel fuel gallons sold, was biodiesel blended fuel. The 50 percent requirement is based on the aggregate number of diesel fuel gallons sold by the taxpayer, and the fact that one retail motor fuel site met the 50 percent requirement does not allow the taxpayer to claim the biodiesel blended fuel tax credit for the 2008 tax year. If the facts in this example had occurred during the 2009 tax year, the taxpayer could claim a biodiesel blended fuel tax credit totaling $750, which is 25,000 gallons multiplied by three cents, since one of the retail motor fuel sites met the 50 percent biodiesel blended fuel requirement.

42.34(1) *Fiscal year filers.* Taxpayers whose tax year is not on a calendar-year basis and whose tax year ends before December 31, 2006, may compute the tax credit on the gallons of biodiesel blended fuel sold during the period from January 1, 2006, through the end of the tax year, provided that 50 percent of all diesel fuel sold during that period was biodiesel blended fuel. Because the tax credit is repealed on January 1, 2018, a taxpayer whose tax year ends prior to December 31, 2017, may continue to claim the tax credit in the following tax year for any biodiesel blended fuel sold through December 31, 2017.

See 701—subrule 52.31(1) for examples illustrating how this subrule is applied.

42.34(2) *Allocation of credit to owners of a business entity.* If a taxpayer claiming the biodiesel blended fuel tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 422.11P as amended by 2011 Iowa Acts, Senate Files 531 and 533.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9821B**, IAB 11/2/11, effective 12/7/11]

701—42.35(422) Soy-based transformer fluid tax credit. Effective for tax periods ending after June 30, 2006, and beginning before January 1, 2009, an electric utility may claim a soy-based transformer fluid tax credit. An electric utility, which is a public utility, city utility, or electric cooperative which furnishes electricity, may claim a credit equal to the costs incurred during the tax year for the purchase and replacement costs relating to the transition from using nonsoy-based transformer fluid to using soy-based transformer fluid.

42.35(1) *Eligibility requirements for the tax credit.* All of the following conditions must be met for the electric utility to qualify for the soy-based transformer fluid tax credit.

a. The costs must be incurred after June 30, 2006, and before January 1, 2009.

b. The costs must be incurred in the first 18 months of the transition from using nonsoy-based transformer fluid to using soy-based transformer fluid.

c. The soy-based transformer fluid must be dielectric fluid that contains at least 98 percent soy-based products.

d. The costs of the purchase and replacement must not exceed $2 per gallon of soy-based transformer fluid used in the transition.

e. The number of gallons used in the transition must not exceed 20,000 gallons per electric utility, and the total number of gallons eligible for the credit must not exceed 60,000 gallons in the aggregate.

f. The electric utility shall not deduct for Iowa income tax purposes the costs incurred in the transition to using soy-based transformer fluid which are deductible for federal income tax purposes.

42.35(2) *Applying for the tax credit.* An electric utility must apply to the department for the soy-based transformer fluid tax credit. The application for the tax credit must be filed no later than 30

days after the close of the tax year for which the credit is claimed. The application must include the following information:

a. A copy of the signed purchase agreement or other agreement to purchase soy-based transformer fluid.

b. The number of gallons of soy-based transformer fluid purchased during the tax year, along with the cost per gallon of each purchase made during the tax year.

c. The name, address, and tax identification number of the electric utility.

d. The type of tax for which the credit will be claimed, and the first year in which the credit will be claimed.

e. If the application is filed by a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, a list of the partners, members, shareholders or beneficiaries of the entity. This list shall include the name, address, tax identification number and pro-rata share of earnings from the entity for each of the partners, members, shareholders or beneficiaries.

42.35(3) *Claiming the tax credit.* After the application is reviewed, the department will issue a tax credit certificate to the electric utility. The tax credit certificate will include the taxpayer's name, address and federal identification number, the tax type for which the credit will be claimed, the amount of the credit and the tax year for which the credit may be claimed. Once the tax credit certificate is issued, the credit may be claimed only against the type of tax reflected on the certificate. If the department refuses to issue the tax credit certificate, the taxpayer shall be notified in writing; and the taxpayer will have 60 days from the date of denial to file a protest in accordance with rule 701—7.41(17A).

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on the partner's, member's, shareholder's or beneficiary's pro-rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

This rule is intended to implement Iowa Code section 422.11R.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.36(175,422) Agricultural assets transfer tax credit. Effective for tax years beginning on or after January 1, 2007, an owner of agricultural assets that rents assets to qualified beginning farmers may claim an agricultural assets transfer tax credit for Iowa individual income tax. The credit is equal to 5 percent of the rental income received by the owner for cash rental agreements, and the credit is equal to 15 percent of the rental income received by the owner for commodity share agreements. The administrative rules for the agricultural assets transfer tax credit for the Iowa agricultural development authority may be found under 25—Chapter 6.

To qualify for the tax credit, an owner of agricultural assets must enter into a lease or rental agreement with a beginning farmer for a term of at least two years, but not more than five years. Both the owner of agricultural assets and the beginning farmer must meet certain qualifications set forth by the Iowa agricultural development authority, and the beginning farmer must be eligible to receive financial assistance under Iowa Code section 175.12.

The Iowa agricultural development authority will issue a tax credit certificate to the owner of agricultural assets which will include the name, address and tax identification number of the owner, the amount of the credit, and the tax period for which the credit may be applied. To claim the tax credit, the owner must attach the tax credit certificate to the tax return for the tax period set forth on the certificate. For fiscal years beginning on or after July 1, 2009, the amount of tax credit certificates issued by the Iowa agricultural development authority cannot exceed $6 million, and the credit certificates will be issued on a first-come, first-served basis.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier. The tax credit shall not be carried back to a

tax year prior to the year in which the owner redeems the credit. The credit is not transferable to any other person other than the taxpayer's estate or trust upon the death of the taxpayer.

If an owner of agricultural assets is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

The lease or rental agreement may be terminated by either the owner or the beginning farmer. If the agricultural development authority determines that the owner is not at fault for the termination, the authority will not issue a tax credit certificate for subsequent years, but any prior tax credit certificates issued will be allowed. If the authority determines that the owner is at fault for the termination, any prior tax credit certificates will be disallowed. The amount of tax credits previously allowed will be recaptured, and the owner will be required to repay the entire amount of tax credits previously claimed on Iowa returns.

This rule is intended to implement Iowa Code section 175.37 as amended by 2009 Iowa Acts, Senate File 483, and Iowa Code section 422.11M.
[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.37(15,422) Film qualified expenditure tax credit. Effective for tax years beginning on or after January 1, 2007, a film qualified expenditure tax credit is available for individual income tax. The tax credit cannot exceed 25 percent of the taxpayer's qualified expenditures in a film, television, or video project registered with the film office of the Iowa department of economic development (IDED). The film office may negotiate the amount of the tax credit. The administrative rules for the film qualified expenditure tax credit for IDED may be found at 261—Chapter 36.

42.37(1) *Qualified expenditures.* A qualified expenditure is a payment to an Iowa resident or an Iowa-based business for the sale, rental or furnishing of tangible personal property or services directly related to the registered project. The qualified expenditures include, but are not limited to, the following:

1. Aircraft.
2. Vehicles.
3. Equipment.
4. Materials.
5. Supplies.
6. Accounting services.
7. Animals and animal care services.
8. Artistic and design services.
9. Graphics.
10. Construction.
11. Data and information services.
12. Delivery and pickup services.
13. Labor and personnel. For limitations on the amount of labor and personnel expenditures, see Iowa department of economic development 261—paragraph 36.7(2)*"b."*
14. Lighting services.
15. Makeup and hairdressing services.
16. Film.
17. Music.
18. Photography.
19. Sound.
20. Video and related services.
21. Printing.
22. Research.
23. Site fees and rental.
24. Travel related to Iowa distant locations.
25. Trash removal and cleanup.

26. Wardrobe.

A detailed list of all qualified expenditures for each of these categories is available from the film office of IDED.

42.37(2) *Claiming the tax credit.* Upon completion of the registered project in Iowa, the taxpayer must submit, in a format approved by IDED prior to production, a listing of the qualified expenditures. Upon verification of the qualified expenditures, IDED will issue a tax credit certificate to the taxpayer. The certificate will list the taxpayer's name, address, and tax identification number; the date of project completion; the amount of the credit; the tax period for which the credit may be applied; and the type of tax for which the credit will be applied.

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on each partner's, member's, shareholder's or beneficiary's pro-rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust.

To claim the tax credit, the taxpayer must attach the tax credit certificate to the tax return for the tax period set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for five years or until the tax credit is used, whichever is the earlier. The tax credit cannot be carried back to a tax year prior to the year in which the taxpayer claimed the tax credit.

42.37(3) *Transfer of the film qualified expenditure tax credit.* The film qualified expenditure tax credit may be transferred no more than two times to any person or entity.

Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department of revenue will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the film qualified expenditure tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

This rule is intended to implement Iowa Code section 15.393 as amended by 2009 Iowa Acts, Senate File 480, and Iowa Code section 422.11T.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.38(15,422) Film investment tax credit. Effective for tax years beginning on or after January 1, 2007, a film investment tax credit is available for individual income tax. The tax credit cannot exceed 25 percent of the taxpayer's investment in a film, television, or video project registered with the film office of the Iowa department of economic development (IDED). The film office may negotiate the amount of the tax credit. The administrative rules for the film investment tax credit for IDED may be found at 261—Chapter 36.

42.38(1) *Claiming the tax credit.* Upon completion of the project in Iowa and verification of the investment in the project, IDED will issue a tax credit certificate to the taxpayer. The certificate will list the taxpayer's name, address, and tax identification number; the date of project completion; the amount of the credit; the tax period for which the credit may be applied; and the type of tax for which the credit will be applied.

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on each partner's, member's, shareholder's or beneficiary's pro-rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust.

To claim the tax credit, the taxpayer must attach the tax credit certificate to the tax return for the tax period set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for five years or until the tax credit is used, whichever is the earlier. The tax credit cannot be carried back to a tax year prior to the year in which the taxpayer claimed the tax credit. In addition, a taxpayer cannot claim the film investment tax credit for qualified expenditures for which the film expenditure tax credit set forth in rule 701—42.37(15,422) is claimed.

The total of all film investment tax credits for a particular project cannot exceed 25 percent of the qualified expenditures as set forth in subrule 42.37(1) for the particular project. If the amount of investment exceeds the qualified expenditures, the tax credit will be allocated proportionately. For example, if three investors each invested $100,000 in a project but the qualified expenditures in Iowa only totaled $270,000, each investor would receive a tax credit based on a $90,000 investment amount.

42.38(2) *Transfer of the film investment tax credit.* The film investment tax credit may be transferred no more than two times to any person or entity.

Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department of revenue will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the film investment tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

This rule is intended to implement Iowa Code section 15.393 as amended by 2009 Iowa Acts, Senate File 480, section 4, and Iowa Code section 422.11U.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.39(422) Ethanol promotion tax credit. Effective for tax years beginning on or after January 1, 2009, a retail dealer of gasoline may claim an ethanol promotion tax credit. For purposes of this rule, tank wagon sales are considered retail sales. The ethanol promotion tax credit is computed on Form IA 137.

42.39(1) *Definitions.* The following definitions are applicable to this rule:

"Biodiesel gallonage" means the total number of gallons of biodiesel which the retail dealer sells from motor fuel pumps during a determination period. For example, 5,000 gallons of biodiesel blended fuel with a 2 percent by volume of biodiesel sold during a determination period results in a biodiesel gallonage of 100 (5,000 times 2%).

"Biofuel distribution percentage" means the sum of the retail dealer's total ethanol gallonage plus the retail dealer's total biodiesel gallonage expressed as a percentage of the retail dealer's total gasoline gallonage.

"Biofuel threshold percentage" is dependent on the aggregate number of gallons of motor fuel sold by a retail dealer during a determination period, as set forth below:

Determination Period	More that 200,000 Gallons Sold by Retail Dealer	200,000 Gallons or Less Sold by Retail Dealer
2009	10%	6%
2010	11%	6%
2011	12%	10%
2012	13%	11%
2013	14%	12%
2014	15%	13%
2015	17%	14%
2016	19%	15%
2017	21%	17%
2018	23%	19%
2019	25%	21%
2020	25%	25%

"Biofuel threshold percentage disparity" means the positive percentage difference between the retail dealer's biofuel threshold percentage and the retail dealer's biofuel distribution percentage. For example, if a retail dealer that sells more than 200,000 gallons of motor fuel in 2009 has a biofuel distribution percentage of 8 percent, the biofuel threshold percentage disparity equals 2 percent (10% minus 2%).

"Determination period" means any 12-month period beginning on January 1 and ending on December 31.

"Ethanol gallonage" means the total number of gallons of ethanol which the retail dealer sells from motor fuel pumps during a determination period. For example, 10,000 gallons of ethanol blended gasoline formulated with a 10 percent by volume of ethanol sold during a determination period results in an ethanol gallonage of 1,000 (10,000 gallons times 10%).

"Gasoline gallonage" means the total number of gallons of gasoline sold by the retail dealer during a determination period.

42.39(2) *Calculation of tax credit.*

a. The tax credit is calculated by multiplying the retail dealer's total ethanol gallonage by the tax credit rate, which is adjusted based upon the retail dealer's biofuel threshold percentage disparity. The tax credit rate is set forth below:

Biofuel Threshold Percentage Disparity	Tax Credit Rate per Gallon 2009-2010	Tax Credit Rate per Gallon 2011	Tax Credit Rate per Gallon 2012-2020
0%	6.5 cents	8 cents	8 cents
0.01% to 2.00%	4.5 cents	6 cents	6 cents
2.01% to 4.00%	2.5 cents	2.5 cents	4 cents
4.01% or more	0 cents	0 cents	0 cents

b. For use in calculating a retail dealer's total ethanol gallonage, the department is required to establish a schedule regarding the average amount of ethanol contained in E-85 gasoline.

c. A taxpayer may claim the ethanol promotion tax credit even if the taxpayer also claims the E-85 gasoline promotion tax credit provided in rule 701—42.33(422) or the E-15 plus gasoline promotion tax credit provided in rule 701—42.46(422) for the same tax year for the same ethanol gallons.

d. The tax credit must be calculated separately for each retail motor fuel site operated by the taxpayer for tax years beginning prior to January 1, 2011. The biofuel threshold percentage disparity of the taxpayer is computed on a statewide basis based on the total ethanol gallonage sold in Iowa. The taxpayer must determine the ethanol gallonage sold at each retail motor fuel site and multiply this ethanol

gallonage by the applicable tax credit rate based on the biofuel threshold percentage disparity to calculate the ethanol promotion tax credit.

e. For tax years beginning on or after January 1, 2011, the taxpayer may elect to compute the biofuel threshold percentage disparity and the tax credit on either a site-by-site basis or on a companywide basis. The election made on the first return beginning on or after January 1, 2011, for either the site-by-site method or the companywide method is binding on the taxpayer for subsequent tax years unless the taxpayer petitions the department for a change in the method. Any petition for a change in the method should be made within a reasonable period of time prior to the due date of the return for which the change is requested. For example, if a change is requested for the tax return beginning January 1, 2012, the petition should be made by January 31, 2013, which is 90 days prior to the due date of the return.

The mere fact that a change in the method will result in a larger tax credit for subsequent years is not, of itself, sufficient grounds for changing the method for computing the credit. An example of a case for which the department may grant a change in the method is if the taxpayer has a significant change in the type of fuel sold at the taxpayer's retail sites in Iowa. For example, if a retail dealer opted to start selling E-85 gasoline at all the taxpayer's retail sites in Iowa for a subsequent tax year, the department may grant a change in the method.

If a taxpayer chooses the site-by-site method to compute the biofuel threshold percentage disparity, the gallons sold at all sites in Iowa must be considered in determining if the biofuel threshold percentage as defined in subrule 42.39(1) is based on more than 200,000 gallons or on 200,000 gallons or less. For example, if a taxpayer operates three motor fuel sites in Iowa and each site sells 80,000 gallons of motor fuel during 2011, the biofuel threshold percentage of 12 percent must be used for each retail site if the tax credit is computed on a site-by-site basis, even though each retail site sold less than 200,000 gallons of motor fuel.

f. Any tax credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming a refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

42.39(3) *Fiscal year filers.* For taxpayers whose tax year is not on a calendar-year basis, the taxpayer may compute the ethanol promotion tax credit on the total ethanol gallonage sold during the year using the designated tax credit rates as shown in subrule 42.39(2), paragraph *"a."* Because the tax credit is repealed on January 1, 2021, a taxpayer whose tax year ends prior to December 31, 2020, may continue to claim the tax credit in the following tax year for the total ethanol gallonage sold through December 31, 2020. A taxpayer whose tax year is not on a calendar-year basis and that did not claim the ethanol promotion tax credit on the previous return may claim the tax credit for the current tax year for the period beginning on January 1 of the previous tax year until the last day of the previous tax year.

42.39(4) *Allocation of tax credit to owners of a business entity.* If a taxpayer claiming the ethanol promotion tax credit is a partnership, limited liability company, S corporation, estate, or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by the individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, estate, or trust.

42.39(5) *Examples.* The following noninclusive examples illustrate how this rule applies:

EXAMPLE 1. A taxpayer that is a retail dealer of gasoline operates only one motor fuel site in Iowa. The number of gallons of gasoline sold at this site in 2009 equals 100,000 gallons. This consisted of 5,000 gallons of E-85 gasoline, 80,000 gallons of E-10 (10% ethanol blended gasoline) and 15,000 gallons not containing ethanol. The average ethanol content of E-85 gasoline is assumed to be 79%. The taxpayer also sold at this site during 2009 15,000 gallons of diesel fuel, of which 5,000 gallons was B-2 (2% biodiesel). The ethanol gallonage is 11,950 (5,000 E-85 gallons times 79% equals 3,950; 80,000 E-10 gallons times 10% equals 8,000; and thus 3,950 plus 8,000 equals 11,950). The biodiesel gallonage sold is 100, or 5,000 times 2%. The sum of 11,950 and 100, or 12,050, is divided by the total gasoline gallonage of 100,000 to arrive at a biofuel distribution percentage of 12.05%. Since this percentage exceeds the biofuel threshold percentage of 6% for a retail dealer selling 200,000 gallons or less, the biofuel threshold disparity percentage is 0%. This calculation results in an ethanol promotion tax credit of 6.5 cents times 11,950, or $776.75.

In addition, the taxpayer is entitled to claim the E-85 gasoline promotion tax credit equal to 20 cents multiplied by 5,000 gallons, or $1,000.

EXAMPLE 2. A taxpayer that is a retail dealer of gasoline operates only one motor fuel site in Iowa. The number of gallons of gasoline sold at this site in 2010 equals 300,000 gallons which consisted of 10,000 gallons of E-85 gasoline, 230,000 gallons of E-10 (10% ethanol blended gasoline) and 60,000 gallons not containing ethanol. The average ethanol content of E-85 gasoline is assumed to be 79%. The taxpayer also sold 60,000 gallons of diesel fuel at this site during 2010, of which 25,000 gallons was B-2 (2% biodiesel). The ethanol gallonage is 30,900 (10,000 E-85 gallons times 79% equals 7,900; 230,000 E-10 gallons times 10% equals 23,000; and thus 7,900 plus 23,000 equals 30,900). The biodiesel gallonage sold is 500, or 25,000 times 2%. The sum of 30,900 and 500, or 31,400, is divided by the total gasoline gallonage of 300,000 to arrive at a biofuel distribution percentage of 10.47%. Since this is less than the biofuel threshold percentage of 11% for a retail dealer selling more than 200,000 gallons, the biofuel threshold disparity percentage is .53%. This calculation results in an ethanol promotion tax credit of 4.5 cents times 30,900, or $1,390.50.

In addition, the taxpayer is entitled to claim the E-85 gasoline promotion tax credit equal to 20 cents multiplied by 10,000 gallons, or $2,000.

EXAMPLE 3. A taxpayer that is a retail dealer of gasoline operates three motor fuel sites in Iowa during 2009, and each site sold 80,000 gallons of gasoline. Sites A and B each sold 70,000 gallons of E-10 (10% ethanol blended gasoline) and 10,000 gallons not containing ethanol. Site C sold 60,000 gallons of E-10, 10,000 gallons of E-85, and 10,000 gallons not containing ethanol. The average ethanol content of E-85 gasoline is assumed to be 79%. The retail dealer did not sell any diesel fuel at any of the motor fuel sites. The ethanol gallonage is 27,900, as shown below:

Site A – 70,000 times 10% equals	7,000
Site B – 70,000 times 10% equals	7,000
Site C – 60,000 times 10% equals	6,000
Site C – 10,000 times 79% equals	7,900
Total	27,900

The ethanol gallonage of 27,900 is divided by the gasoline gallonage of 240,000 to arrive at a biofuel distribution percentage of 11.63%. Since this exceeds the biofuel threshold percentage of 10% for a retail dealer selling more than 200,000 gallons, the biofuel threshold disparity percentage is 0%. The credit is computed separately for each motor fuel site, and the ethanol promotion credit equals $1,813.50, as shown below:

Site A – 7,000 times 6.5 cents equals	$455.00
Site B – 7,000 times 6.5 cents equals	$455.00
Site C – 13,900 times 6.5 cents equals	$903.50
Total	$1,813.50

Since the biofuel distribution percentage and the biofuel threshold percentage disparity are computed on a statewide basis for all gallons sold in Iowa, the 6.5 cent tax credit rate is applied to the total ethanol gallonage, even if Sites A and B did not meet the biofuel threshold percentage of 10% for 2009.

In addition, the taxpayer is entitled to claim the E-85 gasoline promotion tax credit equal to 20 cents multiplied by 10,000 gallons, or $2,000.

EXAMPLE 4. A taxpayer that is a retail dealer of gasoline has a fiscal year ending March 31, 2011, and operates one motor fuel site in Iowa. The taxpayer sold more than 200,000 gallons of gasoline during the 2010 calendar year and expects to sell more than 200,000 gallons of gasoline during the 2011 calendar year. The ethanol gallonage is 30,000 for the period from April 1, 2010, through December 31, 2010, and the ethanol gallonage is 8,000 for the period from January 1, 2011, through March 31, 2011. The biofuel distribution percentage is 11.5% for the period from April 1, 2010, through December 31, 2010, and the biofuel distribution percentage is 11.8% for the period from January 1, 2011, through March 31,

2011. This results in a biofuel threshold percentage disparity of 0% (11.0 minus 11.5) for the period from April 1, 2010, through December 31, 2010, and a biofuel threshold percentage disparity of .2% (12.0 minus 11.8) for the period from January 1, 2011, through March 31, 2011. The taxpayer is entitled to an ethanol promotion tax credit of $2,310 for the fiscal year ending March 31, 2011, as shown below:

30,000 times 6.5 cents equals	$1,950
8,000 times 4.5 cents equals	360
Total	$2,310

EXAMPLE 5. A taxpayer that is a retail dealer of gasoline has a fiscal year ending April 30, 2009, and operates one motor fuel site in Iowa. The taxpayer expects to sell more than 200,000 gallons of gasoline during the 2009 calendar year. The ethanol gallonage is 50,000 gallons for the period from January 1, 2009, through April 30, 2009. The biofuel distribution percentage is 7.7% for the period from January 1, 2009, through April 30, 2009, which results in a biofuel threshold percentage disparity of 2.3% (10.0 minus 7.7). The taxpayer is entitled to claim an ethanol promotion tax credit of $1,250 (50,000 gallons times 2.5 cents) on the taxpayer's Iowa income tax return for the period ending April 30, 2009.

In lieu of claiming the credit on the return for the period ending April 30, 2009, the taxpayer may claim the ethanol promotion tax credit on the tax return for the period ending April 30, 2010, including the ethanol gallonage for the period from January 1, 2009, through April 30, 2010. In this case, the taxpayer will compute the biofuel distribution percentage for the period from January 1, 2009, through December 31, 2009, to determine the proper tax credit rate to be applied to the ethanol gallonage for the period from January 1, 2009, through December 31, 2009.

EXAMPLE 6. Assume the same facts as Example 3, except that the gallons were sold in 2011. The taxpayer chose the companywide method to compute the biofuel threshold percentage disparity and the tax credit. The biofuel distribution percentage is 11.63%, and since the biofuel threshold percentage is 12% for retailers selling more than 200,000 gallons of motor fuel, the biofuel threshold percentage disparity is 0.37%. This results in an ethanol promotion tax credit on a companywide basis of 6 cents multiplied by the ethanol gallonage of 27,900 or $1,674.

EXAMPLE 7. Assume the same facts as Example 3, except that the gallons were sold in 2011. The taxpayer chose the site-by-site method to compute the biofuel threshold percentage disparity and the tax credit. The biofuel threshold percentage is still 12% since the retailer sold more than 200,000 gallons of motor fuel at all sites in Iowa. The biofuel distribution percentage for Site A and Site B is 7,000 divided by 80,000, or 8.75%. The biofuel threshold percentage disparity for Site A and Site B is 3.25%, or 12% less than 8.75%. The biofuel distribution percentage for Site C is 13,900 divided by 80,000, or 17.38%. The biofuel threshold percentage disparity for Site C is 0% since the biofuel distribution percentage exceeds the biofuel threshold percentage. This results in an ethanol promotion tax credit on a site-by-site basis of $1,462, as shown below:

Site A – 7,000 times 2.5 cents equals	$175
Site B – 7,000 times 2.5 cents equals	$175
Site C – 13,900 times 8 cents equals	$1,112
Total	$1,462

This rule is intended to implement Iowa Code section 422.11N as amended by 2011 Iowa Acts, Senate File 531.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9821B**, IAB 11/2/11, effective 12/7/11]

701—42.40(422) Charitable conservation contribution tax credit. Effective for tax years beginning on or after January 1, 2008, a charitable conservation contribution tax credit is available for individual income tax which is equal to 50 percent of the fair market value of a qualified real property interest located in Iowa that is conveyed as an unconditional charitable donation in perpetuity by a taxpayer to a qualified organization exclusively for conservation purposes.

42.40(1) *Definitions.* The following definitions are applicable to this rule:

"Conservation purpose" means the same as defined in Section 170(h)(4) of the Internal Revenue Code, with the exception that a conveyance of land for open space for the purpose of fulfilling density requirements to obtain subdivision or building permits is not considered a conveyance for a conservation purpose.

"Qualified organization" means the same as defined in Section 170(h)(3) of the Internal Revenue Code.

"Qualified real property interest" means the same as defined in Section 170(h)(2) of the Internal Revenue Code. Conservation easements and bargain sales are examples of a qualified real property interest.

42.40(2) *Computation of the credit.* The credit equals 50 percent of the fair market value of the qualified real property interest. There are numerous federal revenue regulations, rulings, court cases and other provisions relating to the determination of the value of a qualified real property interest, and these are equally applicable in determining the amount of the charitable conservation contribution tax credit.

The maximum amount of the tax credit is $100,000. The amount of the contribution for which the tax credit is claimed shall not be claimed as an itemized deduction for charitable contributions for Iowa income tax purposes.

42.40(3) *Claiming the tax credit.* The tax credit is claimed on Form IA 148, Tax Credits Schedule. The taxpayer must attach a copy of federal Form 8283, Noncash Charitable Contributions, which reflects the calculation of the fair market value of the real property interest, to the Iowa return for the year in which the contribution is made. If a qualified appraisal of the property or other relevant information is required to be attached to federal Form 8283 for federal tax purposes, the appraisal and other relevant information must also be attached to the Iowa return.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following 20 years or until used, whichever is the earlier.

If the taxpayer claiming the credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

42.40(4) *Examples.* The following noninclusive examples illustrate how this rule applies:

EXAMPLE 1: A taxpayer conveys a real property interest with a fair market value of $150,000 to a qualified organization during 2008. The tax credit is equal to $75,000, or 50 percent of the $150,000 fair market value of the real property. The taxpayer cannot claim the $150,000 as an itemized deduction for charitable contributions on the Iowa individual income tax return for 2008.

EXAMPLE 2: A taxpayer conveys a real property interest with a fair market value of $500,000 to a qualified organization during 2009. The tax credit is limited to $100,000, which equates to $200,000 of the contribution being eligible for the tax credit. The remaining amount of $300,000 ($500,000 less $200,000) can be claimed as an itemized deduction for charitable contributions on the Iowa individual income tax return for 2009.

This rule is intended to implement Iowa Code section 422.11W.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.41(15,422) Redevelopment tax credit. Effective for tax years beginning on or after July 1, 2009, a taxpayer whose project has been approved by the Iowa brownfield redevelopment advisory council may claim a redevelopment tax credit. The credit is based on the taxpayer's qualifying investment in a brownfield or grayfield site. The administrative rules for a redevelopment project for the brownfield redevelopment authority which qualifies for the tax credit, including definitions of brownfield and grayfield sites, may be found in rules 261—65.11(15) and 261—65.12(15).

42.41(1) *Eligibility for the credit.* The economic development authority is responsible for developing a system for registration and authorization of projects receiving redevelopment tax credits. For the fiscal year beginning July 1, 2009, the maximum amount of tax credits allowed was $1 million, and the amount of credits authorized for any one redevelopment project could not exceed $100,000. For

the fiscal year beginning July 1, 2011, and subsequent fiscal years, the maximum amount of tax credits allowed cannot exceed $5 million, and the amount of credit authorized for any one redevelopment project cannot exceed $500,000.

42.41(2) *Computation and claiming of the credit.*

a. The amount of the tax credit shall equal one of the following:

(1) Twelve percent of the taxpayer's qualifying investment in a grayfield site.

(2) Fifteen percent of the taxpayer's qualifying investment in a grayfield site if the qualifying redevelopment project meets the requirements of green development as defined in rule 261—65.2(15).

(3) Twenty-four percent of the taxpayer's qualifying investment in a brownfield site.

(4) Thirty percent of the taxpayer's qualifying investment in a brownfield site if the qualifying redevelopment project meets the requirements of green development as defined in rule 261—65.2(15).

b. Upon completion of the project, the Iowa department of economic development will issue a tax credit certificate to the taxpayer. The tax credit certificate will include the taxpayer's name, address and federal identification number, the tax type for which the credit will be claimed, the amount of the credit, the tax year for which the credit may be claimed and the tax credit certificate number. In addition, the tax credit certificate will include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 42.41(3).

c. If a taxpayer claiming the tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

d. The increase in the basis of the redevelopment property that would otherwise result from the qualified redevelopment costs shall be reduced by the amount of the redevelopment tax credit. For example, if a qualifying investment in a grayfield site totaled $100,000 whereby a $12,000 redevelopment tax credit was issued, the increase in the basis of the property would total $88,000 for Iowa tax purposes ($100,000 less $12,000).

e. To claim the tax credit, the taxpayer must attach the tax credit certificate to the tax return for the tax period set forth on the certificate. Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier. The tax credit shall not be carried back to a tax year prior to the year in which the taxpayer redeems the credit.

42.41(3) *Transfer of the credit.* The redevelopment tax credit can be transferred to any person or entity.

Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department of revenue will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the redevelopment tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income tax, corporation income tax, or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be

deducted from Iowa taxable income for individual income tax, corporation income tax, or franchise tax purposes.

This rule is intended to implement Iowa Code section 15.293A as amended by 2011 Iowa Acts, Senate File 514, and section 422.11V.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—42.42(15) High quality jobs program. Effective for tax periods beginning on or after July 1, 2009, a business which qualifies under the high quality jobs program is eligible to receive tax credits. The high quality jobs program replaces the high quality job creation program. An eligible business under the high quality jobs program must be approved by the Iowa department of economic development and meet the qualifications of Iowa Code section 15.329. The tax credits available under the high quality jobs program are based upon the number of jobs created or retained that pay a qualifying wage threshold and the amount of qualifying investment. The administrative rules for the high quality jobs program for the Iowa department of economic development may be found at 261—Chapter 68.

42.42(1) *Research activities credit.* An eligible business approved under the high quality jobs program is eligible for an additional research activities credit as described in 701—subrule 52.7(4) for awards issued by the Iowa department of economic development prior to July 1, 2010. The eligible business is eligible for the research activities credit as described in 701—subrule 52.7(6) for awards issued by the Iowa department of economic development on or after July 1, 2010.

Research activities allowable for the Iowa research activities credit include expenses related to the development and deployment of innovative renewable energy generation components manufactured or assembled in Iowa; such expenses related to the development and deployment of innovative renewable energy generation components are not eligible for the federal credit for increasing research activities. For purposes of this subrule, innovative renewable energy generation components do not include components with more than 200 megawatts in installed effective nameplate generating capacity. The research activities credit related to renewable energy generation components under the high quality jobs program and the enterprise zone program shall not exceed $2 million for the fiscal year ending June 30, 2010, and $1 million for the fiscal year ending June 30, 2011.

These expenses related to the development and deployment of innovative renewable energy generation components are applicable only to the additional research activities credit set forth in this subrule and in 701—subrule 52.7(5) for businesses in enterprise zones, and are not applicable to the research activities credit set forth in subrule 42.11(3), paragraphs *"a"* and *"b."*

42.42(2) *Investment tax credit.* An eligible business can claim an investment tax credit equal to a percentage of the new investment directly related to new jobs created or retained by the location or expansion of an eligible business. The percentage is equal to the amount provided in Iowa department of economic development 261—subrule 68.4(7).

The determination of the new investment eligible for the investment tax credit, the eligibility of a refundable investment tax credit for value-added agricultural product or biotechnology-related projects and the repayment of investment tax credits for the high quality jobs program is the same as set forth in subrule 42.29(2) for the high quality job creation program.

This rule is intended to implement Iowa Code chapter 15.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—42.43(16,422) Disaster recovery housing project tax credit. For tax years beginning on or after January 1, 2011, a disaster recovery housing project tax credit is available for individual income tax. The credit is equal to 75 percent of the taxpayer's qualifying investment in a disaster recovery housing project, and is administered by the Iowa finance authority. Qualifying investments are costs incurred on or after May 12, 2009, and prior to July 1, 2010, related to a disaster recovery housing project. Eligible properties must have applied for and received an allocation of federal low-income housing tax credits under Section 42 of the Internal Revenue Code to be eligible for the tax credit.

42.43(1) *Issuance of tax credit certificates.* Upon completion of the project and verification of the amount of investment made in the disaster recovery housing project, the Iowa finance authority will issue a tax credit certificate to the taxpayer. The tax credit certificate shall include the taxpayer's name,

address, tax identification number, amount of credit, and the tax year for which the credit may be claimed. The tax credit certificates will be issued on a first-come, first-served basis. The tax credit cannot be transferred to any person or entity.

42.43(2) *Limitation of tax credits.* The tax credit shall not exceed 75 percent of the taxpayer's qualifying investment in a disaster recovery housing project. The maximum amount of tax credits issued by the Iowa finance authority shall not exceed $3 million in each of the five consecutive years beginning in the 2011 calendar year. A tax credit certificate shall be issued by the Iowa finance authority for each year that the credit can be claimed.

42.43(3) *Claiming the tax credit.* The amount of the tax credit earned by the taxpayer will be divided by five and an amount equal thereto will be claimed on the Iowa individual income tax return commencing with the tax year beginning on or after January 1, 2011. A taxpayer is not entitled to a refund of the excess tax for any tax credit in excess of the tax liability, and also is not entitled to carry forward any excess credit to a subsequent tax year.

If the taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

The increase in the basis of the property that would otherwise result from the disaster recovery housing investment shall be reduced by the amount of the tax credit allowed.

EXAMPLE: An individual whose tax year ends on December 31 incurs $100,000 of costs related to an eligible disaster recovery housing project. The taxpayer receives a tax credit of $75,000, and $15,000 of credit can be claimed on each Iowa individual income tax return for the periods ending December 31, 2011, through December 31, 2015. If the tax liability for the individual for the period ending December 31, 2011, is $10,000, the credit is limited to $10,000, and the remaining $5,000 credit cannot be used. If the tax liability for the individual for the period ending December 31, 2012, is $25,000, the credit is limited to $15,000, and the remaining $5,000 credit from 2011 cannot be used to reduce the tax for 2012.

42.43(4) *Potential recapture of tax credits.* If the taxpayer fails to comply with the eligibility requirements of the project or violates local zoning and construction ordinances, the Iowa finance authority can void the tax credit and the department of revenue shall seek recovery of the value of any tax credit claimed on an individual income tax return.

This rule is intended to implement Iowa Code Supplement sections 16.211, 16.212 and 422.11X.
[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.44(422) Deduction of credits. The credits against computed tax set forth in Iowa Code sections 422.5, 422.8, 422.10 through 422.12C, and 422.110 shall be deducted in the following sequence:

1. Personal exemption credit.
2. Tuition and textbook credit.
3. Nonresident and part-year resident credit.
4. Franchise tax credit.
5. S corporation apportionment credit.
6. Disaster recovery housing project tax credit.
7. School tuition organization tax credit.
8. Venture capital tax credits (excluding redeemed Iowa fund of funds tax credit).
9. Endow Iowa tax credit.
10. Agricultural assets transfer tax credit.
11. Film qualified expenditure tax credit.
12. Film investment tax credit.
13. Redevelopment tax credit.
14. Investment tax credit.
15. Wind energy production tax credit.
16. Renewable energy tax credit.
17. Redeemed Iowa fund of funds tax credit.

18. New jobs tax credit.
19. Economic development region revolving fund tax credit.
20. Charitable conservation contribution tax credit.
21. Alternative minimum tax credit.
22. Historic preservation and cultural and entertainment district tax credit.
23. Ethanol blended gasoline tax credit or ethanol promotion tax credit.
24. Research activities tax credit.
25. Out-of-state tax credit.
26. Child and dependent care credit or early childhood development tax credit.
27. Motor fuel credit.
28. Claim of right credit (if elected in accordance with rule 701—38.18(422)).
29. Wage-benefits tax credit.
30. Soy-based cutting tool oil tax credit.
31. Refundable portion of investment tax credit, as provided in subrule 42.14(2).
32. E-85 gasoline promotion tax credit.
33. Biodiesel blended fuel tax credit.
34. Soy-based transformer fluid tax credit.
35. E-15 plus gasoline promotion tax credit.
36. Earned income tax credit.
37. Estimated payments, payment with vouchers and withholding tax.

This rule is intended to implement Iowa Code sections 422.5, 422.8, 422.10, 422.11, 422.11A, 422.11B, 422.11D, 422.11F, 422.11H, 422.11J, 422.11M, 422.11N, 422.11O, 422.11P, 422.11Q, 422.11S, 422.11T, 422.11U, 422.11W, 422.11X, 422.12, 422.12B and 422.12C and 2011 Iowa Acts, Senate File 531, section 35.
[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—42.45(15) Aggregate tax credit limit for certain economic development programs. Effective for the fiscal year beginning July 1, 2009, awards made under certain economic development programs cannot exceed $185 million during a fiscal year. These programs include the assistive device tax credit program, the enterprise zone program, the housing enterprise zone program, the film, television and video project promotion program and the high quality jobs program. Effective for fiscal years beginning on or after July 1, 2010, awards made under these economic development programs cannot exceed $120 million during a fiscal year. The administrative rules for the aggregate tax credit limit for the Iowa department of economic development may be found at 261—Chapter 76.

This rule is intended to implement 2009 Iowa Code Supplement section 15.119 as amended by 2010 Iowa Acts, Senate File 2380.
[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—42.46(422) E-15 plus gasoline promotion tax credit. Effective for eligible gallons sold on or after July 1, 2011, a retail dealer of gasoline may claim an E-15 plus gasoline promotion tax credit. "E-15 plus gasoline" means ethanol blended gasoline formulated with a minimum percentage of between 15 percent and 69 percent of volume of ethanol, if the formulation meets the standards provided in Iowa Code section 214A.2. For purposes of this rule, tank wagon sales are considered retail sales. The credit is calculated on Form IA138. The tax credit is calculated by multiplying the total number of E-15 plus gallons sold by the retail dealer during the tax year by the following designated rates:

Gallons sold from July 1, 2011, through December 31, 2014	3 cents
Gallons sold from January 1, 2015, through December 31, 2017	2 cents

A taxpayer may claim the E-15 plus gasoline promotion tax credit even if the taxpayer also claims the ethanol promotion tax credit provided in rule 701—42.39(422) for gallons sold for the same tax year for the same ethanol gallons.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

42.46(1) *Fiscal year filers.* For taxpayers whose tax year is not on a calendar-year basis, the taxpayer may compute the tax credit on the gallons of E-15 plus gasoline sold during the year using the designated rates as shown above. Because the tax credit is repealed on January 1, 2018, a taxpayer whose tax year ends prior to December 31, 2017, may continue to claim the tax credit in the following tax year for any E-15 plus gallons sold through December 31, 2017. For a retail dealer whose tax year is not on a calendar-year basis and who did not claim the E-15 plus credit on the previous return, the dealer may claim the credit for the current tax year for gallons sold for the period beginning on July 1 of the previous tax year until the last day of the previous tax year. However, for taxpayers whose fiscal year ends before December 31, 2011, the dealer must claim the credit for the current tax year for gallons sold for the period beginning on July 1 of the previous tax year until the last day of the previous tax year.

EXAMPLE 1: A taxpayer who is a retail dealer of gasoline has a fiscal year ending October 31, 2011. The taxpayer sold 2,000 gallons of E-15 plus gasoline for the period from July 1, 2011, through October 31, 2011, and sold 7,000 gallons of E-15 plus gasoline for the period from November 1, 2011, through October 31, 2012. The taxpayer is entitled to a total E-15 plus gasoline promotion tax credit of $270 for the fiscal year ending October 31, 2012, which consists of a $60 credit (2,000 gallons multiplied by 3 cents) for the period from July 1, 2011, through October 31, 2011, and a credit of $210 (7,000 gallons multiplied by 3 cents) for the period from November 1, 2011, through October 31, 2012.

EXAMPLE 2: A taxpayer who is a retail dealer of gasoline has a fiscal year ending April 30, 2012. The taxpayer sold 4,000 gallons of E-15 plus gasoline between July 1, 2011, and April 30, 2012. The taxpayer sold 9,000 gallons of E-15 plus gasoline between May 1, 2012, and April 30, 2013. The taxpayer is entitled to claim an E-15 plus gasoline promotion tax credit of $120 (4,000 gallons times 3 cents) for the fiscal year ending April 30, 2012. In lieu of claiming the credit on the return for the period ending April 30, 2012, the taxpayer can claim the E-15 plus gasoline promotion tax credit on the tax return for the period ending April 30, 2013, for all E-15 plus gasoline gallons sold for the period from July 1, 2011, through April 30, 2013.

EXAMPLE 3: A taxpayer who is a retail dealer of gasoline has a fiscal year ending February 28, 2018. The taxpayer sold 20,000 gallons of E-15 plus gasoline for the period from March 1, 2017, through February 28, 2018, of which 16,000 gallons were sold between March 1, 2017, and December 31, 2017. The taxpayer is entitled to claim an E-15 plus gasoline promotion tax credit of $320 (16,000 gallons times 2 cents) on the taxpayer's Iowa income tax return for the period ending February 28, 2018.

42.46(2) *Allocation of credit to owners of a business entity.* If a taxpayer claiming the E-15 plus gasoline promotion tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement 2011 Iowa Acts, Senate File 531, section 35, as amended by 2011 Iowa Acts, Senate File 533, sections 63 to 65.

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◊ Two or more ARCs

CHAPTER 43
ASSESSMENTS AND REFUNDS
[Prior to 12/17/86, Revenue Department[730]]

701—43.1(422) Notice of discrepancies.

43.1(1) *Notice of adjustments.* A department employee designated by the director to examine returns and make audits who discovers discrepancies in returns or learns that the income of the taxpayer may not have been listed, in whole or in part, or that no return was filed when one was due is authorized to notify the taxpayer of this discovery by ordinary mail. The notice shall not be termed an assessment, and it may inform the taxpayer what amount would be due if the information discovered is correct.

43.1(2) *Right of taxpayer upon receipt of notice of adjustment.* A taxpayer who has received notice of an adjustment in connection with a return may pay the additional amount stated to be due. If payment is made, and the taxpayer wishes to contest the matter, the taxpayer should then file a claim for refund. However, payment will not be required until assessment has been made (although interest will continue to accrue if payment is not made). If no payment is made, the taxpayer may discuss with the agent, auditor, clerk or employee who notified the taxpayer of the discrepancy, either in person or through correspondence, all matters of fact and law which the taxpayer considers relevant to the situation. Documents and records supporting the taxpayer's position may be required.

43.1(3) Rescinded, effective 7/24/85.

This rule is intended to implement Iowa Code sections 422.25 and 422.30.

701—43.2(422) Notice of assessment, supplemental assessments and refund adjustments. If after following the procedure outlined in 43.1(2) no agreement is reached, and the taxpayer does not pay the amount determined to be correct, a notice of assessment shall be sent to the taxpayer by mail. If the period in which the correct amount of tax can be determined is nearly at an end, either a notice of assessment without compliance with 43.1(2) or a jeopardy assessment may be issued. All notices of assessment shall bear the signature of the director.

The department may, at any time within the period prescribed for assessment or refund adjustment, make a supplemental assessment or refund adjustment whenever it is ascertained that any assessment or refund adjustment is imperfect or incomplete in any respect.

If an assessment or refund adjustment is appealed (protested under rule 701—7.41(17A)) and is resolved whether by informal proceedings or by adjudication, the department and the taxpayer are precluded from making a supplemental assessment or refund adjustment concerning the same issue involved in the appeal for the same tax period unless there is a showing of mathematical or clerical error or a showing of fraud or misrepresentation. Nothing in this rule shall prevent the making of an assessment or refund adjustment for the purpose of taking into account the impact upon Iowa net income of federal audit adjustments.

This rule is intended to implement Iowa Code sections 422.25 and 422.30.

701—43.3(422) Overpayments of tax. The following are provisions for refunding or crediting to the taxpayer's deposits or payments for tax in excess of amounts legally due.

43.3(1) *Claims for refund.* A claim for refund is a formal request made by the taxpayer or the taxpayer's personal representative to the department of revenue for repayment of state income tax that was paid with the taxpayer's previously filed individual income tax return. In order for a claim for refund to be considered to be a valid document, the taxpayer or the taxpayer's personal representative must file the claim on an IA 1040X Amended Return Form or on an IA 1040 Income Tax Return Form for the appropriate tax year, with the notation "Amended for Refund" clearly shown on the face of the return form. The taxpayer or the taxpayer's personal representative must file the claim for refund with the department under separate cover so the claim is not filed with another tax return or with other documents or forms submitted to the department.

In addition, the claim for refund must be filed within one of the time periods specified in Iowa Code section 422.73(2) in order for the refund claim to be timely so that the claim may be considered on its merits by the department.

If the department determines that the taxpayer's claim is without merit and the claim for refund should be rejected, the department will notify the taxpayer or the taxpayer's personal representative by mail that the claim for refund has been rejected and of the reason for rejection. In addition, the rejection letter will advise the taxpayer that the taxpayer has 60 days from the date of the letter to file a protest of the department's rejection of the claim for refund. The taxpayer's appeal of the rejection of the claim for refund must be filed in accordance with rule 701—7.41(17A).

43.3(2) *Offsetting refunds.* A taxpayer shall not offset a refund or overpayment of tax for one year as a prior payment of tax of a subsequent year on the return of a subsequent year without authorization in writing by the department. The department, may, however, apply an overpayment, or a refund otherwise due the taxpayer, to any tax due or to become due from the taxpayer.

43.3(3) *Setoffs of qualifying debts administered by the department of administrative services.* Before any refund or rebate from a taxpayer's individual income tax return is considered for purposes of setoff, the refund or rebate must be applied first to any outstanding tax liability of that taxpayer with the department of revenue. After all outstanding tax liabilities are satisfied, any remaining balance of refund or rebate will be set off against any debt of the taxpayer, setoff of which is overseen by the department of administrative services pursuant to 2003 Iowa Acts, House File 534, section 86.

43.3(4) *College loan setoff.* Rescinded IAB 11/12/03, effective 12/17/03.

43.3(5) *District court debts setoff.* Rescinded IAB 11/12/03, effective 12/17/03.

43.3(6) *Overpayment credited to estimated tax.* Any remaining balance of overpayment, at the election of the taxpayer, will be refunded to the taxpayer or credited as a first payment of the taxpayer's estimated tax for the following year. However, a taxpayer may elect to credit an overpayment from a return to the estimated tax for the following tax year only in cases when the return is filed in the same calendar year that the return is due. For example, a taxpayer's 1994 return is due on April 30, 1995. If the taxpayer files that return on or before December 31, 1995, the taxpayer can elect to credit an overpayment on that return to estimated tax for 1995, and this election will be honored by the department. See also rule 701—49.7(422).

If an overpayment of income tax is shown as a credit to estimated tax for the succeeding taxable year, the amount shall be considered as a payment of the income tax for the succeeding taxable year and no claim for credit or refund of the overpayment shall be allowed on the return where the overpayment arose.

When a taxpayer elects to have an overpayment credited to estimated tax for the succeeding year, interest may properly be assessed on a deficiency of income tax for the year in which the overpayment arose. If a taxpayer elects to have all or part of an overpayment shown on the return applied to the estimated income tax for the succeeding taxable year, the election is binding to the taxpayer.

An overpayment of tax may be used to offset any outstanding tax liability owed by the taxpayer, but once an elected amount is credited as a payment of estimated tax for the succeeding year, it loses its character as an overpayment for the year in which it arose and thereafter cannot offset any subsequently determined tax liability.

43.3(7) *Refunds—statute of limitations for years ending before January 1, 1979.* Rescinded IAB 10/12/94, effective 11/16/94.

43.3(8) *Refunds—statute of limitations for tax years ending on or after January 1, 1979.* The statute of limitations with respect to which refunds or credit may be claimed are:

a. The later of

(1) Three years after due date of payment upon which refund or credit is claimed; or

(2) One year after which such payment was actually made.

b. Six months from the date of final disposition of any federal income tax matter with respect to the particular tax year. The taxpayer, however, must have notified the department of the matter within six months after the specified three-year period, contained in paragraph *"a,"* subparagraph (1), above. The term "matter" includes, but is not limited to, the execution of waivers and commencement of audits.

The refund is limited to those matters between the taxpayer and the Internal Revenue Service which affect Iowa taxable income. *Kelly-Springfield Tire Co. v. Iowa State Board of Tax Review*, 414 N.W.2d 113 (Iowa 1987).

c. For federal audits finalized on or after July 1, 1991, the taxpayer must claim a refund or credit within six months of final disposition of any federal income tax matter with respect to the particular tax year regardless when the tax year ended. It is not necessary for the taxpayer to have previously notified the department within the period of limitations specified in 43.3(8)*"a"*(1) above of a matter between the taxpayer and the Internal Revenue Service in order to receive a refund or credit. The term "matter" includes, but is not limited to, the execution of waivers and commencement of audits. The refund or credit is limited to those matters between the taxpayer and the Internal Revenue Service which affect Iowa taxable income. *Kelly-Springfield Tire Co. v. Iowa State Board of Tax Review*, 414 N.W. 2d 113 (Iowa 1987).

d. Three years after the date of the return for the year in which a net operating loss or capital loss occurs, which if carried back results in a reduction of tax in a prior period and an overpayment results.

43.3(9) *Refunds—statute of limitations for individuals who died as a result of hostile action.* Rescinded IAB 10/12/94, effective 11/16/94.

43.3(10) *Refunds—statute of limitations for MIAs and spouses of MIAs.* Rescinded IAB 10/12/94, effective 11/16/94.

43.3(11) *Refunds—statute of limitations for insolvent farmers who received capital gains from farmland sold in 1982 and 1983.* Rescinded IAB 10/12/94, effective 11/16/94.

43.3(12) *Refunds—statute of limitations for individuals with certain charitable contributions.* Rescinded IAB 10/12/94, effective 11/16/94.

43.3(13) *Refunds—statute of limitations for taxpayers who paid state income tax on 1988 returns on certain supplemental assistance payments.* Rescinded IAB 11/24/04, effective 12/29/04.

43.3(14) *Refunds—statute of limitations for taxpayers who paid state income tax on returns for tax years where federal income tax was refunded due to a provision of the Taxpayer Relief Act of 1997.* Notwithstanding the three-year statute of limitations in Iowa Code section 422.73, claims for refund filed with the department on or before June 30, 1999, will be considered timely if the taxpayer's federal income tax was refunded due to a provision in the Taxpayer Relief Act of 1997 which affected the federal adjusted gross income of an individual or an estate or a trust. This particular provision may affect Iowa returns for a tax year beginning on or after January 1, 1977, to the extent the federal adjusted gross incomes on federal returns for the tax year were affected by the Taxpayer Relief Act of 1997.

43.3(15) *Refunds—statute of limitations for taxpayers who paid 90 percent of the tax by the due date and filed the original return in the six-month extended period.* If a taxpayer has paid 90 percent of the income tax required to be shown due by the original due date of the return and has filed the original income tax return sometime in the six-month extended period after the original due date, the taxpayer may file an amended return by October 31 of the third year following the year the original return was due and shall be within the statute of limitations for refund. This position is supported by the Iowa Supreme Court in *Conoco, Inc. v. Iowa Department of Revenue and Finance*, 477 N.W.2d 377 (Iowa 1991). See also 701—subrule 39.2(4) which pertains to the extended period for filing the Iowa income tax return when 90 percent of the tax is paid by the original due date of the Iowa income tax return.

EXAMPLE 1. Joe Barnes had paid at least 90 percent of the tax shown due on his 1999 Iowa income tax return by the April 30 original due date and filed his original 1999 Iowa return on May 15, 2000. Mr. Barnes determined that he had failed to claim several deductions on the original 1999 Iowa return, so he filed an amended 1999 return on October 31, 2003. The amended return was filed within the three-year statute of limitations for refund since it was filed within three years of the extended due date of the return, October 31, 2000. The six-month extended due date applied in this case because the original return was filed within the six-month extended period.

EXAMPLE 2. Fred Jones paid 90 percent of the tax shown due on his 1999 return by the April 30 original due date and filed the original return on or before the April 30, 2000, original due date for this return. Mr. Jones determined that when he filed the original 1999 Iowa return, he failed to claim the Iowa income tax withheld from a part-time job he held in 1999. Mr. Jones filed an amended 1999 Iowa

return on May 15, 2003, to claim the Iowa tax withheld that he had failed to claim on the original return. This amended return was rejected by the department because it was not filed within three years of the due date of the return. Although Mr. Jones had paid 90 percent of the tax by the due date, the due date was not extended because the original return had been filed by the due date of April 30, 2000.

This rule is intended to implement Iowa Code section 421.17 as amended by 2003 Iowa Acts, House File 534, and sections 422.2, 422.16, and 422.73.

701—43.4(68A,422,456A) Optional designations of funds by taxpayer.

43.4(1) *Iowa fish and game protection fund.* The taxpayer may designate an amount to be donated to the Iowa fish and game protection fund. The donation must be $1 or more, and the designation must be made on the original return for the current year. The donation is allowed only after obligations of the taxpayer to the department of revenue, the child support recovery unit of the department of human services, the foster care recovery unit of the department of human services, the college student aid commission, the office of investigations of the department of human services, the district courts, other state agencies, and the Iowa election campaign checkoff have been satisfied. The designation to the fund is irrevocable and cannot be made on an amended return. If the amount of refund claimed on the original return or the payment remitted with the return is adjusted by the department, the amount of the designation to the fund may be adjusted accordingly.

EXAMPLE A: Overpayment as shown on the original return is $50. $25 is designated to the fund. Due to an error on the return, only $20 is an overpayment. The taxpayer would not receive any refund and all $20 of the overpayment would be credited to the fund.

EXAMPLE B: Overpayment as shown on the original return is $50. $25 is designated to the fund. Due to an error on the return, no overpayment occurred, but instead the taxpayer owes $20. No money would be credited to the fund in this instance.

EXAMPLE C: Amount shown due on return is $30. $20 is designated to the fund. A $50 payment was made with the return. Due to an error on the return, the taxpayer owes $40. Only $10 would be credited to the fund in this situation.

43.4(2) *Iowa election campaign fund.* A person with a tax liability of $1.50 or more on the Iowa individual income tax return may direct or designate that a $1.50 contribution be made to a specific political party or that the contribution be made to the Iowa election campaign fund to be shared by all political parties as clarified further in this paragraph. In the case of married taxpayers filing a joint Iowa individual return with a tax liability of $3.00 or more, each spouse may direct or designate that a $1.50 contribution be made to a specific political party or that a $1.50 contribution be made to the Iowa election campaign fund as a contribution to be shared by all political parties. The designation or direction of a contribution to a political party or to the election campaign fund is irrevocable and cannot be changed on an amended return. The designation to a political party or the election campaign fund is allowed only after obligations of the taxpayer to the department of revenue, the child support recovery unit of the department of human services, the foster care recovery unit of the department of human services, the college student aid commission, the office of investigations of the department of human services, the district courts and other state agencies are satisfied. Note that for purposes of this subrule, "political party" means a party as defined in Iowa Code section 43.2.

In a tax year when there are two political parties for purposes of the Iowa election campaign fund, all undesignated contributions to the fund made on individual income tax returns for that tax year are to be divided equally between the two parties. In a tax year where there are more than two political parties for purposes of the Iowa election campaign fund, all undesignated contributions to the fund made on income tax returns for that tax year are to be divided among the political parties on the basis of the number of registered voters for a particular political party on December 31 of that tax year to the total number of registered voters on December 31 of that tax year that have declared an affiliation with any of the recognized political parties.

Thus, if there were 400,000 registered voters for "x" political party, 500,000 registered voters for "y" political party, and 100,000 registered voters for "z" political party on December 31 of a tax year where there were three recognized political parties, 40 percent of the undesignated political contributions

on 1997 returns would be paid to "x" political party since 40 percent of the registered voters with an affiliation to a political party on December 31 had an affiliation with party "x" on that day.

43.4(3) *Domestic abuse services checkoff.* Rescinded IAB 11/30/11, effective 1/4/12.

43.4(4) *State fair foundation fund checkoff.* For tax years beginning on or after January 1, 1993, a taxpayer filing a state individual income tax return can designate a checkoff of $1 or more to the foundation fund of the Iowa state fair foundation. If the overpayment on the return or the payment made with the filing of the return is not sufficient to cover the amount designated to the foundation fund checkoff, the amount credited to the foundation fund checkoff will be reduced accordingly. The designation to the foundation fund checkoff is irrevocable.

A designation to the foundation fund checkoff may be allowed only after obligations of the taxpayer to the department of revenue, the child support recovery unit of the department of human services, the foster care recovery unit of the department of human services, the college student aid commission, the office of investigations of the department of human services, the district courts, other state agencies, the Iowa election campaign checkoff, and the Iowa fish and game protection fund checkoff are satisfied.

On or before January 31 of the year following the year in which returns with the foundation fund checkoff are due, the department of revenue shall transfer the total amount designated to the foundation fund.

43.4(5) *Limitation of checkoffs on the individual income tax return.* For tax years beginning on or after January 1, 1995, but before January 1, 2004, no more than three checkoffs are allowed on the individual income tax return. The election campaign fund checkoff is not considered for purposes of limiting the number of checkoffs on the income tax return. When the same three checkoffs have been provided on the income tax return for three consecutive years, the checkoff for which the least amount has been contributed in the aggregate for the first two years and through March 15 of the third tax year will be repealed.

For example, the 1999 Iowa individual income tax return due in 2000 includes checkoffs A, B and C which also were shown on the Iowa returns for 1997, 1998 and 1999. Through March 15, 2000, $90,000 was contributed on the 1997, 1998 and 1999 returns for checkoff A, $60,000 was contributed for checkoff B and $120,000 for checkoff C. Since the least amount contributed in the aggregate was for checkoff B, that checkoff is repealed and will not appear on the 2000 Iowa income tax return to be filed in 2001.

For tax years beginning on or after January 1, 2004, no more than four checkoffs are allowed on the individual income tax return. The election campaign fund checkoff is not considered for purposes of limiting the number of checkoffs on the income tax return. When the same four checkoffs have been provided on the income tax return for two consecutive years, the two checkoffs for which the least amount has been contributed in the aggregate for the first year and through March 15 of the second tax year will be repealed.

If more checkoffs are enacted in the same session of the general assembly than there is space for inclusion on the individual income tax return form, the earliest enacted checkoffs for which there is space will be included on the income tax return form, and all other checkoffs enacted during that session of the general assembly are repealed. If the same session of the general assembly enacts more checkoffs on the same day than there is space for inclusion on the individual income tax form, the director of revenue shall determine which checkoffs shall be included on the individual income tax form.

43.4(6) *Keep Iowa beautiful fund checkoff.* For tax years beginning on or after January 1, 2001, but before January 1, 2006, a taxpayer filing an individual income tax return can designate a checkoff of $1 or more to the keep Iowa beautiful fund. If the refund due on the return or the payment remitted with the return is insufficient to pay the additional amount designated by the taxpayer to the keep Iowa beautiful fund, the amount credited to the keep Iowa beautiful fund will be reduced accordingly. Once the taxpayer has designated a contribution to the keep Iowa beautiful fund on an individual income tax return filed with the department of revenue, the taxpayer cannot amend the designation.

A designation to the keep Iowa beautiful checkoff may be allowed only after obligations of the taxpayer to the department of revenue, the child support recovery unit of the department of human services, the foster care recovery unit of the department of human services, the college student aid

commission, the office of investigations of the department of human services, the district courts, other state agencies, the Iowa election campaign checkoff, the Iowa fish and game protection fund checkoff and the state fair foundation checkoff are satisfied.

On or before January 31 of the year following the year in which Iowa income tax returns with contributions to the keep Iowa beautiful fund are due, the department of revenue shall transfer the total amount designated to the keep Iowa beautiful fund.

43.4(7) *Volunteer fire fighter preparedness fund checkoff.* For tax years beginning on or after January 1, 2004, but before January 1, 2006, a taxpayer filing an individual income tax return can designate a checkoff of $1 or more to the volunteer fire fighter preparedness fund. If the refund due on the return or the payment remitted with the return is insufficient to pay the additional amount designated by the taxpayer to the volunteer fire fighter preparedness fund, the amount credited to the volunteer fire fighter preparedness fund will be reduced accordingly. Once the taxpayer has designated a contribution to the volunteer fire fighter preparedness fund on an individual income tax return filed with the department of revenue, the taxpayer cannot amend that designation.

A designation to the volunteer fire fighter preparedness fund checkoff may be allowed only after obligations of the taxpayer to the department of revenue, the child support recovery unit of the department of human services, the foster care recovery unit of the department of human services, the college student aid commission, the office of investigations of the department of human services, the district courts, other state agencies, the Iowa election campaign checkoff, the Iowa fish and game protection fund checkoff, the state fair foundation checkoff and the keep Iowa beautiful fund checkoff are satisfied.

On or before January 31 of the year following the year in which Iowa income tax returns with contributions to the volunteer fire fighter preparedness fund are due, the department of revenue is to certify to the state treasurer the amount designated to the volunteer fire fighter preparedness fund on those returns.

43.4(8) *Veterans trust fund checkoff.* For tax years beginning on or after January 1, 2006, but before January 1, 2008, a taxpayer filing an individual income tax return can designate a checkoff of $1 or more to the veterans trust fund. If the refund due on the return or the payment remitted with the return is insufficient to pay the additional amount designated by the taxpayer to the veterans trust fund, the amount credited to the veterans trust fund will be reduced accordingly. Once the taxpayer has designated a contribution to the veterans trust fund on an individual income tax return filed with the department of revenue, the taxpayer cannot amend that designation.

A designation to the veterans trust fund checkoff may be allowed only after obligations of the taxpayer to the department of revenue, the child support recovery unit of the department of human services, the foster care recovery unit of the department of human services, the college student aid commission, the office of investigations of the department of human services, the district courts, other state agencies, the Iowa election campaign checkoff, the Iowa fish and game protection fund checkoff and the state fair foundation checkoff are satisfied.

On or before January 31 of the year following the year in which Iowa income tax returns with contributions to the veterans trust fund are due, the department of revenue shall transfer the total amount designated to the veterans trust fund.

43.4(9) *Joint keep Iowa beautiful fund and volunteer fire fighter preparedness fund checkoff.* For tax years beginning on or after January 1, 2006, but before January 1, 2008, a taxpayer filing an individual income tax return can designate a checkoff of $1 or more to the joint keep Iowa beautiful fund and volunteer fire fighter preparedness fund. If the refund due on the return or the payment remitted with the return is insufficient to pay the additional amount designated by the taxpayer to the joint keep Iowa beautiful fund and volunteer fire fighter preparedness fund, the amount credited to the joint keep Iowa beautiful fund and volunteer fire fighter preparedness fund will be reduced accordingly. Once the taxpayer has designated a contribution to the joint keep Iowa beautiful fund and volunteer fire fighter preparedness fund on an individual income tax return filed with the department of revenue, the taxpayer cannot amend that designation.

A designation to the joint keep Iowa beautiful fund and volunteer fire fighter preparedness fund checkoff may be allowed only after obligations of the taxpayer to the department of revenue, the child

support recovery unit of the department of human services, the foster care recovery unit of the department of human services, the college student aid commission, the office of investigations of the department of human services, the district courts, other state agencies, the Iowa election campaign checkoff, the Iowa fish and game protection fund checkoff, the state fair foundation checkoff and the veterans trust fund checkoff are satisfied.

On or before January 31 of the year following the year in which Iowa income tax returns with contributions to the joint keep Iowa beautiful fund and volunteer fire fighter preparedness fund are due, the department of revenue shall transfer one-half of the total amount designated to the keep Iowa beautiful fund, and the remaining one-half will be transferred to the volunteer fire fighter preparedness fund.

43.4(10) *Child abuse prevention program fund checkoff.* For tax years beginning on or after January 1, 2008, a taxpayer filing an individual income tax return can designate a checkoff of $1 or more to the child abuse prevention program fund. If the refund due on the return or the payment remitted with the return is insufficient to pay the additional amount designated by the taxpayer to the child abuse prevention program fund, the amount credited to the child abuse prevention program fund will be reduced accordingly. Once the taxpayer has designated a contribution to the child abuse prevention program fund on an individual income tax return filed with the department of revenue, the taxpayer cannot amend that designation.

A designation to the child abuse prevention program fund checkoff may be allowed only after obligations of the taxpayer to the department of revenue, the child support recovery unit of the department of human services, the foster care recovery unit of the department of human services, the college student aid commission, the office of investigations of the department of human services, the district courts, other state agencies, the Iowa election campaign checkoff, the Iowa fish and game protection fund checkoff and the state fair foundation fund checkoff are satisfied.

On or before January 31 of the year following the year in which Iowa income tax returns with contributions to the child abuse prevention program fund are due, the department of revenue shall transfer the total amount designated to the child abuse prevention program fund.

43.4(11) *Joint veterans trust fund and volunteer fire fighter preparedness fund checkoff.* For tax years beginning on or after January 1, 2008, a taxpayer filing an individual income tax return can designate a checkoff of $1 or more to the joint veterans trust fund and volunteer fire fighter preparedness fund. If the refund due on the return or the payment remitted with the return is insufficient to pay the additional amount designated by the taxpayer to the joint veterans trust fund and volunteer fire fighter preparedness fund, the amount credited to the joint veterans trust fund and volunteer fire fighter preparedness fund will be reduced accordingly. Once the taxpayer has designated a contribution to the joint veterans trust fund and volunteer fire fighter preparedness fund on an individual income tax return filed with the department of revenue, the taxpayer cannot amend that designation.

A designation to the joint veterans trust fund and volunteer fire fighter preparedness fund checkoff may be allowed only after obligations of the taxpayer to the department of revenue, the child support recovery unit of the department of human services, the foster care recovery unit of the department of human services, the college student aid commission, the office of investigations of the department of human services, the district courts, other state agencies, the Iowa election campaign checkoff, the Iowa fish and game protection fund checkoff, the state fair foundation fund checkoff and the child abuse prevention program fund checkoff are satisfied.

On or before January 31 of the year following the year in which Iowa income tax returns with contributions to the joint veterans trust fund and volunteer fire fighter preparedness fund are due, the department of revenue shall transfer one-half of the total amount designated to the veterans trust fund, and the remaining one-half will be transferred to the volunteer fire fighter preparedness fund.

This rule is intended to implement Iowa Code sections 422.12D, 422.12E, and 422.12H and 2010 Iowa Acts, House File 2531, division XII.

[**ARC 9103B**, IAB 9/22/10, effective 10/27/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—43.5(422) Abatement of tax. For notices of assessment issued on or after January 1, 1995, if the statutory period for appeal has expired, the director may abate any portion of unpaid tax, penalties or

interest which the director determines to be erroneous, illegal, or excessive. See rule 701—7.31(421) for procedures on requesting abatement of tax.

This rule is intended to implement Iowa Code section 421.60.

701—43.6(422) 1978 Income tax rebate. Rescinded IAB 11/24/04, effective 12/29/04.

701—43.7(422) Special refund for taxpayers with net long-term capital gains in the tax year. Rescinded IAB 11/24/04, effective 12/29/04.

701—43.8(422) Livestock production credit refunds for corporate taxpayers and individual taxpayers. For tax years beginning on or after January 1, 1996, corporate and individual taxpayers who own certain livestock, who have livestock production operations in Iowa in the tax year, and who meet certain qualifications are eligible for a livestock production credit refund. The amount of a livestock production credit refund is determined by adding together for each head of livestock in the taxpayer's operation the product of 10 cents for each corn equivalent deemed to have been consumed by that animal in the taxpayer's operation in the tax year. For tax years beginning on or after January 1, 1998, only qualified taxpayers that have cow-calf livestock operations described in paragraph *"o"* of subrule 43.8(2) will be eligible for the livestock production refunds, notwithstanding the other types of livestock operations mentioned in this rule. Note that the livestock production credit refund is also available to taxpayers who meet the qualifications described in subrule 43.8(1) and operate certain types of poultry operations in this state and own the poultry in the operations. The amounts of the livestock production credit refunds for these taxpayers are determined on the basis of 10 cents for each corn equivalent deemed to have been consumed by the chickens or the turkeys in the taxpayers' poultry operations in the tax year. However, the amount of livestock production credit refund may not exceed $3,000 per livestock or poultry operation for a tax year. In addition, the amount of livestock production credit refund per taxpayer for a tax year may not exceed $3,000. Therefore, if a particular taxpayer is involved in a cow-calf beef operation, a sheep-ewe flock operation, and a farrow-to-finish hog operation, the maximum livestock production credit refund for this taxpayer may not exceed $3,000.

General references in this rule to livestock, livestock production, and livestock production operations also apply to poultry, poultry production, and poultry production operations.

In the case of married taxpayers, each of the spouses may be eligible for a livestock production refund of up to $3,000 if each of the spouses was involved in a livestock production operation independently from the other spouse and independently from other taxpayers in the tax year. If both spouses are involved in the same livestock operation, the maximum refund from that operation is $3,000 which may be allocated between the individuals in the ratio of each spouse's ownership interest in the operation. If a livestock production operation is conducted by a partnership, limited liability company, subchapter S corporation, estate, or a trust, the livestock production credit refund from the entity is to be allocated to the owners of the entity in the same ratio as earnings are allocated to the owners. In situations where a livestock production operation is conducted partly within and partly without Iowa, only the livestock production activity in Iowa during the tax year will be considered for purposes of the livestock credit refund. The livestock production refund amounts for these taxpayers is to be allocated on the basis of sales of Iowa livestock which qualify taxpayers for the livestock production refund to total sales of livestock which qualify taxpayers for the refund. However, the refunds from any operations may not exceed $3,000. The following subrules outline how the livestock production credit refund program is to be administered by the department of revenue:

43.8(1) *Qualifications for the livestock production credit refunds.* For tax years beginning on or after January 1, 1997, individual and corporate taxpayers will be eligible for the livestock production credit refund if the taxpayer's federal taxable income is $99,600 or less. In the case of married taxpayers, their combined federal taxable income must be considered to determine if they are eligible for the credit.

For each tax year beginning after 1997, the federal taxable income specified previously in this subrule shall be multiplied by the cumulative index factor for that tax year to calculate the federal taxable income that will be used to determine whether a taxpayer is eligible for the livestock production refund that is

authorized for that tax year. "Cumulative index factor" means the product of the annual index factor for the 1997 calendar year and all annual index factors for subsequent calendar years. The annual index factor equals the annual inflation factor for that calendar year as computed in Iowa Code section 422.4 for purposes of indexation of the tax rates for individual income tax.

43.8(2) *Definitions related to the livestock production credit refunds.* The following definitions explain livestock and poultry for purposes of this rule. The definitions also describe the various types of livestock operations of taxpayers which may qualify the taxpayers for the livestock production credit refunds and specify how the refunds are to be computed for the various types of livestock operations:

a. For the purposes of this rule, the term "livestock" means domestic bovine animals which will be referred to as bulls, heifers, cattle, calves, or cows in this rule, domestic ovine animals which will be referred to as sheep, lambs, rams, or ewes, or domestic swine which will be referred to as hogs or pigs. That is, for purposes of this rule, "livestock" includes only those farm animals which may qualify their owners for the livestock production credit refund. "Livestock" does not include horses, goats, donkeys, mules, oxen, furbearing mammals, other mammals, or other classes of animals, although some of these animals or species may be considered to be "livestock" in other contexts or situations.

b. For purposes of this rule the term "poultry" means only domestic chickens and domestic turkeys as only these types of birds may qualify their owners for the livestock production credit refunds. "Poultry" does not include ducks, geese, wild turkeys, emus, ostriches, or other fowl or birds, although some of these species may be considered to be poultry in other contexts or situations.

c. For purposes of this rule, the term "farrow-to-finish" hog operations comprises those hog production operations where the majority of the hogs sold from the operation are from animals farrowed and raised in the operation which are sold at a prime market weight of 200 pounds or more.

In order to compute the livestock production credit refund amounts for the "farrow-to-finish" hog production operations, the corn equivalent factor of 13 per animal sold, or $1.30, is multiplied by the number of hogs sold at prime market weight in the tax year which were farrowed and raised in the operation. No corn equivalent credits are given for hogs sold at the prime market weight which have been in the operation less than three months on the date of sale. In the "farrow-to-finish" operations, hogs sold at a weight that is less than the prime market weight also are considered for purposes of computing the livestock production credit refund for the operation, but only at the corn equivalent factor of 2.6 or $.26 per pig sold.

In "farrow-to-finish" hog operations, if any pigs are purchased at the feeder pig weight of less than 60 pounds and are sold at prime market weight (200 pounds or more), see paragraph *"e"* in this subrule for the corn equivalent factor which applies to these transactions.

d. For purposes of this rule, the term "farrow-to-feeder-pig" hog operations includes those operations where essentially all the pigs farrowed in the operation are sold at an average weight of less than 60 pounds per pig, or at "feeder pig" weight.

The potential livestock production credit refunds for these operations are computed by multiplying the corn equivalent factor of 2.6 or $.26 times the number of pigs sold at the "feeder pig" weight from these operations in the tax year. However, the corn equivalent factor of 13 or $1.30 per animal sold can be used for hogs sold at the prime market weight (200 pounds or more) from these operations for those animals where there is documentation that the hogs were born and raised in the operation or that the hogs were in the operation for a minimum of three months at the time the hogs were sold.

e. The term "finishing feeder pigs" hog operations comprises those operations where the majority of the hogs in this operation are purchased when these animals weighed less than 60 pounds or at the "feeder pig" weight and the animals are sold at the time the animals are at the prime market weight of 200 pounds or more per hog. The potential livestock production credit refunds for these operations are computed by multiplying the corn equivalent factor of 10.4 or $1.04 times the number of animals sold in the year at the prime market weight. However, only those animals that were in the operation for a minimum of three months at the time the hogs were sold at prime market weight can be considered for purposes of the livestock production credit refund. Corn equivalent factor credits of 2.6 or $.26 are given for animals which are purchased at the "feeder pig" weight of less than 60 pounds and were in the

operation for a minimum of three months when the hogs were sold at a weight which is less than the prime market weight of 200 pounds or more per hog.

f. For purposes of this rule, the term "layer poultry operations" includes operations where the eggs produced by the chickens in the operation are sold for human consumption. The livestock production credit refunds for these operations are computed on the basis of the average number of chickens in the operation in the tax year multiplied by the corn equivalent factor of .88 or $.088. The average number of chickens in the operation in the tax year is the aggregate of the number of chickens in the operation on the first day in the tax year that the operation was in production and the number of chickens in the operation on the last day of the tax year in which the operation was in production divided by 2.

However, in a situation where the operation was started or was shut down sometime during the tax year, the livestock refund amount otherwise computed must be reduced by 8.33 percent for each month in the tax year in which the operation was not in production. Thus, in the case where the computed livestock refund amount was $2,000 and the operation was in production for only nine months of the tax year, the adjusted refund amount would be $1,500 ($2,000 x .0833 x (3) = $500). ($2,000 - 500 = $1,500)

g. For purposes of this rule, the term "turkey production operations" means operations involved in raising domestic turkeys for sale for human consumption and where the turkeys are sold at a prime market weight. The prime market weight for male or tom turkeys is between 30 and 35 pounds. The prime market weight for hen turkeys is between 22 and 25 pounds. The livestock production credit refund for this type of operation is computed by multiplying the number of turkeys sold in the tax year at the prime market weight times the corn equivalent factor of 1.5 or $.15. However, only those turkeys that were in the operation for a minimum of three months on the date the turkeys were sold may be considered for purposes of computing the livestock production credit for the turkey operation.

h. For purposes of this rule, the term "broiler poultry operations" means poultry production operations whereby the chickens raised in the operations are sold for human consumption at a prime market weight or broiler weight between 3 pounds and 6 pounds depending on the breed or breeds of chickens. The livestock production credit refund for this type of operation is computed by multiplying the number of chickens sold in the tax year at broiler weight by the corn equivalent factor of .15 or $.015. However, only chickens that are in the broiler operation for a minimum of six weeks before the chickens are sold at broiler weight may be considered for purposes of computing the livestock production credit for these operations.

i. Rescinded IAB 5/6/09, effective 6/10/09.

j. For purposes of this rule, "stocker cattle operations" are beef cattle operations where essentially all cattle in the operations are purchased as calves, raised in the operation at least two months, and the cattle are sold in a range from 700 to 900 pounds per head which is deemed to be the "stocker weight." Cattle in the operation that were sold at a weight of less than 700 pounds may not be counted for purposes of computing the livestock production credit refund for the operation. The livestock production credit refunds for these operations is computed on the basis of the number of cattle sold in the year at the stocker weight times the corn equivalent factor of 41.5 or $4.15 per head. Cattle sold in the tax year must be reported on a first-in, first-out basis unless records of the taxpayer can support a different order of sale of the animals. If this operation includes calves that were raised on the farm where they were born, these calves qualify for the corn equivalent factor of 41.5 or $4.15 per head if the calves were unsold at the end of the tax year and the calves were in the operation for a minimum of two months after the calves were weaned.

k. For purposes of this rule, "beef feedlot operations" include those beef cattle operations whereby the cattle are purchased as calves approximately 60 days from the time the calves were weaned or at a "stocker weight" and are sold at a feedlot weight of 900 pounds or more after a three-month period when the animals were on a high concentrate diet. Note that any animals which are purchased for the operation and are maintained in the herd for less than four months at the time of sale do not qualify the taxpayer for the livestock production credit refund of $7.50 per head of cattle sold. The livestock production credit refund for these operations is computed by multiplying the number of cattle sold in the year at the feedlot weight times the corn equivalent amount of 75 or $7.50 per animal. However, if any cattle in the

operation are sold at the "stocker" weight of at least 700 pounds but less than 900 pounds, these animals may be counted for the livestock production credit refund at a corn equivalent amount of 41.5 or $4.15 per head of cattle sold to the extent the cattle were in the operation for two months or more at the time of sale. If any cattle in the operation in the tax year were sold at a weight of less than 700 pounds, the sales of these cattle may not be counted for the livestock production credit refund. Cattle sold in the tax year must be reported on a first-in, first-out basis unless records of the taxpayer can support a different order of sale of the cattle.

l. For purposes of this rule, "dairy cattle operations" includes those cattle operations where the primary purpose of the operations is the production of milk and milk products for human consumption. The livestock production credit refund is computed by multiplying the aggregate of the number of milking cows in lactation on December 31 of the tax year and the number of cows bred to calve within 60 days of December 31 and the number of breeding bulls in inventory on December 31 times the corn equivalent number of 350 or $35 per cow. However, cattle that were purchased in the period between July 1 and December 31 of the calendar year may not be considered for purposes of computation of the livestock production credit for the dairy operation. In the case of a "dairy cattle operation" which started or ceased production in the tax year, the livestock production credit refund otherwise computed must be reduced by 8.33 percent for each month in the tax year in which the livestock operation was not in production. Heifers in the operation are not counted for purposes of the credit until the animals are bred to calve.

m. For purposes of this rule, "ewe flock sheep operations" are sheep operations whereby the majority of the sheep and lambs sold from the operation were born and raised in the operation. The livestock production credit refunds for these operations are computed by multiplying the number of ewes and rams in inventory on December 31 of the tax year times the corn equivalent factor of 20.5 or $2.05 per ewe or ram. Any ewes or rams purchased within three months before December 31 of the tax year may not be considered for purposes of computing the livestock production credit for the operation. In addition, lambs sold in the tax year from the operation may be counted for the production credit refund at 4.1 corn equivalents or $.41 for each lamb sold to the extent the lambs were in the operation for a minimum of three months prior to the date of sale.

n. For purposes of this rule, "sheep feedlot operations" are sheep production operations where lambs born and raised in the operation are sold after the lambs have been in the operation for a minimum of three months prior to the date of sale. The livestock production credit refunds are computed by multiplying the number of lambs sold in the tax year times the corn equivalent factor of 4.1 or $.41.

o. For the purposes of this rule and for tax years beginning on or after January 1, 1998, "cow-calf operations" means those livestock cattle production operations that include bred cows, bred heifers, and breeding bulls. The livestock production credit refunds for cow-calf operations are determined only on the number of bred cows, bred heifers, and breeding bulls in inventory of the operations on December 31 of the tax year times the corn equivalent factor of 111.5 or $11.15. However, only those bred cows, bred heifers, and breeding bulls in inventory on December 31 which were also in inventory on July 1 of the same calendar year may be counted for purposes of computing the livestock production refunds.

43.8(3) *Filing claims for the livestock production credit refunds.* Taxpayers who are eligible for the livestock production credit refunds must file refund requests on claim forms provided by the department that must be attached to their income tax returns for the tax year in which the livestock production occurred. The claim forms must be filed with the income tax returns within ten months after the end of the tax year of the return in order for the refund claims to be timely. Thus, in the case of a taxpayer filing a livestock production refund claim form with the 1996 Iowa income tax return for calendar year 1996, the claim forms must be filed by October 31, 1997, in order for the claims to be timely. Taxpayers may not request extensions for filing claims for the livestock production refunds.

The department will determine by February 28 of the year after the year in which the livestock production credit refund claims are to be filed if the total amount requested on the refund claims exceeds the amount appropriated for the refunds for that tax year. If a taxpayer's refund claim is not payable on February 28 because the taxpayer is a fiscal year filer, that taxpayer's claim will be considered to be a claim for the following tax year. However, in order for this claim to be considered to be a valid refund

claim for the following tax year, the refund claim must have been filed within ten months after the end of the fiscal year of the taxpayer. However, in the case of livestock production credit refund claims for fiscal year periods beginning in 1996 which are not received soon enough to be considered for the refunds to be issued in February 1998, only claims for cow-calf livestock production operations will be considered with the livestock production refund claims for the 1997 tax year.

If a taxpayer files a fraudulent claim for a livestock production credit refund for a tax year, the taxpayer will be considered to have forfeited any right or interest to a livestock production refund for any subsequent tax year after the year of the fraudulent claim.

43.8(4) *Records needed to establish livestock production credit refunds.* The burden is on the taxpayer to maintain those records and documents which support the livestock production credit refund that was claimed by the taxpayer. Necessary records and documents must include, but are not limited to, the ones mentioned in this subrule. Some of the necessary records are inventory schedules showing the number of livestock or poultry in the livestock operation on certain dates in the tax year. Sales of livestock or poultry in the tax year must be supported by scale tickets, packing house invoices, sales receipts, sales barn invoices, and similar documents. Dairy herd improvement association records and similar inventory forms can be used to establish the number of animals or the number of birds on hand in the operation on a certain day in the tax year. These documents are not to be submitted with the taxpayer's income tax return with the livestock production credit refund claim form. Instead, the documents are to be retained with other tax records for at least three years in case of possible audit by the department of revenue.

43.8(5) *Repeal of the livestock production credit refund.* The livestock production credit was repealed on November 1, 2008, for refund claims filed on or after that date. Any livestock production credit refunds requested on Iowa tax returns filed on or after November 1, 2008, will not be issued.

This rule is intended to implement Iowa Code sections 422.120, 422.121, and 422.122 as amended by 2009 Iowa Acts, Senate File 478, section 152.

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◊ Two or more ARCs

CHAPTER 52
FILING RETURNS, PAYMENT OF TAX, PENALTY AND INTEREST, AND TAX CREDITS

[Prior to 12/17/86, Revenue Department[730]]

701—52.1(422) Who must file. Every corporation, organized under the laws of Iowa or qualified to do business within this state or doing business within Iowa, regardless of net income, shall file a true and accurate return of its income or loss for the taxable period. The return shall be signed by the president or other duly authorized officer. If the corporation was inactive or not doing business within Iowa, although qualified to do so, during the taxable year, the return must contain a statement to that effect.

For tax years beginning on or after January 1, 1989, every corporation organized under the laws of Iowa, doing business within Iowa, or deriving income from sources consisting of real or tangible property located or having a situs within Iowa, shall file a true and accurate return of its income or loss for the taxable period. The return shall be signed by the president or other duly authorized officer.

For tax years beginning on or after January 1, 1995, every corporation organized under the laws of Iowa, doing business within Iowa, or deriving income from sources consisting of real, tangible, or intangible property located or having a situs within Iowa, shall file a true and accurate return of its income or loss for the taxable period. The return shall be signed by the president or other duly authorized officer. For tax years beginning on or after January 1, 1999, every corporation doing business within Iowa, or deriving income from sources consisting of real, tangible, or intangible property located or having a situs within Iowa, shall file a true and accurate return of its income or loss for the taxable period. The return shall be signed by the president or other duly authorized officer.

Political organizations described in Internal Revenue Code Section 527 which are domiciled in this state and are required to file federal Form 1120POL and pay federal corporation income tax are subject to Iowa corporation income tax to the same extent as they are subject to federal corporation income tax.

Homeowners associations described in Internal Revenue Code Section 528 which are domiciled in this state and are required to file federal Form 1120H and pay federal corporation income tax are subject to Iowa corporation income tax to the same extent as they are subject to federal corporation income tax.

52.1(1) *Definitions.*

a. Doing business. The term "doing business" is used in a comprehensive sense and includes all activities or any transactions for the purpose of financial or pecuniary gain or profit. Irrespective of the nature of its activities, every corporation organized for profit and carrying out any of the purposes of its organization shall be deemed to be "doing business." In determining whether a corporation is doing business, it is immaterial whether its activities actually result in a profit or loss.

b. Representative. A person may be considered a representative even though that person may not be considered an employee for other purposes such as withholding of income tax from commissions.

c. Tangible property having a situs within this state. The term "tangible property having a situs within this state" means that tangible property owned or used by a foreign corporation is habitually present in Iowa or it maintains a fixed and regular route through Iowa sufficient so that Iowa could constitutionally under the 14th Amendment and Commerce Clause of the United States Constitution impose an apportioned ad valorem tax on the property. *Central R. Co. v. Pennsylvania*, 370 U.S. 607, 82 S. Ct. 1297, 8 L.Ed.2d (1962); *New York Central & H. Railroad Co. v. Miller*, 202 U.S. 584, 26 S. Ct. 714, 50 L.Ed. 1155 (1906); *American Refrigerator Transit Company v. State Tax Commission*, 395 P.2d 127 (Or. 1964); *Upper Missouri River Corporation v. Board of Review*, Woodbury County, 210 N.W.2d 828.

d. Intangible property located or having a situs within Iowa. Intangible property does not have a situs in the physical sense in any particular place. *Wheeling Steel Corporation v. Fox*, 298 U.S. 193, 80 L.Ed. 1143, 56 S.Ct. 773 (1936); *McNamara v. George Engine Company, Inc.*, 519 So.2d 217 (La. App. 1988). The term "intangible property located or having a situs within Iowa" means generally that the intangible property belongs to a corporation with its commercial domicile in Iowa or, regardless of where the corporation which owns the intangible property has its commercial domicile, the intangible property has become an integral part of some business activity occurring

regularly in Iowa. *Beidler v. South Carolina Tax Commission*, 282 U.S. 1, 75 L.Ed. 131, 51 S.Ct. 54 (1930); *Geoffrey, Inc. v. South Carolina Tax Commission*, 437 S.E.2d 13 (S.C. 1993), cert. denied, 114 S.Ct. 550 (1993); *Kmart Properties, Inc. v. Taxation & Revenue Department of New Mexico*, 131 P. 3d 27 (N.M. Ct. App. 2001), rev'd on other issues, 131 P. 3d 22 (N.M. 2005); *Secretary, Department of Revenue v. Gap (Apparel), Inc.*, 886 So. 2d 459 (La.Ct.App. 2004); *A & F Trademark v. Tolson*, 605 S.E. 2d 187 (N.C.App. 2004), cert. denied 126 S.Ct. 353 (2005); *Lanco, Inc. v. Director, Division of Taxation*, 879 A.2d 1234 (N.J.Super.A.D. 2005), aff'd, 908 A.2d 176 (N.J. 2006) (per curiam), cert. denied 127 S.Ct. 2974 (June 18, 2007); *Geoffrey, Inc. v. Oklahoma Tax Commission*, 132 P. 3d 632 (Okla. Ct. Civ. App. 2005), cert. denied (Mar. 20, 2006), as corrected (Apr. 12, 2006); *FIA Card Services, Inc. v. Tax Comm'r*, 640 S.E.2d 226 (W. Va. 2006), cert. denied, 127 S.Ct. 2997 (June 18, 2007); *Capital One Bank v. Commissioner of Revenue*, 899 N.E.2d 76 (Mass. 2009); *Geoffrey, Inc. v. Commissioner of Revenue*, 899 N.E.2d 87 (Mass. 2009). The following is a noninclusive list of types of intangible property: copyrights, patents, processes, trademarks, trade names, franchises, contracts, bank deposits including certificates of deposit, repurchase agreements, mortgage loans, consumer loans, business loans, shares of stocks, bonds, licenses, partnership interests including limited partnership interests, leaseholds, money, evidences of an interest in property, evidences of debts such as credit card debt, leases, an undivided interest in a loan, rights-of-way, and interests in trusts.

The term also includes every foreign corporation which has acquired a commercial domicile in Iowa and whose property has not acquired a constitutional tax situs outside of Iowa.

52.1(2) *Corporate activities not creating taxability.* Public Law 86-272, 15 U.S.C.A., Sections 381-385, in general prohibits any state from imposing an income tax on income derived within the state from interstate commerce if the only business activity within the state consists of the solicitation of orders of tangible personal property by or on behalf of a corporation by its employees or representatives. Such orders must be sent outside the state for approval or rejection and, if approved, must be filled by shipment or delivery from a point outside the state to be within the purview of Public Law 86-272. Public Law 86-272 does not extend to those corporations which sell services, real estate, or intangibles in more than one state or to domestic corporations. For example, Public Law 86-272 does not extend to brokers or manufacturers' representatives or other persons or entities selling products for another person or entity.

a. If the only activities in Iowa of a foreign corporation selling tangible personal property are those of the type described in the noninclusive listing below, the corporation is protected from the Iowa corporation income tax law by Public Law 86-272.

(1) The free distribution by salespersons of product samples, brochures, and catalogues which explain the use of or laud the product, or both.

(2) The lease or ownership of motor vehicles for use by salespersons in soliciting orders.

(3) Salespersons' negotiation of a price for a product, subject to approval or rejection outside the taxing state of such negotiated price and solicited order.

(4) Demonstration by salesperson, prior to the sale, of how the corporation's product works.

(5) The placement of advertising in newspapers, radio, and television.

(6) Delivery of goods to customers by foreign corporation in its own or leased vehicles from a point outside the taxing state. Delivery does not include nonimmune activities, such as picking up damaged goods.

(7) Collection of state or local-option sales taxes or state use taxes from customers.

(8) Audit of inventory levels by salespersons to determine if corporation's customer needs more inventory.

(9) Recruitment, training, evaluation, and management of salespersons pertaining to solicitation of orders.

(10) Salespersons' intervention/mediation in credit disputes between customers and non-Iowa located corporate departments.

(11) Use of hotel rooms and homes for sales-related meetings pertaining to solicitation of orders.

(12) Salespersons' assistance to wholesalers in obtaining suitable displays for products at retail stores.

(13) Salespersons' furnishing of display racks to retailers.

(14) Salespersons' advice to retailers on the art of displaying goods to the public.

(15) Rental of hotel rooms for short-term display of products.

(16) Mere forwarding of customer questions, concerns, or problems by salespersons to non-Iowa locations.

b. For tax years beginning on or after January 1, 1996, a foreign corporation will not be considered doing business in this state or deriving income from sources within this state if its only activities within this state are one or more of the following activities:

(1) Holding meetings of the board of directors or shareholders, or holiday parties, or employee appreciation dinners.

(2) Maintaining bank accounts.

(3) Borrowing money, with or without security.

(4) Utilizing Iowa courts for litigation.

(5) Owning and controlling a subsidiary corporation which is incorporated in or which is transacting business within this state where the holding or parent company has no physical presence in the state as that presence relates to the ownership or control of the subsidiary.

(6) Recruiting personnel where hiring occurs outside the state.

c. For tax years beginning on or after January 1, 1997, a foreign corporation will not be considered doing business in this state or deriving income from sources within this state if its only activities within this state, in addition to the activities listed in paragraph *"b"* above, are training its employees or educating its employees, or using facilities in this state for this purpose.

d. For tax years beginning on or after January 1, 2006, a foreign corporation will not be considered to be doing business in Iowa or deriving income from sources within Iowa if its only activities within Iowa, in addition to the activities listed in paragraphs "b" and "c" of this subrule, are utilizing a distribution facility in Iowa, owning or leasing property at a distribution facility in Iowa, or selling property shipped or distributed from a distribution facility in Iowa.

A distribution facility is an establishment at which shipments of tangible personal property are processed for delivery to customers. A distribution facility does not include an establishment at which retail sales of tangible personal property or returns of such property are undertaken with respect to retail customers more than 12 days in a year. However, an exception to the 12-day requirement is allowed for distribution facilities that process customer orders by mail, telephone, or electronic means, if the distribution facility also processes shipments of tangible personal property to customers, as long as no more than 10 percent of the goods are delivered or shipped to a purchaser in Iowa.

The following nonexclusive examples illustrate how this subrule applies:

EXAMPLE 1: A, a foreign corporation, stores its inventory of books at a facility in Iowa. The facility processes orders for these books solely by mail, telephone and the Internet on behalf of A, and customers are not allowed to purchase books at the facility's site in Iowa. The facility processes shipments of these books, and 5 percent of the books at this facility are delivered to purchasers located in Iowa. A does not conduct any other business activities in Iowa. A is not considered to be doing business in Iowa because less than 10 percent of the books at the facility are delivered to an Iowa customer.

EXAMPLE 2: B, a foreign corporation, stores its inventory of compact disks at a facility in Iowa. The facility processes orders for these compact disks solely by mail, telephone and the Internet on behalf of B, and customers are not allowed to purchase compact disks at the facility's site in Iowa. The facility processes shipments of these compact disks, and 15 percent of the compact disks at the facility are delivered to purchasers located in Iowa. B does not conduct any other business activities in Iowa. B is considered to be doing business in Iowa because more than 10 percent of the compact disks at the facility are delivered to an Iowa customer.

EXAMPLE 3: C, a foreign corporation, stores its inventory of doors and windows at a facility in Iowa. The facility processes orders for these windows and doors solely by mail, telephone and the Internet, and customers are not allowed to purchase these windows and doors at the facility's site in Iowa. The facility processes shipments of these windows and doors, and 7 percent of the windows and doors are delivered to purchasers located in Iowa. C will also install these windows and doors in Iowa upon customer request.

C is considered to be doing business in Iowa even though less than 10 percent of the windows and doors are delivered to Iowa customers because C is also conducting installation activities in Iowa which are not protected under Public Law 86-272.

EXAMPLE 4: D, a foreign corporation, stores its inventory of home decorating and craft kits at a facility in Iowa. The facility does not process any customer orders by mail, telephone or the Internet, and does not process any shipments of these kits directly to customers. D allows customers to come to the facility 14 days each year to directly purchase these kits, and customers must arrange for their own delivery of the kits. D is considered to be doing business in Iowa because sales to retail customers are conducted more than 12 days in a year, and the facility does not process customer orders or shipments to customers.

52.1(3) *Corporate activities creating taxability.* "Solicitation of orders" within Public Law 86-272 is limited to those activities which explicitly or implicitly propose a sale or which are entirely ancillary to requests for purchases. Activities that are entirely ancillary to requests for purchases are ones that serve no independent business function apart from their connection to the soliciting of orders. An activity that is not ancillary to requests for purchases is one that a corporation (taxpayer) has a reason to do anyway whether or not it chooses to allocate it to its sales force operating in Iowa (such as repair, installation, service-type activities, or collection on accounts). Activities that take place after a sale ordinarily will not be entirely ancillary to a request for purchases and, therefore, ordinarily will not be considered in "solicitation of orders." *Wisconsin Department of Revenue v. William Wrigley, Jr. Company*, 505 U.S. 214, 120 L.Ed.2d 174, 112 S.Ct. 2447 (1992).

De minimis activities which are not "solicitation of orders" are protected under Public Law 86-272. Whether in-state nonsolicitation activities are sufficiently de minimis to avoid loss of tax immunity depends upon whether those activities establish only a trivial additional connection with the taxing state. Whether a corporation's nonsolicitation in-state activities are de minimis should not be decided solely by the quantity of one type of such activity but, rather, all types of nonsolicitation activities of the taxpayer should be considered in their totality. *Wisconsin v. Wrigley*, 505 U.S. 214, 120 L.Ed.2d 174, 112 S.Ct. 2447 (1992). Frequency of the activity may be relevant, but an isolated activity is not invariably trivial. The mere fact that an activity involves small amounts of money or property does not invariably mean it is trivial.

If a foreign corporation has greater than a de minimis amount of Iowa nonsolicitation activity which includes activity of the types described in the noninclusive listing below, whether done by the salesperson, other employee, or other representative, it is not immunized from the Iowa corporation income tax by Public Law 86-272.

a. Installation or assembly of the corporate product.

b. Ownership or lease of real estate by corporation.

c. Solicitation of orders for, or sale of, services or real estate.

d. Sale of tangible personal property (as opposed to solicitation of orders) or performance of services within Iowa.

e. Maintenance of a stock of inventory.

f. Existence of an office or other business location.

g. Managerial activities pertaining to nonsolicitation activities.

h. Collections on regular or delinquent accounts.

i. Technical assistance and training given after the sale to purchaser and user of corporate products.

j. The repair or replacement of faulty or damaged goods.

k. The pickup of damaged, obsolete, or returned merchandise from purchaser or user.

l. Rectification of or assistance in rectifying any product complaints, shipping complaints, etc., if more is involved than relaying complaints to a non-Iowa location.

m. Delivery of corporate merchandise inventory to corporation's distributors or dealers on consignment.

n. Maintenance of personal property which is not related to solicitation of orders.

o. Participation in recruitment, training, monitoring, or approval of servicing distributors, dealers, or others where purchasers of corporation's products can have such products serviced or repaired.

p. Inspection or verification of faulty or damaged goods.

q. Inspection of the customer's installation of the corporate product.

r. Research.

s. Salespersons' use of part of their homes or other places as an office if the corporation pays for such use.

t. The use of samples for replacement or sale; storage of such samples at home or in rented space.

u. Removal of old or defective products.

v. Verification of the destruction of damaged merchandise.

w. Independent contractors, agents, brokers, representatives and other individuals or entities who act on behalf of or at the direction of the corporation (taxpayer) and who do non-de minimis amounts of nonsolicitation activities remove the corporation from the protection of Public Law 86-272. However, the maintenance of an office in Iowa or the making of sales in Iowa by independent contractors does not remove the corporation from the protection of Public Law 86-272. The term "independent contractors" means commission agents, brokers, or other independent contractors who are engaged in selling or soliciting orders for the sale of tangible personal property or perform other services for more than one principal and who hold themselves out as such in the regular course of their business activities. If a person is subject to the direct control of the foreign corporation that person may not qualify as an independent contractor.

52.1(4) *Taxation of corporations having only intangible property located or having a situs in Iowa.* For tax years beginning on or after January 1, 1995, corporations whose only connection with Iowa is their ownership of intangible property located or having a situs in Iowa are subject to Iowa income tax and must file an Iowa income tax return. Intangible property is located or has a situs in Iowa if the corporation's commercial domicile is in Iowa and the intangible property has not become an integral part of some business activity occurring regularly within or without Iowa. Regardless whether the corporation's commercial domicile is in or out of Iowa, intangible property is located or has a situs in Iowa if the intangible property has become an integral part of some business activity occurring regularly in Iowa. *Geoffrey, Inc. v. South Carolina Tax Commission*, 437 S.E.2d 13 (S.C. 1993), cert. denied, 114 S.Ct. 550 (1993); *Arizona Tractor Company v. Arizona State Tax Commission*, 115 Ariz. 602, 566 P.2d 1348 (Ariz. App. 1977). In the event that the intangible property interest is a general or limited partnership interest, the location or situs of that partnership interest is the place(s) where the partnership conducts business. *Arizona Tractor Company v. Arizona State Tax Commission*, supra.

The following nonexclusive examples illustrate how this subrule applies:

EXAMPLE 1: A, a corporation with a commercial domicile in State X, has a limited partnership interest in a partnership which does a regular business in Iowa. A has no physical presence in Iowa and has no other contact with Iowa. A's interest in the limited partnership is intangible personal property. A is required to file an Iowa income tax return because A's intangible personal property limited partnership interest has a business situs in Iowa. *Arizona Tractor Company v. Arizona State Tax Commission*, supra.

EXAMPLE 2: B, a corporation with a commercial domicile in State X, owns stock in a subsidiary corporation doing business regularly in Iowa. B has no physical presence in Iowa and has no other contact with Iowa. B controls the subsidiary and has a unitary relationship with it. B pledged the subsidiary stock to secure a line of credit from a bank and used the loaned funds in B's business. Under these circumstances, the subsidiary stock is not an integral part of the subsidiary's business and, therefore, the stock does not have a location or situs in Iowa. Accordingly, B is not required to file an Iowa income tax return as a result of any dividends received by B or capital gains received by B from the sale of the stock. *McNamara v. George Engine Company, Inc.*, 519 So.2d 217 (La. App. 1988).

EXAMPLE 3: C, a corporation with a commercial domicile in State X, owns trademarks and trade names which it, by license agreements, allows other corporations to use. Some of those other corporations do business in Iowa. The trademarks and trade names are used by these other corporations at their Iowa stores in connection with their business activities at those stores. C has no physical presence in Iowa and has no other contact with Iowa. C is paid royalties of 1 percent of net sales of the

licensed products or services. C is required to file an Iowa income tax return because C's intangible property interests in the trademarks and trade names have situses in Iowa. *Geoffrey, Inc. v. South Carolina Tax Commission*, 437 S.E.2d 13 (S.C. 1993), cert. denied, 114 S.Ct. 550 (1993).

EXAMPLE 4: D, a corporation with a commercial domicile in Iowa, is a holding company which does not sell any tangible personal property or sell any business service but which does own the stock of five subsidiaries, all of which do business outside of Iowa. D has no physical presence outside of Iowa and has no other contact outside of Iowa. D has a unitary relationship with each subsidiary. Under these circumstances, the stock is not an integral part of each subsidiary's business so the stock does not have a location or situs outside of Iowa. The location or situs of the stock is in Iowa because D's commercial domicile is in Iowa. Accordingly, all of the dividends from the stock paid to D and any capital gains incurred as a result of D's sale of the stock are wholly taxed by Iowa.

EXAMPLE 5: E, a corporation with a commercial domicile in Iowa, owns trademarks and trade names which it, by license agreements, allows other corporations, located outside of Iowa, to use. The trademarks and trade names are used by these other corporations at their non-Iowa stores in connection with their business activities at those stores. E has no physical presence outside of Iowa and has no other contact outside of Iowa. E has business activities in Iowa. The fees and royalties paid to E are part of E's unitary business income. Under these circumstances, E is entitled to apportion its net income within and without Iowa because E's intangible property interests in the trademarks and trade names have situses outside of Iowa and E has business activities in Iowa.

EXAMPLE 6: F, a corporation with a commercial domicile in State X, owns all of the stock of a subsidiary corporation doing business in Iowa. F has no physical presence in Iowa and no other contact with Iowa. F loans funds to the subsidiary which the subsidiary uses in its Iowa business. Under these circumstances, the interest-bearing asset is not an integral part of the subsidiary's business and, therefore, that intangible asset does not have a location or situs in Iowa. Accordingly, F is not required to file an Iowa income tax return. *Beidler v. South Carolina Tax Commission*, 282 U.S. 1, 75 L.Ed.131, 51 S.Ct. 54 (1930).

EXAMPLE 7: G, a corporation with a commercial domicile in State X, earns fees from the licensing of custom computer software. G has no physical presence in Iowa and no other contact with Iowa. G licenses the software to other corporations which do business in Iowa and which use the software in that business in Iowa. Under these circumstances, regardless whether the fees constitute royalties or something else, the license fees are earned from intangible personal property with a location or situs in Iowa. Accordingly, G is required to file an Iowa income tax return.

EXAMPLE 8: H, a corporation with a commercial domicile in State X, has no physical presence in Iowa. H has entered into a contract with an independent contractor to solicit sales of H's magazines in Iowa. The independent contractor does business in Iowa and receives payment for the magazines and deposits the funds in an Iowa bank for H's account. H earns interest on this account. Under these circumstances which are H's only contact with Iowa, H's interest-bearing account is an integral part of business activity in Iowa. Accordingly, H is required to file an Iowa income tax return and include the interest income in the numerator of the business activity formula.

EXAMPLE 9: J, a corporation with a commercial domicile in State X, earns income from mortgages that the corporation has purchased. J has no physical presence in Iowa and no other contact with Iowa. J earns interest income from the mortgages on property located in Iowa. Under these circumstances, the interest income is an integral part of business activity in Iowa. Accordingly, J is required to file an Iowa income tax return and include the interest income from the mortgages related to Iowa property in the numerator of the apportionment factor.

52.1(5) *Taxation of "S" corporations, domestic international sales corporations and real estate investment trusts.* Certain corporations and other types of entities, which are taxable as corporations for federal purposes, may by federal election and qualification have a portion or all of their income taxable to the shareholders or the beneficiaries. Generally, the state of Iowa follows the federal provisions (with adjustments provided by Iowa law) for determining the amount and to whom the income is taxable. Examples of entities which may avail themselves of pass-through provisions for taxation of at least part of their net income are real estate investment trusts, small business corporations electing to file

under Sections 1371-1378 of the Internal Revenue Code, domestic international sales corporations as authorized under Sections 991-997 of the Internal Revenue Code, and certain types of cooperatives and regulated investment companies. The entity's portion of the net income which is taxable as corporation net income for federal purposes is generally also taxable as Iowa corporation income (with adjustments as provided by Iowa law) and the shareholders or beneficiaries will report on their Iowa returns their share of the organization's income reportable for federal purposes as shareholder income (with adjustments provided by Iowa law). Nonresident shareholders or beneficiaries are required to report their distributive share of said income reasonably attributable to Iowa sources. Schedules shall be filed with the individual's return showing the computation of the income attributable to Iowa sources and the computation of the nonresident taxpayer's distributive share thereof. Entities with a nonresident beneficiary or shareholder shall include a schedule in the return computing the amount of income as determined under 701—Chapter 54. It will be the responsibility of the entity to make the apportionment of the income and supply the nonresident taxpayer with information regarding the nonresident taxpayer's Iowa taxable income.

For tax years beginning on or after January 1, 1995, S corporations which are subject to tax on built-in gains under Section 1374 of the Internal Revenue Code or passive investment income under Section 1375 of the Internal Revenue Code are subject to Iowa corporation income tax on this income to the extent received from business carried on in this state or from sources in this state.

a. The starting point for computing the Iowa tax on built-in gains is the amount of built-in gains subject to federal tax after considering the federal income limitation. The starting point for computing the capital gains subject to Iowa tax is the amount of capital gains subject to federal tax. The starting point for computing the passive investment income subject to Iowa income tax is the amount of passive investment income subject to federal tax. To the extent that any of the above three types of income exist for federal income tax purposes, they are combined for Iowa income tax purposes.

b. No adjustment is made to the above amounts for either 50 percent of federal income tax or Iowa corporation income tax deducted in computing the federal net income of the S corporation for tax years beginning prior to January 1, 2008. The 50 percent of federal income tax and Iowa corporation income tax deducted in computing federal net income are adjustments to the Iowa net income which flows through to the shareholders for tax years beginning prior to January 1, 2008. For tax years beginning on or after January 1, 2008, an adjustment is made to the above amounts for either 50 percent of federal income tax or Iowa corporation income tax deducted in computing the federal net income of the S corporation.

c. The allocation and apportionment rules of 701—Chapter 54 apply to nonresident shareholders if the S corporation is carrying on business within and without the state of Iowa.

d. Any net operating loss carryforward arising in a taxable year for which the corporation was a C corporation shall be allowed as a deduction against the net recognized built-in gain, capital gains, or passive investment income of the S corporation for the taxable year. For purposes of determining the amount of any such loss which may be carried to any of the 15 subsequent taxable years, after the year of the net operating loss, the amount of the net recognized built-in gain shall be treated as taxable income. For taxable years beginning after August 5, 1997, a net operating loss can be carried forward 20 taxable years.

e. Except for estimated and other advance tax payments and any credit carryforward under Iowa Code section 422.33 arising in a taxable year for which the corporation was a C corporation no credits shall be allowed against the built-in gains tax or the tax on capital gains or passive investment income.

For tax years beginning after 1996, Iowa recognizes the federal election to treat subsidiaries of a parent corporation that has elected S corporation status as "qualified subchapter S subsidiaries" (QSSSs). To the extent that, for federal income tax purposes, the incomes and expenses of the QSSSs are combined with the parent's income and expenses, they must be combined for Iowa tax purposes.

52.1(6) *Exempted corporations and organizations filing requirements.*

a. Exempt status. An organization that is exempt from federal income tax under Section 501 of the Internal Revenue Code, unless the exemption is denied under Section 501, 502, 503 or 504 of the Internal Revenue Code, is exempt from Iowa corporation income tax except as set forth in paragraph *"e"*

of this subrule. The department may, if a question arises regarding the exempt status of an organization, request a copy of the federal determination letter.

b. Information returns. Every corporation shall file returns of information as provided by Iowa Code sections 422.15 and 422.16 and any regulations regarding information returns.

c. Annual return. An organization or association which is exempt from Iowa corporation income tax because it is exempt from federal income tax is not required to file an annual income tax return unless it is subject to the tax on unrelated business income. The organization shall inform the director in writing of any revocation of or change of exempt status by the Internal Revenue Service within 30 days after the federal determination.

d. Tax on unrelated business income for tax years beginning on or after January 1, 1988. A tax is imposed on the unrelated business income of corporations, associations, and organizations exempt from the general business tax on corporations by Iowa Code section 422.34, subsection 2, to the extent this income is subject to tax under the Internal Revenue Code. The exempt organization is also subject to the alternative minimum tax imposed by Iowa Code section 422.33(4).

The exempt corporation, association, or organization must file Form IA 1120, Iowa Corporation Income Tax Return, to report its income and complete Form IA 4626 if subject to the alternative minimum tax. The exempt organization must make estimated tax payments if its expected income tax liability for the year is $1,000 or more.

The tax return is due the last day of the fourth month following the last day of the tax year and may be extended for six months by filing Form IA 7004 prior to the due date. For tax years beginning on or after January 1, 1991, the tax return is due on the fifteenth day of the fifth month following close of the tax year and may be extended six months if 90 percent of the tax is paid prior to the due date.

The starting point for computing Iowa taxable income is federal taxable income as properly computed before deduction for net operating losses. Federal taxable income shall be adjusted as required in Iowa Code section 422.35.

If the activities which generate the unrelated business income are carried on partly within and partly without the state, then the taxpayer should determine the portion of unrelated business income attributable to Iowa by the apportionment and allocation provisions of Iowa Code section 422.33.

The provisions of 701—Chapters 51, 52, 53, 54, 55 and 56 apply to the unrelated business income of organizations exempt from the general business tax on corporations.

e. Certain posts or organizations of past or present armed forces members may be tax-exempt corporations for tax years beginning after May 21, 2003. An organization that would have qualified as an organization exempt from federal income tax under Section 501(c)(19) of the Internal Revenue Code but for the fact that the requirement that 75 percent of the members need to be past or present armed forces members is not met because the membership includes ancestors or lineal descendants is considered to be an organization exempt from federal income tax.

This change is effective for tax years beginning after May 21, 2003.

52.1(7) *Income tax of corporations in liquidation.* When a corporation is in the process of liquidation, or in the hands of a receiver, the income tax returns must be made under oath or affirmation of the persons responsible for the conduct of the affairs of such corporations, and must be filed at the same time and in the same manner as required of other corporations.

52.1(8) *Income tax returns for corporations dissolved.* Corporations which have been dissolved during the income year must file income tax returns for the period prior to dissolution which has not already been covered by previous returns. Officers and directors are responsible for the filing of the returns and for the payment of taxes, if any, for the audit period provided by law.

Where a corporation dissolves and disposes of its assets without making provision for the payment of its accrued Iowa income tax, liability for the tax follows the assets so distributed and upon failure to secure the unpaid amount, suit to collect the tax may be instituted against the stockholders and other persons receiving the property, to the extent of the property received, except bona fide purchasers or others as provided by law.

52.1(9) *Income tax returns for corporations storing goods in an Iowa warehouse.* For tax years beginning on or after January 1, 2001, foreign corporations are not required to file income tax returns

if their only activities in Iowa are the storage of goods for a period of 60 consecutive days or less in a warehouse for hire located in Iowa, provided that the foreign corporation transports or causes a carrier to transport such goods to that warehouse and that none of these goods are delivered or shipped to a purchaser in Iowa.

The following nonexclusive examples illustrate how this subrule applies:

EXAMPLE 1: A, a foreign corporation, stores goods in a warehouse for hire in Iowa for a period of 45 consecutive days. The goods are then delivered to a purchaser outside Iowa. If this is A's only activity in Iowa, A is not required to file an Iowa income tax return.

EXAMPLE 2: B, a foreign corporation, stores goods in a warehouse for hire in Iowa for a period of 75 consecutive days. The goods are then delivered to a purchaser outside Iowa. B is required to file an Iowa income tax return because the goods were stored in Iowa for more than 60 consecutive days.

EXAMPLE 3: C, a foreign corporation, stores goods in a warehouse for hire in Iowa for a period of 30 consecutive days. One percent of these goods are shipped to a purchaser in Iowa, and the other 99 percent are shipped to a purchaser outside Iowa. C is required to file an Iowa income tax return because a portion of the goods were shipped to a purchaser in Iowa.

EXAMPLE 4: D, a foreign corporation, has retail stores in Iowa. D also stores goods in a warehouse for hire in Iowa for a period of 30 consecutive days. The goods are then delivered to a purchaser outside Iowa. D is required to file an Iowa income tax return because its Iowa activities are not limited to the storage of goods in a warehouse for hire in Iowa.

EXAMPLE 5: E, a foreign corporation, has goods delivered by a common carrier, F, into a warehouse for hire in Iowa. The goods are stored in the warehouse for a period of 40 consecutive days, and are then delivered to a purchaser outside Iowa. If this is E's only activity in Iowa, E is not required to file an Iowa income tax return. However, F is required to file an Iowa income tax return because it derives income from transportation operations in Iowa.

52.1(10) *Deferment of income for start-up companies.* For tax periods beginning on or after January 1, 2002, but before January 1, 2008, a business that qualifies as a "start-up" business can defer taxable income for the first three years that the business is in operation. The deferment of income for start-up companies is repealed effective for tax years beginning on or after January 1, 2008.

a. Definition of start-up business. A start-up business for purposes of this subrule does not include any of the following:

(1) An existing business locating in Iowa from another state.

(2) An existing business locating in Iowa from another location in Iowa.

(3) A newly created business which is the result of the merger of two or more businesses.

(4) A newly created subsidiary or new business of a corporation.

(5) A previously existing business which has been dissolved and reincorporated.

(6) An existing business operating under a different name and located in a different location.

(7) A newly created partnership owned by two or more of the same partners as an existing business and engaging in similar business activity as the existing business.

(8) A business entity that reorganizes or experiences a change in either the legal or trade name of the business.

(9) A joint venture.

b. Criteria for deferment of taxable income. In order to qualify for the deferment of taxable income for a start-up business, each of the following criteria must be met:

(1) The taxpayer is a business that is a wholly new start-up business beginning operations during the first tax year for which the deferment of taxable income is claimed.

(2) The business has its commercial domicile, as defined by Iowa Code section 422.32, in Iowa.

(3) The operations of the business are funded by at least 25 percent venture capital moneys. "Venture capital moneys" means an equity investment from an individual or a private seed and venture capital fund whose only business is investing in seed and venture capital opportunities. "Venture capital moneys" does not mean a loan or other nonequity financing from a person, financial institution or other entity.

(4) The taxpayer does not have any delinquent taxes or other debt outstanding and owing to the state of Iowa.

c. Request for deferment of income. A taxpayer must submit a request to the department for the deferment of taxable income. The request must provide evidence that all of the criteria to qualify as a start-up business have been met. The request should be made as soon as possible after the close of the first tax year of the business. The request is to be filed with the Iowa Department of Revenue, Policy Section, Compliance Division, P.O. Box 10457, Des Moines, Iowa 50306-0457. Upon determination that the criteria have been met, the department will notify the taxpayer that the deferment of taxable income is approved. If the request for deferment of taxable income is denied, the taxpayer may file a protest within 60 days of the date of the letter denying the request for deferment of taxable income. The department's determination letter shall set forth the taxpayer's rights to protest the department's determination.

d. Filing of tax returns. If the request for deferment of taxable income is approved, taxable income for the first three years that the business is in operation is deferred. The taxpayer shall pay taxes on the deferred taxable income in five equal annual installments during the five tax years following the three years of deferment. Tax returns must be filed for each tax year in which the deferment is approved. If the taxpayer has a net loss during any tax year during the three-year deferment period, the loss may be applied to any deferred taxable income during that period. For purposes of assessing penalty and interest, the tax on any deferred income is not due and payable until the tax years in which the five equal annual installments are due and payable.

The following nonexclusive examples illustrate how this subrule applies:

EXAMPLE 1: A qualifying start-up business reports Iowa taxable income of $1,000 in year one, $5,000 in year two and $10,000 in year three. The total tax deferred is $60 in year 1, $300 in year two and $600 in year three, or $960. The taxpayer shall pay $192 ($960 divided by 5) in deferred tax for each of the next five tax returns. No penalty or interest is due on the deferred annual tax of $192 if the returns for years four through eight are filed by the due date and the tax is timely paid. After the return for year three is filed, the department will issue a schedule to the qualifying business indicating that $192 of additional tax is due annually for years four through eight, and when the additional payments of $192 are due.

EXAMPLE 2: A qualifying start-up business reports an Iowa taxable loss of $10,000 in year one, a loss of $2,000 in year two and taxable income of $22,000 in year three. The losses for year one and year two can be netted against the income in year three, resulting in deferred taxable income of $10,000. The tax of $600 computed on income of $10,000 will be paid in five equal installments of $120 for the next five tax returns. No penalty or interest is due on the deferred annual tax of $120 if the returns for years four through eight are filed by the due date and the tax is timely paid. After the return for year three is filed, the department will issue a schedule to the qualifying business indicating that $120 of additional tax is due annually for years four through eight and when the additional payments of $120 are due.

This rule is intended to implement Iowa Code sections 422.21, 422.32, 422.33, 422.34, 422.34A, and 422.36 and Iowa Code section 422.24A as amended by 2008 Iowa Acts, Senate File 2400, section 66.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—52.2(422) Time and place for filing return.

52.2(1) *Returns of corporations.* A return of income for all corporations must be filed on or before the due date. The due date for all corporations excepting cooperative associations as defined in Section 6072(d) of the Internal Revenue Code is the last day of the fourth month following the close of the taxpayer's taxable year, whether the return be made on the basis of the calendar year or the fiscal year; or the last day of the period covered by an extension of time granted by the director. When the due date falls on a Saturday, Sunday or a legal holiday, the return will be due the first business day following the Saturday, Sunday or legal holiday. If a return is placed in the mails, properly addressed and postage paid in ample time to reach the department on or before the due date for filing, no penalty will attach should the return not be received until after that date. Mailed returns should be addressed to Corporate Income Tax Processing, Hoover State Office Building, Des Moines, Iowa 50319.

52.2(2) *Returns of cooperatives.* A return of income for cooperatives, defined in Section 6072(d) of the Internal Revenue Code, must be filed on or before the fifteenth day of the ninth month following the close of the taxpayer's taxable year.

52.2(3) *Short period returns.* Where under a provision of the Internal Revenue Code, a corporation is required to file a tax return for a period of less than 12 months, a short period Iowa return must be filed for the same period. The short period Iowa return is due 45 days after the federal due date, not considering any federal extension of time to file.

52.2(4) *Extension of time for filing returns for tax years beginning on or after January 1, 1991.* See 701—subrule 39.2(4).

This rule is intended to implement Iowa Code sections 422.21 and 422.24.

701—52.3(422) Form for filing.

52.3(1) *Use and completeness of prescribed forms.* Returns shall be made by corporations on forms supplied by the department. Taxpayers not supplied with the proper forms shall make application for same to the department in ample time to have their returns made, verified and filed on or before the due date. Each taxpayer shall carefully prepare the taxpayer's return so as to fully and clearly set forth the data required. For lack of a prescribed form, a statement made by a taxpayer disclosing the taxpayer's gross income and the deductions therefrom may be accepted as a tentative return, and if verified and filed within the prescribed time, will relieve the taxpayer from liability to penalties, provided that without unnecessary delay such a tentative return is replaced by a return made on the proper form. Each question shall be answered and each direction complied with in the same manner as if the forms and instructions were embodied in these rules.

Failure to receive the proper forms does not relieve the taxpayer from the obligation of making any return required by the statute.

Returns received which are not completed, but merely state "see schedule attached" are not considered to be a properly filed return and may be returned to the taxpayer for proper completion. This may result in the imposition of penalties and interest due to the return being filed after the due date.

52.3(2) *Form for filing—domestic corporations.* A domestic corporation, as defined by Iowa Code subsection 422.32(5), is required to file a complete Iowa return for each year of its existence regardless of whether the corporation has income, loss, or inactivity. For tax periods beginning on or after January 1, 1999, domestic corporations are required to file a complete Iowa return only if they are doing business in Iowa, or deriving income from sources within Iowa. However, the corporation may substitute a copy of the true and accurate federal income tax return as filed with the Internal Revenue Service in lieu of certain Iowa return schedules. This substitution is optional, but in all instances a detailed computation of the federal tax liability actually due the federal government shall be required as a part of the Iowa return. The Iowa schedules subject to the substitution provision are: income statement, balance sheet, reconciliation of income per books with income per return and analysis of unappropriated retained earnings per books.

When a domestic corporation is included in the filing of a consolidated federal income tax return, the Iowa corporation income tax return shall include a schedule of the consolidating income statements as properly computed for federal income tax purposes showing the income and expenses of each member of the consolidated group, and a schedule of capital gains on a separate basis.

If a domestic corporation claims a foreign tax credit, research activities credit, alcohol fuel credit, employer social security credit, or work opportunity credit on its federal income tax return, a detailed computation of the credits claimed shall be included with the Iowa return upon filing. In those instances where the domestic corporation is involved in the filing of a consolidated federal income tax return, the credit computations shall be reported on a separate entity basis.

Similarly, where a domestic corporation is charged with a holding company tax or an alternative minimum tax, the details of the taxes levied shall be put forth in a schedule to be included with the Iowa return. Furthermore, these taxes shall be identified on a separate company basis where the domestic corporation files as a member of a consolidated group for federal purposes.

52.3(3) *Form for filing—foreign corporations.* Foreign corporations, as defined by Iowa Code subsection 422.32(6), must include a true and accurate copy of their federal corporation income tax

return as filed with the Internal Revenue Service with the filing of their Iowa return. At a minimum this return includes the following federal schedules: income statement, balance sheet, reconciliation of income per books with income per return, analysis of unappropriated retained earnings per books, dividend income and special deductions, cost of goods sold, capital gains, tax computation and tax deposits, research activities credit computation, work opportunity credit computation, foreign tax credit computation, alcohol fuel credit computation, employer social security credit computation, alternative minimum tax computation, and statements detailing other income and other deductions.

When a foreign corporation whose income is included in a consolidated federal income tax return files an Iowa return, federal consolidating income statements as properly computed for federal income tax purposes showing the income and expenses of each member of the consolidated group shall be required together with the following additional schedules on a separate basis:

a. Capital gains.
b. Dividend income and special deductions.
c. Research activities credit, alcohol fuel credit and employer social security credit computations.
d. Work opportunity credit computation.
e. Foreign tax credit computation.
f. Holding company tax computation.
g. Alternative minimum tax computation.
h. Schedules detailing other income and other deductions.

52.3(4) *Amended returns.* If it becomes known to the taxpayer that the amount of income reported to be federal net income or Iowa taxable income was erroneously stated on the Iowa return, or changed by Internal Revenue Service audit, or otherwise, the taxpayer shall file an amended Iowa return along with supporting schedules, to include the amended federal return and a copy of the federal revenue agent's report if applicable. A copy of the federal revenue agent's report and notification of final federal adjustments provided by the taxpayer will be acceptable in lieu of an amended return. The assessment or refund of tax shall be dependent on the statute of limitations as set forth in 701—subrule 51.2(1) and rule 701—55.3(422).

This rule is intended to implement Iowa Code section 422.21.

701—52.4(422) Payment of tax.

52.4(1) *Quarterly estimated payments.* Effective for taxable years beginning on or after July 1, 1977, corporations are required to make quarterly payments of estimated income tax. Rules pertaining to the estimated tax are contained in 701—Chapter 56.

52.4(2) *Full estimated payment on original due date.* Rescinded IAB 3/15/95, effective 4/19/95.

52.4(3) *Penalty and interest on unpaid tax.* See rule 701—10.6(421) for penalty for tax periods beginning on or after January 1, 1991. See rule 701—10.8(421) for statutory exemptions to penalty for tax periods beginning on or after January 1, 1991.

Interest shall accrue on tax due from the original due date of the return. Interest on refunds of any portion of the tax imposed by statute which has been erroneously refunded and which is recoverable by the department shall bear interest as provided by law from the date of payment of the refund, considering each fraction of a month as an entire month. See rule 701—10.2(421) for the statutory interest rate.

All payments shall be first applied to the penalty and then to the interest, and the balance, if any, to the amount of tax due.

52.4(4) *Payment of tax by uncertified checks.* The department will accept uncertified checks in payment of income taxes, provided the checks are collectible for their full amount without any deduction for exchange or other charges unless requirements for electronic transmission of remittances and related information specify otherwise. The date on which the department receives the check will be considered the date of payment, so far as the taxpayer is concerned, unless the check is dishonored. If one check is remitted to cover two or more corporations' taxes, the remittance must be accompanied by a letter of transmittal stating: (a) the name of the drawer of the check; (b) the amount of the check; (c) the amount of any cash, money order or other instrument included in the same remittance; (d) the

name of each corporation whose tax is to be paid by the remittance; and (e) the amount of payment on account of each corporation.

52.4(5) *Procedure with respect to dishonored checks.* If any check is returned unpaid, all expenses incidental to the collection thereof will be charged to the taxpayer. If any taxpayer whose check has been returned by the depository bank uncollected should fail at once to make the check good, the director will proceed to collect the tax as though no check had been given. A taxpayer who tenders a certified check in payment for taxes is not relieved from his obligation until the check has been paid.

52.4(6) *New jobs credit.* Transferred to 701—52.8(422) IAB 11/28/90, effective 1/2/91.

This rule is intended to implement Iowa Code sections 422.21, 422.24, 422.25, 422.33 and 422.86.

701—52.5(422) Minimum tax.

52.5(1) Rescinded IAB 11/24/04, effective 12/29/04.

52.5(2) For tax years beginning after 1997, a small business corporation or a new corporation for its first year of existence, which through the operation of Internal Revenue Code Section 55(e) is exempt from the federal alternative minimum tax, is not subject to Iowa alternative minimum tax. A small business corporation may apply any alternative minimum tax credit carryforward to the extent of its regular corporation income tax liability.

For tax years beginning on or after January 1, 1987, the minimum tax is imposed only to the extent that it exceeds the taxpayer's regular tax liability computed under Iowa Code subsection 422.33(1). The minimum tax rate is 60 percent of the maximum corporate tax rate rounded to the nearest one-tenth of 1 percent or 7.2 percent. Minimum taxable income is computed as follows:

	State taxable income as adjusted by Iowa Code section 422.35
Plus:	Tax preference items, adjustments and losses added back
Less:	Allocable income including allocable preference items and adjustments under Section 56 of the Internal Revenue Code including adjusted current earnings related to allocable income including the allocable preference items
	Subtotal
Times:	Apportionment percentage
	Result
Plus:	Income allocable to Iowa including allocable preference items and adjustments under Section 56 of the Internal Revenue Code including adjusted current earnings related to allocable income including the allocable preference items
Less:	Iowa alternative tax net operating less deduction
	$40,000 exemption amount
Equals:	Iowa alternative minimum taxable income

For tax years beginning on or after January 1, 1987, the items of tax preference are the same items of tax preference under Section 57 except for Subsections (a)(1) and (a)(5) of the Internal Revenue Code used to compute federal alternative minimum taxable income. The adjustments to state taxable income are those adjustments required by Section 56 except for Subsections (a)(4) and (d) of the Internal Revenue Code used to compute federal alternative minimum taxable income. In making the adjustment under Section 56(c)(1) of the Internal Revenue Code, interest and dividends from federal securities net of amortization of any discount or premium shall be subtracted. For tax years beginning on or after January 1, 1988, in making the adjustment under Section 56(c)(1) of the Internal Revenue Code, interest and dividends from state and other political subdivisions and from regulated investment companies exempt from federal income tax under the Internal Revenue Code shall be subtracted net of amortization of any discount or premium. In making the adjustment for adjusted current earnings, subtract Foreign Sales Company (FSC) dividend income and Puerto Rican dividend income computed under Internal Revenue Code Section 936 to the extent they are included in the federal computation of adjusted current earnings.

Losses to be added are those losses required to be added by Section 58 of the Internal Revenue Code in computing federal alternative minimum taxable income.

a. Tax preference items are:

1. Intangible drilling costs;
2. Incentive stock options;
3. Reserves for losses on bad debts of financial institutions;
4. Appreciated property charitable deductions;
5. Accelerated depreciation or amortization on certain property placed in service before January 1, 1987.

b. Adjustments are:

1. Depreciation;
2. Mining exploration and development;
3. Long-term contracts;
4. Iowa alternative minimum net operating loss deduction;
5. Book income or adjusted earnings and profits.

c. Losses added back are:

1. Farm losses;
2. Passive activity losses.

Computation of Iowa alternative minimum tax net operating loss deduction.

Net operating losses computed under rule 701—53.2(422) carried forward from tax years which begin before January 1, 1987, are deductible without adjustment.

Net operating losses from tax years which begin after December 31, 1986, which are carried back or carried forward to the current tax year shall be reduced by the amount of tax preferences and adjustments taken into account in computing the net operating loss prior to applying rule 701—53.2(422). The deduction for a net operating loss from a tax year beginning after December 31, 1986, which is carried back or carried forward shall not exceed 90 percent of the alternative minimum taxable income computed without regard for the net operating loss deduction.

The exemption amount shall be reduced by 25 percent of the amount that the alternative minimum taxable income computed without regard to the $40,000 exemption exceeds $150,000. The exemption shall not be reduced below zero.

EXAMPLE: The following example shows the computation of the alternative minimum tax when there are net operating loss carryforwards and carrybacks including an alternative minimum tax net operating loss.

For tax year 1987, the following information is available:

Federal taxable income before NOL	$182,000
Federal NOL carryforward	<97,000>
Federal income tax	19,750
Tax preferences and adjustments	48,000
Iowa income tax expensed on federal	2,570
Iowa NOL carryforward	147,000

For tax year 1988, the following information is available:

Federal taxable income before NOL	$<154,000>
Federal income tax refund	15,460
Tax preferences and adjustments	78,000
Iowa income tax refund reported on federal	2,570

The alternative minimum tax for 1987 before the 1988 net operating loss carryback should be computed as follows:

Regular Iowa Tax	
Federal taxable income	$182,000
less 50% federal tax	<9,875>
add Iowa income tax expensed	2,570
Iowa taxable income before NOL carryforward	$174,695
less NOL carryforward	<147,000>
Iowa taxable income	$ 27,695
Iowa income tax	$ 1,716
Alternative Minimum Tax	
Iowa taxable income before NOL	$174,695
add preferences and adjustments	48,000
Total	$222,695
less NOL carryforward*	<147,000>
Iowa alternative taxable income	$ 75,695
less exemption amount	<40,000>
Total	$ 35,695
Times 7.2%	2,570
Less regular tax	<1,715>
Alternative minimum tax	$ 855

*Net operating loss carryforwards from tax years beginning before January 1, 1987, are deductible at 100 percent without reduction for items of tax preference or adjustments arising in the tax year.

The alternative minimum tax for 1987 after the 1988 net operating loss carryback should be computed as follows:

Regular Iowa Tax	
Federal taxable income	$ 182,000
less 50% federal tax	<9,875>
add Iowa income tax expensed	2,570
Iowa taxable income before NOL carryforward	$ 174,695
less NOL carryforward	<147,000>
	$ 27,695
less NOL carryback from 1988[1]	<148,840>
NOL carryforward	$ <121,145>
Alternative Minimum Tax	
Iowa taxable income before NOL	$ 174,695
add preferences and adjustments	48,000
Total	$ 222,695
less NOL carryforward from pre-1987 tax year	<147,000>
Total	$ 75,695
less alternative minimum tax NOL[2]	<68,126>
Total	$ 7,569
less exemption	<40,000>
Alternative minimum taxable income after NOL	$ -0-

[1]Computation of 1988 Iowa NOL

Federal NOL	$<154,000>
add 50% of federal refund	7,730
less Iowa refund in federal income	<2,570>
Iowa NOL	$<148,840>

[2]Computation of 1988 Alternative Minimum Tax NOL

Iowa NOL	$<148,840>
add preferences and adjustments	78,000
Total	$ <70,840>
NOL carryback limited to 90% of alternative minimum income before NOL and exemption*	$ <68,126>
Alternative minimum tax NOL carryforward	$ 2,705

*For purposes of the alternative minimum tax, net operating loss carryforward or carryback from tax years beginning after December 31, 1986, must be reduced by items of tax preference and adjustments, and are limited to 90 percent of alternative minimum taxable income before deduction of the post-1986 NOL and the $40,000 exemption amount ($75,695 × 90% = $68,126).

52.5(3) Effective for tax years beginning on or after January 1, 1986, estimated payments are required for minimum tax.

52.5(4) Alternative minimum tax credit for minimum tax paid in a prior tax year. Minimum tax paid by a taxpayer in prior tax years commencing with tax years beginning on or after January 1, 1987, can be claimed as a tax credit against the taxpayer's regular income tax liability in a subsequent tax year. Therefore, 1988 is the first tax year that the minimum tax credit is available for use and the credit is based on the minimum tax paid by the taxpayer for 1987. The minimum tax credit may only be used against regular income tax for a tax year to the extent that the regular tax is greater than the minimum tax for the tax year. If the minimum tax credit is not used up against the regular tax for a tax year, the remaining credit is carried to the following tax year to be applied against the regular income tax liability for that period.

a. Computation of minimum tax credit on Schedule IA 8827. The minimum tax credit is computed on Schedule IA 8827 from information on Schedule IA 4626 for prior tax years, from Form IA 1120 and Schedule IA 4626 for the current year and from Schedule IA 8827 for prior tax years.

b. Examples of computation of the minimum tax credit and carryover of the credit.

EXAMPLE 1. Taxpayer reported $5,000 of minimum tax for 2007. For 2008, taxpayer reported regular tax less credits of $8,000 and the minimum tax liability is $6,000. The minimum tax credit is $2,000 for 2008 because, although the taxpayer had an $8,000 regular tax liability, the credit is allowed only to the extent that the regular tax exceeds the minimum tax. Since only $2,000 of the carryover credit from 2007 was used, there is a $2,000 minimum tax carryover credit to 2009.

EXAMPLE 2. Taxpayer reported $2,500 of minimum tax for 2007. For 2008, taxpayer reported regular tax less credits of $8,000 and the minimum tax liability is $5,000. The minimum tax credit is $2,500 for 2008 because, although the regular tax less credits exceeded the minimum tax by $3,000, the credit is allowed only to the extent of minimum tax paid for prior tax years. There is no minimum tax carryover credit to 2009.

c. Computation of the minimum tax credit attributable to a member leaving an affiliated group filing a consolidated Iowa corporation income tax return. The amount of minimum tax credit available for carryforward attributable to a member of a consolidated Iowa income tax return shall be computed as follows: The consolidated minimum tax credit available for carryforward from each tax year is multiplied by a fraction, the numerator of which is the separate member's tax preferences and adjustments for the

tax year and the denominator of which is the total tax preferences and adjustments of all members of the consolidated Iowa income tax return for the tax year.

d. Computation of the amount of minimum tax credit which may be used by a new member of a consolidated Iowa corporation income tax return. The amount of minimum tax credit carryforward which may be used by a new member of a consolidated Iowa income tax return is limited to the separate member's contribution to the amount by which the regular income tax less credits set forth in Iowa Code section 422.33 exceeds the tentative minimum tax.

The separate member's contribution to the amount by which the regular income tax less nonrefundable credits exceeds the tentative minimum tax shall be computed as follows:

$$\frac{\left[\frac{A}{B} \times C + D\right] \times F}{E} = \text{Separate member's contribution to the amount by which regular income tax less credits set forth in section 422.33 exceeds the tentative minimum tax.}$$

A = Separate corporation gross sales within Iowa after elimination of all intercompany transactions.
B = Consolidated gross sales within and without Iowa after elimination of all intercompany transactions.
C = Iowa consolidated income subject to apportionment.
D = Separate corporation income allocable to Iowa.
E = Iowa consolidated income subject to tax.
F = The amount by which the regular income tax less credits set forth in Iowa Code section 422.33 exceeds the tentative minimum tax.

e. Minimum tax credit after merger. When two or more corporations merge or consolidate into one corporation, the minimum tax credit of the merged or consolidated corporations is available for use by the survivor of the merger or consolidation.

This rule is intended to implement Iowa Code section 422.33.
[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—52.6(422) Motor fuel credit. A corporation may elect to receive an income tax credit in lieu of the motor fuel tax refund provided by Iowa Code chapter 452A. A corporation which holds a motor fuel tax refund permit when it makes this election must cancel the permit within 30 days after the first day of the tax year. However, if the refund permit is not canceled within this period, the permit becomes invalid at the time the election to receive an income tax credit is made. The election will continue for subsequent tax years unless a new motor fuel tax refund permit is obtained.

The amount of the income tax credit must be the amount of Iowa motor fuel tax paid on qualifying fuel purchases as determined by Iowa Code chapter 452A and Iowa Code section 422.110 less any state sales tax as determined by 701—subrule 231.2(2). The credit must be claimed on the tax return covering the tax year in which the motor fuel tax was paid. If the motor fuel credit results in an overpayment of income tax, the overpayment may be refunded or may be credited to income tax due in the subsequent tax year.

Shareholders of S corporations may claim an income tax credit on their individual income tax returns for their respective shares of the motor vehicle fuel taxes paid by the corporations. The credit for a shareholder is that person's pro-rata share of the fuel tax paid by the corporation. A schedule must be attached to the individual's return showing the distribution of gallons and the amount of credit claimed by each shareholder.

The corporation must attach to its return a schedule showing the allocation to each shareholder of the motor fuel purchased by the corporation.

This rule is intended to implement Iowa Code section 422.33.

701—52.7(422) Research activities credit. Effective for tax years beginning on or after January 1, 1985, taxpayers are allowed a tax credit equal to 6.5 percent of the state's apportioned share of qualifying expenditures for increasing research activities. For purposes of this credit, "qualifying expenditures" means the qualifying expenditures for increasing research activities as defined for purposes of the federal

credit for increasing research activities computed under Section 41 of the Internal Revenue Code. For tax years beginning on or after January 1, 1991, "qualifying expenditures" means the qualifying expenditures for increasing research activities as defined for purposes of the federal credit for increasing research activities computed under Section 41 of the Internal Revenue Code as in effect on January 1, 1998. The Iowa research activities credit is made permanent for tax years beginning on or after January 1, 1991, even though there may no longer be a research activities credit for federal income tax purposes. The "state's apportioned share of qualifying expenditures for increasing research activities" must be the ratio of the qualified expenditures in Iowa to total qualified expenditures times total qualifying expenditures for increasing research activities.

52.7(1) *Qualified expenditures in Iowa are:*

a. Wages for qualified research services performed in Iowa.

b. Cost of supplies used in conducting qualified research in Iowa.

c. Rental or lease cost of personal property used in Iowa in conducting qualified research. Where personal property is used both within and without Iowa in conducting qualified research, the rental or lease cost must be prorated between Iowa and non-Iowa use by the ratio of days used in Iowa to total days used both within and without Iowa.

d. Sixty-five percent of contract expenses paid by a corporation to a qualified organization for basic research performed in Iowa.

52.7(2) *Total qualified expenditures are:*

a. Wages paid for qualified research services performed everywhere.

b. Cost of supplies used in conducting qualified research everywhere.

c. Rental or lease cost of personal property used in conducting qualified research everywhere.

d. Sixty-five percent of contract expenses paid by a corporation to a qualified organization for basic research performed everywhere.

Qualifying expenditures for increasing research activities is the smallest of the amount by which the qualified research expenses for the taxable year exceed the base period research expenses or 50 percent of the qualified research expenses for the taxable year.

A shareholder in an S corporation may claim the pro-rata share of the Iowa credit for increasing research expenditures on the shareholder's individual income tax return. The S corporation must provide each shareholder with a schedule showing the computation of the corporation's Iowa credit for increasing research expenditures and the shareholder's pro-rata share. The shareholder's pro-rata share of the Iowa credit for increasing research activities must be in the same ratio as the shareholder's pro-rata share in the earnings of the S corporation.

Any research credit in excess of the corporation's tax liability less the credits authorized in Iowa Code sections 422.33, 422.91 and 422.111 may be refunded to the taxpayer or credited to the estimated tax of the taxpayer for the following year.

52.7(3) *Research activities credit for tax years beginning in 2000.* Effective for tax years beginning on or after January 1, 2000, the taxes imposed for corporate income tax purposes will be reduced by a tax credit for increasing research activities.

a. The credit equals the sum of the following:

(1) Six and one-half percent of the excess of qualified research expenses during the tax year over the base amount for the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities.

(2) Six and one-half percent of the basic research payments determined under Section 41(e)(1)(A) of the Internal Revenue Code during the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities.

The state's apportioned share of the qualifying expenditures for increasing research activities is a percent equal to the ratio of qualified research expenditures in this state to total qualified research expenditures.

b. In lieu of the credit computed under paragraph 52.7(3)*"a,"* a taxpayer may elect to compute the credit amount for qualified research expenses incurred in this state in a manner consistent with the alternative incremental credit described in Section 41(c)(4) of the Internal Revenue Code for tax years

beginning on or after January 1, 2000, but beginning before January 1, 2010. The taxpayer may make this election regardless of the method used by the taxpayer on the taxpayer's federal income tax return. The election made under this paragraph is for the tax year and the taxpayer may use another method or this same method for any subsequent tax year.

For purposes of this alternative incremental research credit computation, the credit percentages applicable to qualified research expenses described in clauses (i), (ii), and (iii) of Section 41(c)(4)(A) of the Internal Revenue Code are 1.65 percent, 2.20 percent, and 2.75 percent, respectively.

c. In lieu of the credit computed under paragraph 52.7(3)*"a,"* a taxpayer may elect to compute the credit amount for qualified research expenses incurred in this state in a manner consistent with the alternative simplified credit described in Section 41(c)(5) of the Internal Revenue Code for tax years beginning on or after January 1, 2010. The taxpayer may make this election regardless of the method used by the taxpayer on the taxpayer's federal income tax return. The election made under this paragraph is for the tax year, and the taxpayer may use another method or this same method for any subsequent tax year.

For purposes of this alternative simplified research credit computation, the credit percentages applicable to qualified research expenses described in Section 41(c)(5)(A) and clause (ii) of Section 41(c)(5)(B) of the Internal Revenue Code are 4.55 percent and 1.95 percent, respectively.

d. For purposes of this subrule, the terms "base amount," "basic research payment," and "qualified research expense" mean the same as defined for the federal credit for increasing research activities under Section 41 of the Internal Revenue Code, except that, for purposes of the alternative incremental credit described in paragraph 52.7(3)*"b"* and the alternative simplified credit described in paragraph 52.7(3)*"c,"* such amounts are limited to research activities conducted within this state. For purposes of this rule, "Internal Revenue Code" means the Internal Revenue Code in effect on January 1, 2011.

e. A shareholder in an S corporation may claim the pro-rata share of the Iowa credit for increasing research activities on the shareholder's individual return. The S corporation must provide each shareholder with a schedule showing the computation of the corporation's Iowa credit for increasing research activities and the shareholder's pro-rata share. The shareholder's pro-rata share of the Iowa credit for increasing research activities must be in the same ratio as the shareholder's pro-rata share in the earnings of the S corporation.

Any research credit in excess of the corporation's tax liability less the credits authorized in Iowa Code sections 422.33, 422.91 and 422.111 may be refunded to the taxpayer or credited to the estimated tax of the corporation for the following year.

52.7(4) *Research activities credit for an eligible business.* Effective for tax years beginning on or after January 1, 2000, an eligible business may claim a tax credit for increasing research activities in this state during the period the eligible business is participating in the new jobs and income program with the Iowa department of economic development. An eligible business must meet all the conditions listed under Iowa Code section 15.329, which include requirements to make an investment of $10 million as indexed for inflation and the creation of a minimum of 50 full-time positions. The research credit authorized in this subrule is in addition to the research activities credit described in 701—subrule 42.11(3) or the research credit described in subrule 52.7(3).

a. The additional research activities credit for an eligible business is computed under the criteria for computing the research activities credit under 701—subrule 42.11(3) or under subrule 52.7(3), depending on which of those subrules the initial research credit was computed. The same qualified research expenses and basic research expenses apply in computation of the research credit for an eligible business as were applicable in computing the credit in 701—subrule 42.11(3) or 52.7(3). In addition, if the alternative incremental credit method was used to compute the initial research credit under 701—subrule 42.11(3) or 52.7(3), that method would be used to compute the research credit for an eligible business. Therefore, if a taxpayer that met the qualifications of an eligible business had a research activities credit of $200,000 as computed under subrule 52.7(3), the research activities credit for the eligible business would result in an additional credit for the taxpayer of $200,000.

b. If the eligible business is a partnership, S corporation, limited liability company, estate or trust where the income from the eligible business is taxed to the individual owners of the business, these

individual owners may claim the additional research activities credit allowed to the eligible business. The research credit is allocated to each of the individual owners of the eligible business on the basis of the pro-rata share of that individual's earnings from the eligible business.

52.7(5) *Corporate tax research credit for increasing research activities within an enterprise zone.* Effective for tax years beginning on or after January 1, 2000, for awards made by the Iowa department of economic development prior to July 1, 2010, the taxes imposed for corporate income tax purposes will be reduced by a tax credit for increasing research activities within an area designated as an enterprise zone. This credit for increasing research activities is in lieu of the research activities credit described in 701—subrule 42.11(3) or the research activities credit described in subrule 52.7(3). For the amount of the credit for increasing research activities within an enterprise zone for awards made by the economic development authority on or after July 1, 2010, see subrule 52.7(6).

a. The credit equals the sum of the following:

(1) Thirteen percent of the excess of qualified research expenses during the tax year over the base amount for the tax year based upon the state's apportioned share of the qualifying expenditures for research activities.

(2) Thirteen percent of the basic research payments determined under Section 41(e)(1)(A) of the Internal Revenue Code during the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities. The state's apportioned share of the qualifying expenditures for increasing research activities is a percent equal to the ratio of qualified research expenditures in the enterprise zone to total qualified research expenditures.

b. In lieu of the credit computed under paragraph 52.7(5)*"a,"* a taxpayer may elect to compute the credit amount for qualified research expenses incurred in the enterprise zone in a manner consistent with the alternative incremental credit described in Section 41(c)(4) of the Internal Revenue Code for tax years beginning prior to January 1, 2010. The taxpayer may make this election regardless of the method used by the taxpayer on the taxpayer's federal income tax return. The election made under this paragraph is for the tax year and the taxpayer may use another method or this same method for any subsequent tax year. For purposes of this alternative research credit computation, the credit percentages applicable to qualified research expenses described in clauses (i), (ii), and (iii) of Section 41(c)(4)(A) of the Internal Revenue Code are 3.30 percent, 4.40 percent, and 5.50 percent, respectively.

c. In lieu of the credit computed under paragraph 52.7(5)*"a,"* a taxpayer may elect to compute the credit amount for qualified research expenses incurred in the enterprise zone in a manner consistent with the alternative simplified credit described in Section 41(c)(5) of the Internal Revenue Code for tax years beginning on or after January 1, 2010. The taxpayer may make this election regardless of the method used by the taxpayer on the taxpayer's federal income tax return. The election made under this paragraph is for the tax year and the taxpayer may use another method or this same method for any subsequent tax year. For purposes of this alternative research credit computation, the credit percentages applicable to qualified research expenses described in Section 41(c)(5)(A) and clause (ii) of Section 41(c)(5)(B) are 9.10 percent and 3.90 percent, respectively.

d. For purposes of this subrule, the terms "base amount," "basic research payment," and "qualified research expense" mean the same as defined for the federal credit for increasing research activities under Section 41 of the Internal Revenue Code, except that, for purposes of the alternative incremental credit described in paragraph 52.7(3)*"b"* and the alternative simplified credit described in paragraph 52.7(3)*"c"* of this rule, such amounts are limited to research activities conducted within the enterprise zone. For purposes of this rule, "Internal Revenue Code" means the Internal Revenue Code in effect on January 1, 2011.

e. Any research credit in excess of the corporation's tax liability for the taxable year may be refunded to the taxpayer or credited to the corporation's tax liability for the following year.

52.7(6) *Research activities credit for awards made by the Iowa department of economic development on or after July 1, 2010.* For eligible businesses approved under the enterprise zone program by the Iowa department of economic development when an award is made on or after July 1, 2010, the taxes imposed for corporate income tax purposes will be reduced by a tax credit for increasing research activities within an area designated as an enterprise zone. This credit for increasing research activities is in lieu of the

research activities credit described in 701—subrule 42.11(3) or the research activities credit described in subrule 52.7(3). The amount of the credit depends upon the gross revenues of the eligible business.

a. The credit equals the sum of the following for eligible businesses with gross revenues of less than $20 million.

(1) Sixteen and one-half percent of the excess of qualified research expenses during the tax year over the base amount for the tax year based upon the state's apportioned share of the qualifying expenditures for research activities.

(2) Sixteen and one-half percent of the basic research payments determined under Section 41(e)(1)(A) of the Internal Revenue Code during the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities. The state's apportioned share of the qualifying expenditures for increasing research activities is a percentage equal to the ratio of qualified research expenditures in the enterprise zone to total qualified research expenditures.

b. The credit equals the sum of the following for eligible businesses with gross revenues of $20 million or more.

(1) Nine and one-half percent of the excess of qualified research expenses during the tax year over the base amount for the tax year based upon the state's apportioned share of the qualifying expenditures for research activities.

(2) Nine and one-half percent of the basic research payments determined under Section 41(e)(1)(A) of the Internal Revenue Code during the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities. The state's apportioned share of the qualifying expenditures for increasing research activities is a percentage equal to the ratio of qualified research expenditures in the enterprise zone to total qualified research expenditures.

c. In lieu of the credit computed under paragraphs 52.7(6)*"a"* and *"b,"* a taxpayer may elect to compute the credit amount for qualified research expenses incurred in the enterprise zone in a manner consistent with the alternative simplified credit described in Section 41(c)(5) of the Internal Revenue Code. The taxpayer may make this election regardless of the method used by the taxpayer on the taxpayer's federal income tax return. The election made under this paragraph is for the tax year and the taxpayer may use another method or this same method for any subsequent tax year. For purposes of this alternative research credit computation, the credit percentages applicable to qualified research expenses described in Section 41(c)(5)(A) and clause (ii) of Section 41(c)(5)(B) of the Internal Revenue Code depend upon the gross revenues of the eligible business.

(1) The percentages are 7 percent and 3 percent, respectively, for eligible businesses with gross revenues of less than $20 million.

(2) The percentages are 2.1 percent and 0.9 percent, respectively, for eligible businesses with gross revenues of $20 million or more.

d. For purposes of this subrule, the terms "base amount," "basic research payment," and "qualified research expense" mean the same as defined for the federal credit for increasing research activities under Section 41 of the Internal Revenue Code, except that, for purposes of the alternative simplified credit described in paragraph 52.7(3)*"c"* of this rule, such amounts are limited to research activities conducted within the enterprise zone. For purposes of this rule, "Internal Revenue Code" means the Internal Revenue Code in effect on January 1, 2011.

e. Any research credit in excess of the corporation's tax liability for the taxable year may be refunded to the taxpayer or credited to the corporation's tax liability for the following year.

52.7(7) *Reporting of research activities credit claims.* Beginning with research activities credit claims filed on or after July 1, 2009, the department shall issue an annual report to the general assembly of all research activities credit claims in excess of $500,000. The report, which is due by February 15 of each year, will contain the name of each claimant and the amount of the research activities credit for all claims filed during the previous calendar year in excess of $500,000.

This rule is intended to implement Iowa Code section 422.33 as amended by 2011 Iowa Acts, Senate File 512.

[**ARC 8589B**, IAB 3/10/10, effective 4/14/10; **ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 9820B**, IAB 11/2/11, effective 12/7/11]

701—52.8(422) New jobs credit. A tax credit is available to a corporation which has entered into an agreement under Iowa Code chapter 260E and has increased employment by at least 10 percent.

52.8(1) *Definitions.*

a. The term *"new jobs"* means those jobs directly resulting from a project covered by an agreement authorized by Iowa Code chapter 260E (Iowa Industrial New Jobs Training Act) but does not include jobs of recalled workers or replacement jobs or other jobs that formerly existed in the industry in the state.

b. The term *"jobs directly related to new jobs"* means those jobs which directly support the new jobs but does not include in-state employees transferred to a position which would be considered to be a job directly related to new jobs unless the transferred employee's vacant position is filled by a new employee.

EXAMPLE A. A taxpayer who has entered into a chapter 260E agreement to train new employees for a new product line transfers an in-state employee to be supervisor of the new product line but does not fill the transferred employee's position. The new supervisor's position would not be considered a job directly related to new jobs even though it directly supports the new jobs because the transferred employee's old position was not refilled.

EXAMPLE B. A taxpayer who has entered into a chapter 260E agreement to train new employees for a new product line transfers an in-state employee to be supervisor of the new product line and fills the transferred employee's position with a new employee. The new supervisor's position would be considered a job directly related to new jobs because it directly supports the new jobs and the transferred employee's old position was filled by a new employee.

The burden of proof that a job is directly related to new jobs is on the taxpayer.

c. The term *"taxable wages"* means those wages upon which an employer is required to contribute to the state unemployment fund as defined in Iowa Code subsection 96.19(37) for the year in which the taxpayer elects to take the new jobs tax credit. For fiscal-year taxpayers, "taxable wages" shall not be greater than the maximum wage upon which an employer is required to contribute to the state unemployment fund for the calendar year in which the taxpayer's fiscal year begins.

d. The term *"agreement"* means an agreement entered into under Iowa Code chapter 260E after July 1, 1985, an amendment to that agreement, or an amendment to an agreement entered into before July 1, 1985, if the amendment sets forth the base employment level as of the date of the amendment. The term "agreement" also includes a preliminary agreement entered into under Iowa Code chapter 260E provided the preliminary agreement contains all the elements of a contract and includes the necessary elements and commitment relating to training programs and new jobs.

e. The term *"base employment level"* means the number of full-time jobs an industry employs at a plant site which is covered by an agreement under chapter 260E on the date of the agreement.

f. The term *"project"* means a training arrangement which is the subject of an agreement entered into under Iowa Code chapter 260E.

g. The term *"industry"* means a business engaged in interstate or intrastate commerce for the purpose of manufacturing, processing, or assembling products, conducting research and development, or providing services in interstate commerce, but excludes retail, health or professional services. Industry does not include a business which closes or substantially reduces its operations in one area of the state and relocates substantially the same operation in another area of the state. Industry is a business engaged in the above listed activities rather than the generic definition encompassing all businesses in the state engaged in the same activities. For example, in the meat-packing business, an industry is considered to be a single corporate entity or operating division, rather than the entire meat-packing business in the state.

h. The term *"new employees"* means the same as new jobs or jobs directly related to new jobs.

i. The term *"full-time job"*means any of the following:

(1) An employment position requiring an average work week of 35 or more hours;

(2) An employment position for which compensation is paid on a salaried full-time basis without regard to hours worked; or

(3) An aggregation of any number of part-time or job-sharing employment positions which equal one full-time employment position. For purposes of this subrule each part-time or job-sharing employment position shall be categorized with regard to the average number of hours worked each week as one-quarter, half, three-quarters, or full-time position, as set forth in the following table:

Average Number of Weekly Hours	Category
More than 0 but less than 15	¼
15 or more but less than 25	½
25 or more but less than 35	¾
35 or more	1 (full-time)

52.8(2) *How to compute the credit.* The credit is 6 percent of the taxable wages paid to employees in new jobs or jobs directly related to new jobs for the taxable year in which the taxpayer elects to take the credit.

EXAMPLE 1. A taxpayer enters into an agreement to increase employment by 20 new employees which is greater than 10 percent of the taxpayer's base employment level of 100 employees. In year one of the agreement the taxpayer hires 20 new employees but elects not to take the credit in that year. In year two of the agreement only 18 of the new employees hired in year one are still employed and the taxpayer elects to take the credit. The credit would be 6 percent of the taxable wages of the 18 remaining new employees. In year three of the agreement the taxpayer hires two additional new employees under the agreement to replace the two employees which left in year two and elects to take the credit. The credit would be 6 percent of the taxable wages paid to the two replacement employees. In year four of the agreement three of the employees for which a credit had been taken left employment and three additional employees were hired. No credit is available for these employees. A credit can only be taken one time for each new job or job directly related to a new job.

EXAMPLE 2. A taxpayer operating two plants in Iowa enters into a chapter 260E agreement to train new employees for a new product line at one of the taxpayer's plants. The base employment level on the date of the agreement at plant A is 300 and at plant B is 100. Under the agreement 20 new employees will be trained for plant B which is greater than a 10 percent increase of the base employment level for plant B. In the year in which the taxpayer elects to take the credit, the employment level at plant A is 290 and at plant B is 120. The credit would be 6 percent of the wages of 10 new employees at plant B as 10 new jobs were created by the industry in the state. A credit for the remaining 10 employees can be taken if the employment level at plant A increases back to 300 during the period of time that the credit can be taken.

52.8(3) *When the credit can be taken.* The taxpayer may elect to take the credit in any tax year which either begins or ends during the period beginning with the date of the agreement and ending with the date by which the project is to be completed under the agreement. However, the taxpayer may not take the credit until the base employment level has been exceeded by at least 10 percent.

EXAMPLE: A taxpayer enters into an agreement to increase employment from a base employment level of 200 employees to 225 employees. In year one of the agreement the taxpayer hires 20 new employees which is a 10 percent increase over the base employment level but elects not to take the credit. In year two of the agreement 2 of the new employees leave employment. The taxpayer elects to take the credit which would be 6 percent of the taxable wages of the 18 employees currently employed. In year three the taxpayer hires 7 new employees and elects to take the credit. The credit would be 6 percent of the taxable wages of the seven new employees.

A shareholder in an S corporation may claim the pro-rata share of the Iowa new jobs credit on the shareholder's individual tax return. The S corporation shall provide each shareholder with a schedule showing the computation of the corporation's Iowa new jobs credit and the shareholder's pro-rata share. The shareholder's pro-rata share of the Iowa new jobs credit shall be in the same ratio as the shareholder's pro-rata share in the earnings of the S corporation. All shareholders of an S corporation shall elect to take the Iowa new jobs credit the same year.

Any new jobs credit in excess of the corporation's tax liability less the credits authorized in Iowa Code sections 422.33, 422.91, and 422.110 may be carried forward for ten years or until it is used, whichever is the earliest.

This rule is intended to implement Iowa Code section 422.33.

701—52.9(422) Seed capital income tax credit. Rescinded IAB 3/6/02, effective 4/10/02.

701—52.10(15) New jobs and income program tax credits. For tax years ending after May 1, 1994, for programs approved after May 1, 1994, but before July 1, 2005, an investment tax credit under Iowa Code section 15.333 and an additional research activities credit under Iowa Code section 15.335 are available to an eligible business. The new jobs and income program was repealed on July 1, 2005, and has been replaced with the high quality job creation program. See rule 701—52.28(15) for information on the investment tax credit and additional research activities credit under the high quality job creation program. Any investment tax credit and additional research activities credit earned by businesses approved under the new jobs and income program prior to July 1, 2005, remains valid, and can be claimed on tax returns filed after July 1, 2005.

52.10(1) *Definitions:*

a. "Eligible business" means a business meeting the conditions of Iowa Code section 15.329.

b. "Improvements to real property" includes the cost of utility lines, drilling wells, construction of sewage lagoons, parking lots and permanent structures. The term does not include temporary structures.

c. "Machinery and equipment" means machinery used in manufacturing establishments and computers except point-of-sale equipment as defined in Iowa Code section 427A.1. The term does not include computer software.

d. "New investment directly related to new jobs created by the location or expansion of an eligible business under the program" means the cost of machinery and equipment purchased for use in the operation of the eligible business which has been depreciated in accordance with generally accepted accounting principles and the cost of improvements to real property.

For the cost of improvements to real property to be eligible for an investment tax credit, the improvements to real property must have received an exemption from property taxes under Iowa Code section 15.332. Replacement machinery and equipment and additional improvements to real property placed in service during the period of property tax exemption by an eligible business qualify for an investment tax credit.

For tax years beginning on or after January 1, 2001, the requirement that the improvements to real property must have received an exemption from property taxes under Iowa Code section 15.332 has been eliminated.

52.10(2) *Investment tax credit.* An investment tax credit of up to 10 percent of the new investment which is directly related to new jobs created by the location or expansion of an eligible business is available. The credit is available for machinery and equipment or improvements to real property placed in service after May 1, 1994. The credit is to be taken in the year the qualifying asset is placed in service. For business applications received on or after July 1, 1999, for purposes of the investment tax credit claimed under Iowa Code section 15.333, the cost of land and any buildings and structures located on the land will be considered to be a new investment which is directly related to new jobs for purposes of determining the amount of new investment upon which an investment tax credit may be taken.

For eligible businesses approved by the Iowa department of economic development on or after March 17, 2004, certain lease payments made by eligible businesses to a third-party developer will be considered to be new investment for purposes of computing the investment tax credit. The eligible business shall enter into a lease agreement with the third-party developer for a minimum of ten years. The investment tax credit is based on the annual base rent paid to a third-party developer by the eligible business for a period not to exceed ten years. The total costs of the annual base rent payments for the ten-year period cannot exceed the cost of the land and the third-party developer's cost to build or renovate the building used by the eligible business. The annual base rent is defined as the total lease payment less taxes, insurance and operating and maintenance expenses.

If an eligible business fails to maintain the requirements of the new jobs and income program, the taxpayer may be required to repay all or a portion of the tax incentives taken on Iowa returns. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the tax credits may have expired, the department may proceed to collect the tax incentives forfeited by failure to maintain the requirements of the new jobs and income program because this is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability.

If the eligible business, within five years of purchase, sells, disposes of, razes, or otherwise renders unusable all or a part of the land, buildings, or other existing structures for which tax credit was claimed under this subrule, the income tax liability of the eligible business for the year in which all or part of the property is sold, disposed of, razed, or otherwise rendered unusable shall be increased by one of the following amounts:

a. One hundred percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within one full year after being placed in service.

b. Eighty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within two full years after being placed in service.

c. Sixty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within three full years after being placed in service.

d. Forty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within four full years after being placed in service.

e. Twenty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within five full years after being placed in service.

Any credit in excess of the tax liability for the tax year may be carried forward seven years or until used, whichever is the earlier.

If the business is a partnership, S corporation, limited liability company, or an estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

52.10(3) *Research activities credit.* An additional research activities credit of 6½ percent of the state's apportioned share of "qualifying expenditures" is available to an eligible business. The credit is available for qualifying expenditures incurred after May 1, 1994. The additional research activities credit is in addition to the credit set forth in Iowa Code section 422.33(5).

See rule 701—52.7(422) for the computation of the research activities credit.

See also subrule 52.7(3) for the computation of the research activities credit for tax years beginning on or after January 1, 2000, and subrule 52.7(4) for the research activities credit for an eligible business for tax years beginning on or after January 1, 2000.

Any credit in excess of the tax liability for the tax year may be carried forward seven years or until used, whichever is the earlier. This is in contrast to the research activities credit in Iowa Code section 422.33(5) where any credit in excess of the tax liability for the tax year may be carried forward until used or refunded. For tax years ending on or after July 1, 1996, the additional research activities credit may at the option of the taxpayer be refunded.

If the business is a partnership, S corporation, limited liability company, or an estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

52.10(4) *Investment tax credit—value-added agricultural products.* For tax years beginning on or after July 1, 2001, an eligible business whose project primarily involves the production of value-added agricultural products may elect to receive a refund for all or a portion of an unused investment credit. For tax years beginning on or after July 1, 2001, but before July 1, 2003, an eligible business includes a cooperative described in Section 521 of the Internal Revenue Code which is not required to file an Iowa corporation tax return, and whose project primarily involves the production of ethanol. For tax years beginning on or after July 1, 2003, an eligible business includes a cooperative described in Section 521 of the Internal Revenue Code which is not required to file an Iowa corporation income tax return.

Eligible businesses that elect to receive a refund shall apply to the Iowa department of economic development for tax credit certificates between May 1 and May 15 of each fiscal year through the fiscal year ending June 30, 2009. The election to receive a refund of all or a portion of an unused investment tax credit is no longer available beginning with the fiscal year ending June 30, 2010. Only those businesses that have completed projects before the May 1 filing date may apply for a tax credit certificate. The Iowa department of economic development will not issue tax credit certificates for more than $4 million during a fiscal year. If applications are received for more than $4 million, the applicants shall receive certificates for a prorated amount.

The Iowa department of economic development will issue tax credit certificates within a reasonable period of time. Tax credit certificates are valid for the tax year following project completion. The tax credit certificate must be attached to the tax return for the tax year during which the tax credit is claimed. The tax credit certificate shall not be transferred, except for a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return and whose project primarily involves the production of ethanol for tax years beginning on or after January 1, 2002, or for a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return for tax years beginning on or after July 1, 2003.

For value-added agricultural projects for cooperatives that are not required to file an Iowa income tax return because they are exempt from federal income tax, the cooperative must submit a list of its members and the share of each member's interest in the cooperative. The Iowa department of economic development will issue a tax credit certificate to each member on the list.

For tax years beginning on or after January 1, 2002, but before July 1, 2003, a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return and whose project primarily involves the production of ethanol may elect to transfer all or a portion of its tax credit to its members. For tax years beginning on or after July 1, 2003, a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return may elect to transfer all or a portion of its tax credit to its members. The amount of tax credit transferred and claimed by a member shall be based upon the pro-rata share of the member's earnings in the cooperative. The Iowa department of economic development will issue a tax credit certificate to each member of the cooperative to whom the credit was transferred provided that tax credit certificates which total no more than $4 million are issued during a fiscal year.

The following nonexclusive examples illustrate how this subrule applies:

EXAMPLE 1. Corporation A completes a value-added agricultural project in October 2001 and has an investment tax credit of $1 million. Corporation A is required to file an Iowa income tax return but expects no tax liability for the year ending December 31, 2001. Thus, Corporation A applies for a tax credit certificate for the entire unused credit of $1 million in May 2002. The entire $1 million is approved by the Iowa department of economic development, so the tax credit certificate is attached to the tax return for the year ending December 31, 2002. Corporation A will request a refund of $1 million on this tax return.

EXAMPLE 2. Corporation B completes a value-added agricultural project in October 2001 and has an investment tax credit of $1 million. Corporation B is required to file an Iowa income tax return but expects no tax liability for the year ending December 31, 2001. Thus, Corporation B applies for a tax credit of $1 million in May 2002. Due to the proration of available credits, Corporation B is awarded a tax credit certificate for $400,000. The tax credit certificate is attached to the tax return for the year ending December 31, 2002. Corporation B will request a refund of $400,000 on this tax return. The remaining $600,000 of unused credit can be carried forward for the following seven tax years or until the credit is depleted, whichever occurs first. If Corporation B expects no tax liability for the tax period ending December 31, 2002, Corporation B may apply for a tax credit certificate in May 2003 for this $600,000 amount.

EXAMPLE 3. Corporation C completes a value-added agricultural project in March 2002 and has an investment tax credit of $1 million. Corporation C is required to file an Iowa income tax return and expects a tax liability of $200,000 for the tax period ending December 31, 2002. Thus, Corporation C applies for a tax credit certificate for the unused credit of $800,000 in May 2002. A tax credit certificate

is awarded for the entire $800,000. The tax credit certificate for $800,000 shall be attached to the tax return for the period ending December 31, 2003, since the certificate is not valid until the year following the project's completion. The tax return for the period ending December 31, 2002, reports a tax liability of $150,000. The investment credit is limited to $150,000 for the period ending December 31, 2002, and the remaining $50,000 can be carried forward for the following seven tax years.

EXAMPLE 4. Corporation D is a cooperative described in Section 521 of the Internal Revenue Code that completes a project involving ethanol in August 2002. Corporation D has an investment tax credit of $500,000. Corporation D is not required to file an Iowa income tax return because Corporation D is exempt from federal income tax. When filing for the tax credit certificate in May 2003 for the $500,000 unused credit, Corporation D must attach a list of its members and the share of each member's interest in the cooperative. The Iowa department of economic development will issue tax credit certificates to each member on the list based on each member's interest in the cooperative. The members can attach the tax credit certificate to their Iowa income tax returns for the year ending December 31, 2003, since the certificate is not valid until the year following project completion.

EXAMPLE 5. Corporation E is a cooperative described in Section 521 of the Internal Revenue Code that completes a project involving ethanol in August 2002. Corporation E has an investment tax credit of $500,000. Corporation E is required to file an Iowa income tax return because Corporation E is not exempt from federal income tax. Corporation E expects a tax liability of $100,000 on its Iowa income tax return for the year ending December 31, 2002. Corporation E applies for a tax credit certificate for the unused credit of $400,000 and elects to transfer the $400,000 unused credit to its members. When applying for the tax credit certificate in May 2003, Corporation E must provide a list of its members and the pro rata share of each member's earnings in the cooperative. The Iowa department of economic development will issue tax credit certificates to each member of the cooperative. The members can attach the tax credit certificate to their Iowa income tax returns for the year ending December 31, 2003, since the certificate is not valid until the year following project completion.

EXAMPLE 6. Corporation F is a cooperative described in Section 521 of the Internal Revenue Code that completes a project involving ethanol in August 2002. Corporation F is a limited liability company that files a partnership return for federal income tax purposes. Corporation F is required to file an Iowa partnership return because Corporation F is not exempt from federal income tax. Corporation F has an investment tax credit of $500,000 which must be claimed by the individual partners of the partnership based on their pro-rata share of individual earnings of the partnership. Corporation F expects a tax liability of $200,000 for the individual partners. Corporation F may apply for a tax credit certificate in May 2003 for the unused credit of $300,000. Corporation F must list the names of each partner and the ownership interest of each partner in order to allocate the investment credit for each partner. The tax credit certificate may be claimed on the partner's Iowa income tax return for the period ending December 31, 2003.

52.10(5) *Corporate tax credit—certain sales taxes paid by developer.* For eligible businesses approved by the Iowa department of economic development on or after March 17, 2004, the eligible business may claim a corporate tax credit for certain sales taxes paid by a third-party developer.

a. Sales taxes eligible for the credit. The sales taxes paid by the third-party developer which are eligible for this credit include the following:

(1) Iowa sales and use tax for gas, electricity, water, or sewer utility services, goods, wares, or merchandise, or on services rendered to, furnished to or performed for a contractor or subcontractor and used in the fulfillment of a written contract relating to the construction or equipping of a facility within the economic development area.

(2) Iowa sales and use tax paid for racks, shelving, and conveyor equipment to be used in a warehouse or distribution center within the economic development area.

Any Iowa sales and use tax paid relating to intangible property, furniture and other furnishings is not eligible for the corporate tax credit.

b. How to claim the credit. The third-party developer must provide to the Iowa department of economic development the amount of Iowa sales and use tax paid as described in paragraph *"a."* Beginning on July 1, 2009, this information must be provided to the Iowa department of revenue. The

amount of Iowa sales and use tax attributable to racks, shelving, and conveyor equipment must be identified separately.

The Iowa department of economic development will issue a tax credit certificate to the eligible business equal to the Iowa sales and use tax paid by the third-party developer for gas, electricity, water, or sewer utility services, goods, wares, or merchandise, or on services rendered to, furnished to or performed for a contractor or subcontractor and used in the fulfillment of a written contract relating to the construction or equipping of a facility. In addition, the Iowa department of economic development will also issue a separate tax credit certificate to the eligible business equal to the Iowa sales and use tax paid by the third-party developer for racks, shelving, and conveyor equipment to be used in a warehouse or distribution center. Beginning on July 1, 2009, the Iowa department of revenue shall issue these tax credit certificates.

The tax credit certificate shall contain the name, address, and tax identification number of the eligible business, along with the amount of the tax credit and the year in which the tax credit can be claimed. The tax credit certificate must be attached to the taxpayer's income tax return for the tax year for which the tax credit is claimed. Any tax credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following seven years or until it is used, whichever is the earlier.

For the tax credit certificate relating to Iowa sales and use tax paid by the third-party developer for racks, shelving, and conveyor equipment, the aggregate amount of tax credit certificates and tax refunds for Iowa sales and use tax paid for racks, shelving, and conveyor equipment to eligible businesses under the new jobs and income program, enterprise zone program and new capital investment program cannot exceed $500,000 in a fiscal year. The requests for tax credit certificates or refunds will be processed in the order they are received on a first-come, first-served basis until the amount of credits authorized for issuance has been exhausted. If applications for tax credit certificates or refunds exceed the $500,000 limitation for any fiscal year, the applications shall be considered in succeeding fiscal years.

This rule is intended to implement Iowa Code sections 15.331C, 15.333 as amended by 2010 Iowa Acts, Senate File 2380, and 15.335.

[**ARC 8605B**, IAB 3/10/10, effective 4/14/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—52.11(422) Refunds and overpayments.

52.11(1) to **52.11(6)** Reserved.

52.11(7) *Computation of interest on refunds resulting from net operating losses or net capital losses for tax years or periods beginning on or after January 1, 1974.* Rescinded IAB 11/24/04, effective 12/29/04.

52.11(8) *Computation of interest on refunds resulting from net operating losses or net capital losses for tax years or periods beginning on or after January 1, 1974, and ending on or after July 1, 1980.* Rescinded IAB 11/24/04, effective 12/29/04.

52.11(9) *Computation of interest on refunds resulting from net operating losses or net capital losses for tax years ending on or after April 30, 1981.* Rescinded IAB 11/24/04, effective 12/29/04.

52.11(10) *For refund claims received by the department after June 11, 1984.* If the amount of tax is reduced as a result of a net operating loss or net capital loss, interest shall accrue on the refund resulting from the loss carryback beginning on the date a claim for refund or amended return carrying back the net operating loss or net capital loss is filed with the department or the first day of the second calendar month following the actual payment date, whichever is later.

52.11(11) *Overpayment—interest accruing before July 1, 1980.* Rescinded IAB 11/24/04, effective 12/29/04.

52.11(12) *Interest commencing on or after January 1, 1982.* See rule 701—10.2(421) regarding the rate of interest charged by the department on delinquent taxes and the rate paid by the department on refunds commencing on or after January 1, 1982.

52.11(13) *Overpayment—interest accruing on or after July 1, 1980, and before April 30, 1981.* Rescinded IAB 11/24/04, effective 12/29/04.

52.11(14) *Overpayment—interest accruing on overpayments resulting from returns due on or after April 30, 1981.* If the amount of tax determined to be due by the department is less than the amount paid, the excess to be refunded will accrue interest from the first day of the second calendar month following the date of payment or the date the return was due to be filed or was filed, whichever is the later.

This rule is intended to implement Iowa Code section 422.25.

701—52.12(422) Deduction of credits. The credits against computed tax set forth in Iowa Code sections 422.33 and 422.110 shall be deducted in the following sequence.

1. Franchise tax credit.
2. Disaster recovery housing project tax credit.
3. School tuition organization tax credit.
4. Venture capital tax credits (excluding redeemed Iowa fund of funds tax credit).
5. Endow Iowa tax credit.
6. Agricultural assets transfer tax credit.
7. Film qualified expenditure tax credit.
8. Film investment tax credit.
9. Redevelopment tax credit.
10. Investment tax credit.
11. Wind energy production tax credit.
12. Renewable energy tax credit.
13. Redeemed Iowa fund of funds tax credit.
14. New jobs tax credit.
15. Economic development region revolving fund tax credit.
16. Charitable conservation contribution tax credit.
17. Alternative minimum tax credit.
18. Historic preservation and cultural and entertainment district tax credit.
19. Corporate tax credit for certain sales tax paid by developer.
20. Ethanol blended gasoline tax credit or ethanol promotion tax credit.
21. Research activities tax credit.
22. Assistive device tax credit.
23. Motor fuel credit.
24. Wage-benefits tax credit.
25. Soy-based cutting tool oil tax credit.
26. Refundable portion of investment tax credit, as provided in subrule 52.10(4).
27. E-85 gasoline promotion tax credit.
28. Biodiesel blended fuel tax credit.
29. Soy-based transformer fluid tax credit.
30. E-15 plus gasoline promotion tax credit.
31. Estimated tax and payment with vouchers.

This rule is intended to implement Iowa Code sections 15.333, 15.335, 422.33, 422.91 and 422.110.

[**ARC 8589B**, IAB 3/10/10, effective 4/14/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—52.13(422) Livestock production credits. For rules relating to the livestock production income tax credit refunds see rule 701—43.8(422).

This rule is intended to implement 1996 Iowa Acts, chapter 1197, sections 19, 20, and 21.

701—52.14(15E) Enterprise zone tax credits. For tax years ending after July 1, 1997, for programs approved after July 1, 1997, a business which qualifies under the enterprise zone program is eligible to receive tax credits. An eligible business under the enterprise zone program must be approved by the Iowa department of economic development and meet the requirements of Iowa Code section 15E.193. The administrative rules for the enterprise zone program for the Iowa department of economic development may be found at 261—Chapter 59.

52.14(1) *Supplemental new jobs credit from withholding.* An eligible business approved under the enterprise zone program is allowed the supplemental new jobs credit from withholding as provided in 701—subrule 46.9(1).

52.14(2) *Investment tax credit.* An eligible business approved under the enterprise zone program is allowed an investment tax credit of up to 10 percent of the new investment which is directly related to new jobs created by the location or expansion of the eligible business.

The provisions under the new jobs and income program for the investment tax credit described in rule 701—52.10(15) are applicable to the enterprise zone program with the following exceptions:

a. The corporate tax credit for certain sales taxes paid by a developer described in subrule 52.10(5) does not apply for the enterprise zone program.

b. For projects approved on or after July 1, 2005, under the enterprise zone program, the investment tax credit will be amortized over a five-year period, as described in subrule 52.28(2).

c. For tax years ending on or after July 1, 2005, an eligible business approved under the enterprise zone program whose project primarily involves biotechnology-related processes may elect to receive a refund for all or a portion of an unused investment credit as described in subrule 52.10(4).

52.14(3) *Research activities credit.* An eligible business approved under the enterprise zone program is eligible for an additional research activities credit as described in subrules 52.7(5) and 52.7(6).

a. Tax years ending on or after July 1, 2005, but before July 1, 2009. For eligible businesses approved under the enterprise zone program, research activities allowable for the Iowa research activities credit include expenses related to the development and deployment of innovative renewable energy generation components manufactured or assembled in Iowa; such expenses related to the development and deployment of innovative renewable energy generation components are not eligible for the federal credit for increasing research activities. For purposes of this subrule, innovative renewable energy generation components do not include components with more than 200 megawatts in installed effective nameplate capacity. The research activities credit related to renewable energy generation components under the enterprise zone program and the high quality job creation program described in subrule 52.28(1) shall not exceed $1 million in the aggregate.

These expenses related to the development and deployment of innovative renewable energy generation components are applicable only to the additional research activities credit set forth in subrule 52.7(5) for businesses in enterprise zones and the additional research activities credit set forth in subrule 52.28(1) for businesses approved under the high quality job creation program, and are not applicable to the research activities credit set forth in subrule 52.7(3).

b. Tax years ending on or after July 1, 2009. For eligible businesses approved under the enterprise zone program, research activities allowable for the Iowa research activities credit include expenses related to the development and deployment of innovative renewable energy generation components manufactured or assembled in Iowa; such expenses related to the development and deployment of innovative renewable energy generation components are not eligible for the federal credit for increasing research activities.

(1) For purposes of this paragraph, innovative renewable energy generation components do not include components with more than 200 megawatts in installed effective nameplate capacity.

(2) The research activities credit related to renewable energy generation components under the enterprise zone program and the high quality jobs program described in subrule 52.28(1) shall not exceed $2 million for the fiscal year ending June 30, 2010, and $1 million for the fiscal year ending June 30, 2011.

(3) These expenses related to the development and deployment of innovative renewable energy generation components are applicable only to the additional research activities credit set forth in subrule 52.7(5) for businesses in enterprise zones and the additional research activities credit set forth in subrule 52.40(1) for businesses approved under the high quality jobs program, and are not applicable to the research activities credit set forth in subrule 52.7(3).

52.14(4) *Repayment of incentives.* Effective July 1, 2003, eligible businesses in an enterprise zone may be required to repay all or a portion of the tax incentives received on Iowa returns if the eligible business experiences a layoff of employees in Iowa or closes any of its facilities in Iowa.

This rule is intended to implement Iowa Code section 15E.193 and Supplement section 15E.196.
[**ARC 8589B**, IAB 3/10/10, effective 4/14/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—52.15(15E) Eligible housing business tax credit. A corporation which qualifies as an eligible housing business may receive a tax credit of up to 10 percent of the new investment which is directly related to the building or rehabilitating of homes in an enterprise zone. The tax credit may be taken on the tax return for the tax year in which the home is ready for occupancy.

An eligible housing business is one which meets the criteria in Iowa Code section 15E.193B.

52.15(1) *Computation of tax credit.* New investment which is directly related to the building or rehabilitating of homes includes but is not limited to the following costs: land, surveying, architectural services, building permits, inspections, interest on a construction loan, building materials, roofing, plumbing materials, electrical materials, amounts paid to subcontractors for labor and materials provided, concrete, labor, landscaping, appliances normally provided with a new home, heating and cooling equipment, millwork, drywall and drywall materials, nails, bolts, screws, and floor coverings.

New investment does not include the machinery, equipment, hand or power tools necessary to build or rehabilitate homes.

A taxpayer may claim on the taxpayer's corporation income tax return the pro-rata share of the Iowa eligible housing business tax credit from a partnership, limited liability company, estate, or trust. The portion of the credit claimed by the taxpayer shall be in the same ratio as the taxpayer's pro-rata share of the earnings of the partnership, limited liability company, or estate or trust, except for projects beginning on or after July 1, 2005, which used low-income housing credits authorized under Section 42 of the Internal Revenue Code to assist in the financing of the housing development. For these projects, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder.

Any Iowa eligible housing business tax credit in excess of the corporation's tax liability may be carried forward for seven years or until it is used, whichever is the earlier.

If the eligible housing business fails to maintain the requirements of Iowa Code section 15E.193B, to be an eligible housing business, the taxpayer may be required to repay all or a part of the tax incentives the business received. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the income tax credit may have expired, the department may proceed to collect the tax incentives forfeited by failure to maintain the requirements of Iowa Code section 15E.193B. This is because it is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability.

Prior to January 1, 2001, the tax credit cannot exceed 10 percent of $120,000 for each home or individual unit in a multiple dwelling unit building. Effective January 1, 2001, the tax credit cannot exceed 10 percent of $140,000 for each home or individual unit in a multiple dwelling unit building.

Effective for tax periods beginning on or after January 1, 2003, the taxpayer must receive a tax credit certificate from the Iowa department of economic development to claim the eligible housing business tax credit. The tax credit certificate shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the date the project was completed, the amount of the eligible housing business tax credit and the tax year for which the credit may be claimed. In addition, the tax credit certificate shall include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 52.15(2). The tax credit certificate must be attached to the income tax return for the tax period in which the home is ready for occupancy. The administrative rules for the eligible housing business tax credit for the Iowa department of economic development may be found under 261—Chapter 59.

52.15(2) *Transfer of the eligible housing business tax credit.* For tax periods beginning on or after January 1, 2003, the eligible housing business tax credit certificates may be transferred to any person or entity if low-income housing tax credits authorized under Section 42 of the Internal Revenue Code are used to assist in the financing of the housing development. In addition, the eligible housing business tax

credit certificates may be transferred to any person or entity for projects beginning on or after July 1, 2005, if the housing development is located in a brownfield site as defined in Iowa Code section 15.291, or if the housing development is located in a blighted area as defined in Iowa Code section 403.17. No more than $3 million of tax credits for housing developments located in brownfield sites or blighted areas may be transferred in a calendar year, with no more than $1.5 million being transferred for any one eligible housing business in a calendar year.

Within 90 days of transfer of the tax credit certificate for transfers prior to July 1, 2006, the transferee must submit the transferred tax credit certificate to the Iowa department of economic development, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. For transfers on or after July 1, 2006, the transferee must submit the transferred tax credit certificate to the department of revenue. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee for transfers prior to July 1, 2006, the Iowa department of economic development will issue a replacement tax credit certificate to the transferee. For transfers on or after July 1, 2006, the department of revenue will issue the replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company or S corporation, the transferee shall provide a list of the partners, members or shareholders and information on how the housing business tax credit should be divided among the partners, members or shareholders. The transferee shall also provide the tax identification numbers and addresses of the partners, members or shareholders. The replacement tax credit certificate must contain the same information that was on the original certificate and must have the same expiration date as the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax period for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

This rule is intended to implement Iowa Code Supplement section 15E.193B as amended by 2006 Iowa Acts, chapter 1158.

701—52.16(422) Franchise tax credit. For tax years beginning on or after January 1, 1998, a shareholder in a financial institution as defined in Section 581 of the Internal Revenue Code which has elected to have its income taxed directly to the shareholders may take a tax credit equal to the shareholder's pro-rata share of the Iowa franchise tax paid by the financial institution.

The credit must be computed by recomputing the amount of tax computed under Iowa Code section 422.33 by reducing the shareholder's taxable income by the shareholder's pro-rata share of the items of income and expenses of the financial institution and deducting from the recomputed tax the credits allowed by Iowa Code section 422.33. The recomputed tax must be subtracted from the amount of tax computed under Iowa Code section 422.33 reduced by the credits allowed in Iowa Code section 422.33.

The resulting amount, not to exceed the shareholder's pro-rata share of the franchise tax paid by the financial institution, is the amount of tax credit allowed the shareholder.

This rule is intended to implement Iowa Code section 422.33, as amended by 1999 Iowa Acts, chapter 95.

701—52.17(422) Assistive device tax credit. Effective for tax years beginning on or after January 1, 2000, a taxpayer who is a small business that purchases, rents, or modifies an assistive device or makes workplace modifications for an individual with a disability who is employed or will be employed by the taxpayer may qualify for an assistive device tax credit, subject to the availability of the credit. The assistive device credit is equal to 50 percent of the first $5,000 paid during the tax year by the small business for the purchase, rental, or modification of an assistive device or for making workplace modifications. Any credit in excess of the tax liability may be refunded or applied to the taxpayer's tax liability for the following tax year. If the taxpayer elects to take the assistive device tax credit, the taxpayer is not to deduct for Iowa income tax purposes any amount of the cost of the assistive device or workplace modification that is deductible for federal income tax purposes. A small business will not be

eligible for the assistive device credit if the device is provided for an owner of the small business unless the owner is a bona fide employee of the small business.

52.17(1) *Submitting applications for the credit.* A small business wanting to receive the assistive device tax credit must submit an application for the credit to the Iowa department of economic development and provide other information and documents requested by the Iowa department of economic development. If the taxpayer meets the criteria for qualification for the credit, the Iowa department of economic development will issue the taxpayer a certificate of entitlement for the credit. However, the aggregate amount of assistive device tax credits that may be granted by the Iowa department of economic development to all small businesses during a fiscal year cannot exceed $500,000. The certificate for entitlement of the assistive device credit is to include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the estimated amount of the tax credit, the date on which the taxpayer's application was approved and the date when it is anticipated that the assistive device project will be completed and a space on the application where the taxpayer is to enter the date that the assistive device project was completed. The certificate for entitlement will not be considered to be valid for purposes of claiming the assistive device credit on the taxpayer's Iowa income tax return until the taxpayer has completed the assistive device project and has entered the completion date on the certificate of entitlement form. The tax year of the small business in which the assistive device project is completed is the tax year for which the assistive device credit may be claimed. For example, in a case where taxpayer A received a certificate of entitlement for an assistive device credit on September 15, 2000, and completed the assistive device workplace modification project on January 15, 2001, taxpayer A could claim the assistive device credit on taxpayer A's 2001 Iowa return assuming that taxpayer A is filing returns on a calendar-year basis.

The department of revenue will not allow the assistive device credit on a taxpayer's return if the certificate of entitlement or a legible copy of the certificate is not attached to the taxpayer's income tax return. If the taxpayer has been granted a certificate of entitlement and the taxpayer is an S corporation, where the income of the taxpayer is taxed to the individual owner(s) of the business entity, the taxpayer must provide a copy of the certificate to each of the shareholders with a statement showing how the credit is to be allocated among the individual owners of the S corporation. An individual owner is to attach a copy of the certificate of entitlement and the statement of allocation of the assistive device credit to the individual's state income tax return.

52.17(2) *Definitions.* The following definitions are applicable to this subrule:

"Assistive device" means any item, piece of equipment, or product system which is used to increase, maintain, or improve the functional capabilities of an individual with a disability in the workplace or on the job. "Assistive device" does not mean any medical device, surgical device, or organ implanted or transplanted into or attached directly to an individual. "Assistive device" does not include any device for which a certificate of title is issued by the state department of transportation, but does include any item, piece of equipment, or product system otherwise meeting the definition of "assistive device" that is incorporated, attached, or included as a modification in or to such a device issued a certificate of title.

"Business entity" means partnership, limited liability company, S corporation, estate or trust, where the income of the business is taxed to the individual owners of the business, whether the individual owner is a partner, member, shareholder, or beneficiary.

"Disability" means the same as defined in Iowa Code section 15.102. Therefore, "disability" means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of the individual, a record of physical or mental impairment that substantially limits one or more of the major life activities of the individual, or being regarded as an individual with a physical or mental impairment that substantially limits one or more of the major life activities of the individual. "Disability" does not include any of the following:

1. Homosexuality or bisexuality;
2. Transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders, or other sexual behavior disorders;
3. Compulsive gambling, kleptomania, or pyromania;
4. Psychoactive substance abuse disorders resulting from current illegal use of drugs;

5. Alcoholism.

"Employee" means an individual who is employed by the small business who meets the criteria in Treasury Regulation § 31.3401(c)-1(b), which is the definition of an employee for federal income tax withholding purposes. An individual who receives self-employment income from the small business is not to be considered to be an employee of the small business for purposes of this rule.

"Small business" means that the business either had gross receipts in the tax year before the current tax year of $3 million or less or employed not more than 14 full-time employees during the tax year prior to the current tax year.

"Workplace modifications" means physical alterations to the office, factory, or other work environment where the disabled employee is working or is to work.

52.17(3) *Allocation of credit to owners of a business entity.* If the taxpayer that was entitled to an assistive device credit is a business entity, the business entity is to allocate the allowable credit to each of the individual owners of the entity on the basis of each owner's pro-rata share of the earnings of the entity to the total earnings of the entity. Therefore, if an S corporation has an assistive device credit for a tax year of $2,500 and one shareholder of the S corporation receives 25 percent of the earnings of the corporation, that shareholder would receive an assistive device credit for the tax year of $625 or 25 percent of the total assistive device credit of the S corporation.

This rule is intended to implement Iowa Code section 422.33.

701—52.18(404A,422) Historic preservation and cultural and entertainment district tax credit. A historic preservation and cultural and entertainment district tax credit, subject to the availability of the credit, may be claimed against a taxpayer's Iowa corporate income tax liability for 25 percent of the qualified costs of rehabilitation of property to the extent the costs were incurred on or after July 1, 2000, for the approved rehabilitation projects of eligible property in Iowa. The administrative rules for the historic preservation and cultural and entertainment district tax credit for the historical division of the department of cultural affairs may be found under 223—Chapter 48.

52.18(1) *Eligible property for the historic preservation and cultural and entertainment district tax credit.* The following types of property are eligible for the historic preservation and cultural and entertainment district tax credit:

a. Property verified as listed on the National Register of Historic Places or eligible for such listing.

b. Property designated as of historic significance to a district listed in the National Register of Historic Places or eligible for such designation.

c. Property or district designated a local landmark by a city or county ordinance.

d. Any barn constructed prior to 1937.

52.18(2) *Application and review process for the historic preservation and cultural and entertainment district tax credit.*

a. Taxpayers who want to claim an income tax credit for completing a historic preservation and cultural and entertainment district project must submit an application for approval of the project. The application forms for the historic preservation and cultural and entertainment district tax credit may be requested from the State Tax Credit Program Manager, State Historic Preservation Office, Department of Cultural Affairs, 600 E. Locust, Des Moines, Iowa 50319-0290. The telephone number for this office is (515)281-4137. Applications for the credit will be accepted by the state historic preservation office on or after July 1, 2000, until such time as all the available credits allocated for each fiscal year are encumbered. For fiscal years beginning on or after July 1, 2000, $2.4 million shall be appropriated for historic preservation and cultural and entertainment district tax credits for each year. For the fiscal years beginning July 1, 2005, and July 1, 2006, an additional $4 million of tax credits is appropriated for projects located in cultural and entertainment districts which are certified by the department of cultural affairs. If less than $4 million of tax credits is appropriated during a fiscal year, the remaining amount shall be applied to reserved tax credits for projects not located in cultural and entertainment districts in the order of original reservation by the department of cultural affairs. For the fiscal year beginning July 1, 2007, $10 million in historic preservation and cultural and entertainment district tax credits is available. For the fiscal year beginning July 1, 2008, $15 million in historic preservation and cultural

and entertainment district tax credits is available. For the fiscal year beginning July 1, 2009, through the fiscal year beginning July 1, 2011, $50 million in historic preservation and cultural and entertainment district tax credits is available. The allocation of the $50 million of credits for the fiscal year beginning July 1, 2009, through the fiscal year beginning July 1, 2011, is set forth in rule 223—48.7(303,404A). For fiscal years beginning on or after July 1, 2012, $45 million in historic preservation and cultural and entertainment district tax credits is available. Tax credits shall not be reserved by the department of cultural affairs for more than three years except for tax credits issued for contracts entered into prior to July 1, 2007.

b. For the state fiscal year beginning on July 1, 2009, $20 million of the credits may be claimed on tax returns beginning on or after January 1, 2009, and $30 million of the credits may be claimed on tax returns beginning on or after January 1, 2010. For the state fiscal year beginning July 1, 2010, $20 million of the credits may be claimed on tax returns beginning on or after January 1, 2010, and $30 million of the credits may be claimed on tax returns beginning on or after January 1, 2011. For the state fiscal year beginning July 1, 2011, $20 million of the credits may be claimed on tax returns beginning on or after January 1, 2011, and $30 million of the credits may be claimed on tax returns beginning on or after January 1, 2012.

c. Applicants for the historic preservation and cultural and entertainment district tax credit must include all information and documentation requested on the application forms for the credit in order for the applications to be processed.

d. The state historic preservation office (SHPO) is to establish selection criteria and standards for rehabilitation projects involving eligible property. The approval process is not to exceed 90 days from the date the application is received by SHPO. To the extent possible, the standards used by SHPO are to be consistent with the standards of the United States Secretary of the Interior for rehabilitation of eligible property.

e. Once SHPO approves a particular historic preservation and cultural and entertainment district tax credit project application, the office will encumber an estimated historic preservation and cultural and entertainment district tax credit under the name of the applicant(s) for the year the project is approved.

52.18(3) *Computation of the amount of the historic preservation and cultural and entertainment district tax credit.* The amount of the historic preservation and cultural and entertainment district tax credit is 25 percent of the qualified rehabilitation costs made to eligible property in a project. Qualified rehabilitation costs are those rehabilitation costs approved by SHPO for a project for a particular taxpayer to the extent those rehabilitation costs are actually expended by that taxpayer.

In the case of commercial property, qualified rehabilitation costs must equal at least 50 percent of the assessed value of the property, excluding the value of the land, prior to rehabilitation. In the case of residential property or barns, the qualified rehabilitation costs must equal at least $25,000 or 25 percent of the assessed value, excluding the value of the land, prior to the rehabilitation, whichever amount is less. In computing the tax credit, the only costs which may be included are the qualified rehabilitation costs incurred commencing from the date on which the first qualified rehabilitation cost is incurred and ending with the end of the taxable year in which the property is placed in service. The rehabilitation period may include dates that precede approval of a project, provided that any qualified rehabilitation costs incurred prior to the date of approval of the project must be qualified rehabilitation costs.

For purposes of the historic preservation and cultural and entertainment district tax credit, qualified rehabilitation costs include those costs properly included in the basis of the eligible property for income tax purposes. Costs treated as expenses and deducted in the year paid or incurred and amounts that are otherwise not added to the basis of the property for income tax purposes are not qualified rehabilitation costs. Amounts incurred for architectural and engineering fees, site survey fees, legal expenses, insurance premiums, development fees, and other construction-related costs are qualified rehabilitation costs to the extent they are added to the basis of the eligible property for tax purposes. Costs of sidewalks, parking lots, and landscaping do not constitute qualified rehabilitation costs. Any rehabilitation costs used in the computation of the historic preservation and cultural and entertainment district tax credit are not added to the basis of the property for Iowa income tax purposes if the rehabilitation costs were incurred in a tax year beginning on or after January 1, 2000, but prior to

January 1, 2001. Any rehabilitation costs incurred in a tax year beginning on or after January 1, 2001, are added to the basis of the rehabilitated property for income tax purposes except those rehabilitation costs that are equal to the amount of the computed historic preservation and cultural and entertainment district tax credit for the tax year.

For example, the basis of a commercial building in a historic district was $500,000, excluding the value of the land, before the rehabilitation project. During a project to rehabilitate this building, $600,000 in rehabilitation costs were expended to complete the project and $500,000 of those rehabilitation costs were qualified rehabilitation costs which were eligible for the historic preservation and cultural and entertainment district tax credit of $125,000. Therefore, the basis of the building for Iowa income tax purposes was $975,000, since the qualified rehabilitation costs of $125,000, which are equal to the amount of the historic preservation and cultural and entertainment district tax credit for the tax year, are not added to the basis of the rehabilitated property. The basis of the building for federal income tax purposes was $1,100,000. However, for tax years beginning only in the 2000 calendar year, the basis of the rehabilitated property would have been $600,000, since for those tax periods any qualified rehabilitation costs used to compute the historic preservation and cultural and entertainment district tax credit for the tax year could not be added to the basis of the property. It should be noted that this example does not consider any possible reduced basis for the building for federal income tax purposes due to the rehabilitation investment credit provided in Section 47 of the Internal Revenue Code. If the building in this example were eligible for the federal rehabilitation credit provided in Section 47 of the Internal Revenue Code, the basis of the building for Iowa tax purposes would be reduced accordingly by the same amount as the reduction required for federal tax purposes.

52.18(4) *Completion of the historic preservation and cultural and entertainment district project and claiming the historic preservation and cultural and entertainment district tax credit on the Iowa return.* After the taxpayer completes an authorized rehabilitation project, the taxpayer must get a certificate of completion of the project from the state historic preservation office of the department of cultural affairs. After verifying the taxpayer's eligibility for the historic preservation and cultural and entertainment district tax credit, the state historic preservation office shall issue a historic preservation and cultural and entertainment district tax credit certificate, which shall be attached to the taxpayer's income tax return for the tax year in which the rehabilitation project is completed or the year the credit was reserved, whichever is the later. For example, if a project was completed in 2008 and the credit was reserved for the state fiscal year ending June 30, 2010, the credit can be claimed on the 2009 calendar year return that is due on April 30, 2010. The tax credit certificate is to include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the address or location of the rehabilitation project, the date the project was completed, the year the tax credit was reserved, and the amount of the historic preservation and cultural and entertainment district tax credit. In addition, the tax credit certificate shall include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 52.18(6). In addition, if the taxpayer is a partnership, limited liability company, estate or trust, where the tax credit is allocated to the owners or beneficiaries of the entity, a list of the owners or beneficiaries and the amount of credit allocated to each owner or beneficiary should be provided with the certificate. The tax credit certificate should be attached to the income tax return for the period in which the project was completed. If the amount of the historic preservation and cultural and entertainment district tax credit exceeds the taxpayer's income tax liability for the tax year for which the credit applies, the taxpayer is entitled to a refund of the excess portion of the credit at a discounted value for tax periods ending prior to July 1, 2007. However, the refund cannot exceed 75 percent of the allowable tax credit. The refund of the tax credit is to be computed on the basis of the following table:

Annual Interest Rate	Five-Year Present Value/Dollar Compounded Annually
5%	$.784
6%	$.747
7%	$.713
8%	$.681
9%	$.650
10%	$.621
11%	$.594
12%	$.567
13%	$.543
14%	$.519
15%	$.497
16%	$.476
17%	$.456
18%	$.437

EXAMPLE: The following is an example to show how the table can be used to compute a refund for a taxpayer. An individual has a historic preservation and cultural and entertainment district tax credit of $800,000 for a project completed in 2001. The individual had an income tax liability prior to the credit of $300,000 on the 2001 return, which leaves an excess credit of $500,000. We will assume that the annual interest rate for tax refunds issued by the department of revenue in the 2001 calendar year is 11 percent. Therefore, to compute the five-year present value of the $500,000 excess credit, $500,000 is multiplied by the compound factor for 2001 which is 11 percent or .594 which results in a refund of $297,000.

For tax years ending on or after July 1, 2007, any historic preservation and cultural and entertainment district tax credit in excess of the taxpayer's tax liability is fully refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

52.18(5) *Allocation of historic preservation and cultural and entertainment district tax credits to individual owners of the entity.* When the business entity that has earned a historic preservation and cultural and entertainment district tax credit is an S corporation, partnership, limited liability company, estate or trust where the individual owners of the business entity are taxed on the income of the entity, the historic preservation and cultural and entertainment district tax credit is to be allocated to the individual owners. The business entity is to allocate the historic preservation and cultural and entertainment district tax credit to each individual owner in the same pro-rata basis that the earnings or profits of the business entity are allocated to the owners for projects beginning prior to July 1, 2005. For example, if a shareholder of an S corporation received 25 percent of the earnings of the corporation and the corporation had earned a historic preservation and cultural and entertainment district tax credit, 25 percent of the credit would be allocated to the shareholder.

For projects beginning on or after July 1, 2005, which used low-income housing tax credits authorized under Section 42 of the Internal Revenue Code to assist in the financing of the rehabilitation project, the credit does not have to be allocated based on the pro-rata share of earnings of the partnership, limited liability company or S corporation. For these projects, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder.

52.18(6) *Transfer of the historic preservation and cultural and entertainment district tax credit.* For tax periods beginning on or after January 1, 2003, the historic preservation and cultural and entertainment district tax credit certificates may be transferred to any person or entity. A tax credit certificate of less than $1,000 shall not be transferable.

Within 90 days of transfer of the tax credit certificate for transfers prior to July 1, 2006, the transferee must submit the transferred tax credit certificate to the state historic preservation office of the department of cultural affairs, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. For transfers on or after July 1, 2006, the transferee must submit the transferred tax credit certificate to the department of revenue. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee for transfers prior to July 1, 2006, the state historic preservation office shall issue a replacement tax credit certificate to the transferee. For transfers on or after July 1, 2006, the department of revenue will issue the replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company or S corporation, the transferee shall provide a list of the partners, members or shareholders and information on how the historic preservation and cultural and entertainment district tax credit should be divided among the partners, members or shareholders. The transferee shall also provide the tax identification numbers and addresses of the partners, members or shareholders. The replacement tax credit certificate must contain the same information that was on the original certificate and must have the same expiration date as the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax period for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

If the historic preservation and cultural and entertainment district tax credit of the transferee exceeds the tax liability shown on the transferee's return, the refund shall be discounted as described in subrule 52.18(4) for tax years ending prior to July 1, 2007, just as the refund would have been discounted on the Iowa income tax return of the taxpayer. For tax years ending on or after July 1, 2007, any historic preservation and cultural and entertainment district tax credit of the transferee in excess of the transferee's tax liability is fully refundable.

This rule is intended to implement Iowa Code chapter 404A as amended by 2011 Iowa Acts, Senate Files 517 and 521, and Iowa Code section 422.33.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09; **ARC 8589B**, IAB 3/10/10, effective 4/14/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—52.19(422) Ethanol blended gasoline tax credit. Effective for tax years beginning on or after January 1, 2002, an ethanol blended gasoline tax credit may be claimed against a taxpayer's corporation income tax liability for retail dealers of gasoline. The taxpayer must operate at least one retail motor fuel site at which more than 60 percent of the total gallons of gasoline sold and dispensed through one or more motor fuel pumps by the taxpayer in the tax year is ethanol blended gasoline. The tax credit shall be calculated separately for each retail motor fuel site operated by the taxpayer. The amount of the credit for each eligible retail motor fuel site is two and one-half cents multiplied by the total number of gallons of ethanol blended gasoline sold and dispensed through all motor fuel pumps located at that retail motor fuel site during the tax year in excess of 60 percent of all gasoline sold and dispensed through motor fuel pumps at that retail motor fuel site during the tax year.

For fiscal years ending in 2002, the tax credit is available for each eligible retail motor fuel site based on the total number of gallons of ethanol blended gasoline sold and dispensed through all motor fuel pumps located at the taxpayer's retail motor fuel site from January 1, 2002, until the end of the taxpayer's fiscal year. Assuming a tax period that began on July 1, 2001, and ended on June 30, 2002, the taxpayer would be eligible for the tax credit based on the gallons of ethanol blended gasoline sold from January 1, 2002, through June 30, 2002. For taxpayers having a fiscal year ending in 2002, a claim for refund to claim the ethanol blended gasoline tax credit must be filed before October 1, 2003, even though the statute of limitations for refund set forth in 701—subrule 55.3(5) has not yet expired.

EXAMPLE: A taxpayer sold 100,000 gallons of gasoline at the taxpayer's retail motor fuel site during the tax year, 70,000 gallons of which was ethanol blended gasoline. The taxpayer is eligible for the credit since more than 60 percent of the total gallons sold was ethanol blended gasoline. The number of

gallons in excess of 60 percent of all gasoline sold is 70,000 less 60,000, or 10,000 gallons. Two and one-half cents multiplied by 10,000 equals a $250 credit available.

The credit may be calculated on Form IA 6478. The credit must be calculated separately for each retail motor fuel site operated by the taxpayer. Therefore, if the taxpayer operates more than one retail motor fuel site, it is possible that one retail motor fuel site may be eligible for the credit while another retail motor fuel site may not. The credit can be taken only for those retail motor fuel sites for which more than 60 percent of gasoline sales involve ethanol blended gasoline.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

Starting with the 2006 calendar tax year, a taxpayer may claim the ethanol blended gasoline tax credit even if the taxpayer also claims the E-85 gasoline promotion tax credit provided in rule 701—52.30(422) for the same tax year for the same ethanol gallons.

EXAMPLE: A taxpayer sold 200,000 gallons of gasoline at a retail motor fuel site in 2006, of which 160,000 gallons was ethanol blended gasoline. Of these 160,000 gallons, 1,000 gallons was E-85 gasoline. Taxpayer is entitled to claim the ethanol blended gasoline tax credit of two and one-half cents multiplied by 40,000 gallons, since this constitutes the gallons in excess of 60 percent of the total gasoline gallons sold. Taxpayer may also claim the E-85 gasoline promotion tax credit on the 1,000 gallons of E-85 gasoline sold.

52.19(1) *Definitions.* The following definitions are applicable to this rule:

"Ethanol blended gasoline" means the same as defined in Iowa Code section 214A.1 as amended by 2006 Iowa Acts, House File 2754, section 3.

"Gasoline" means any liquid product prepared, advertised, offered for sale or sold for use as, or commonly and commercially used as, motor fuel for use in a spark-ignition, internal combustion engine, and which meets the specifications provided in Iowa Code section 214A.2.

"Motor fuel pump" means a pump, meter, or similar commercial weighing and measuring device used to measure and dispense motor fuel for sale on a retail basis.

"Retail dealer" means a person engaged in the business of storing and dispensing motor fuel from a motor fuel pump for sale on a retail basis, regardless of whether the motor fuel pump is located at a retail motor fuel site including a permanent or mobile location.

"Retail motor fuel site" means a geographic location in this state where a retail dealer sells and dispenses motor fuel on a retail basis. For example, tank wagons are considered retail motor fuel sites.

"Sell" means to sell on a retail basis.

52.19(2) *Allocation of credit to owners of a business entity.* If the taxpayer that was entitled to the ethanol blended gasoline tax credit is a partnership, limited liability company, S corporation, estate, or trust, the business entity shall allocate the allowable credit to each of the individual owners of the entity on the basis of each owner's pro-rata share of the earnings of the entity to the total earnings of the entity. Therefore, if a partnership has an ethanol blended gasoline tax credit of $3,000 and one partner of the partnership receives 25 percent of the earnings of the partnership, that partner would receive an ethanol blended gasoline tax credit for the tax year of $750 or 25 percent of the total ethanol blended gasoline tax credit of the partnership.

52.19(3) *Repeal of ethanol blended gasoline tax credit.* The ethanol blended gasoline tax credit is repealed on January 1, 2009. However, the tax credit is available for taxpayers whose fiscal year ends after December 31, 2008, for those ethanol gallons sold beginning on the first day of the taxpayer's fiscal year until December 31, 2008. The ethanol promotion tax credit described in rule 701—52.36(422) is available beginning January 1, 2009, for retail dealers of gasoline.

EXAMPLE: A taxpayer who is a retail dealer of gasoline has a fiscal year end of April 30, 2009. The taxpayer sold 150,000 gallons of gasoline from May 1, 2008, through December 31, 2008, at the taxpayer's retail motor fuel site, of which 110,000 gallons was ethanol blended gasoline. The number of gallons in excess of 60 percent of all gasoline sold is 110,000 less 90,000, or 20,000 gallons. The

taxpayer may claim the ethanol blended gasoline tax credit for the fiscal year ending April 30, 2009, in the amount of $500, or 20,000 gallons times two and one-half cents.

This rule is intended to implement Iowa Code section 422.33 as amended by 2006 Iowa Acts, House File 2754.

701—52.20(15E) Eligible development business investment tax credit. Effective for tax years beginning on or after January 1, 2001, a business which qualifies as an eligible development business may receive a tax credit of up to 10 percent of the new investment which is directly related to the construction, expansion or rehabilitation of building space to be used for manufacturing, processing, cold storage, distribution, or office facilities.

An eligible development business must be approved by the Iowa department of economic development prior to March 17, 2004, and meet the qualifications of Iowa Code section 15E.193C. Effective March 17, 2004, the eligible development business program is repealed.

New investment includes the purchase price of land and the cost of improvements made to real property. The tax credit may be claimed by an eligible development business in the tax year in which the construction, expansion or rehabilitation is completed.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following seven years or until used, whichever is the earlier.

If the business is a partnership, S corporation, limited liability company, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

If the eligible development business fails to meet and maintain any one of the requirements to be an eligible business, the business shall be subject to repayment of all or a portion of the amount of tax incentives received. For example, if within five years of project completion the development business sells or leases any space to any retail business, the development business shall proportionally repay the value of the investment credit. The proportion of the investment credit that would be due for repayment by an eligible development business for selling or leasing space to a retail business would be determined by dividing the square footage of building space occupied by the retail business by the square footage of the total building space.

An eligible business, which is not a development business, which operates in an enterprise zone cannot claim an investment tax credit if the property is owned, or was previously owned, by an approved development business that has already received an investment tax credit. An eligible business, which is not a development business, can claim an investment tax credit only on additional, new improvements made to real property that was not included in the development business's approved application for the investment tax credit.

This rule is intended to implement Iowa Code section 15E.193C.

701—52.21(15E,422) Venture capital credits.

52.21(1) *Investment tax credit for an equity investment in a community-based seed capital fund or qualifying business.* See rule 123—2.1(15E) for the discussion of the investment tax credit for an equity investment in a community-based seed capital fund or an equity investment made on or after January 1, 2004, in a qualifying business, along with the issuance of tax credit certificates by the Iowa capital investment board.

The department of revenue will be notified by the Iowa capital investment board when the tax credit certificates are issued. The tax credit certificate must be attached to the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

For equity investments made in a community-based seed capital fund and equity investments made on or after January 1, 2004, in a qualifying business, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have

the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

52.21(2) *Investment tax credit for an equity investment in a venture capital fund.* See rule 123—3.1(15E) for the discussion of the investment tax credit for an equity investment in a venture capital fund, along with the issuance of tax credit certificates by the Iowa capital investment board. This credit is repealed for investments in venture capital funds made after July 1, 2010.

The department of revenue will be notified by the Iowa capital investment board when the tax credit certificates are issued. The tax credit certificate must be attached to the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

For equity investments made in a venture capital fund, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

52.21(3) *Contingent tax credit for investments in Iowa fund of funds.* See rule 123—4.1(15E) for the discussion of the contingent tax credit available for investments made in the Iowa fund of funds organized by the Iowa capital investment corporation. Tax credit certificates related to the contingent tax credits will be issued by the Iowa capital investment board.

The department of revenue will be notified by the Iowa capital investment board when these tax credit certificates are issued and, if applicable, when they are redeemed. If the tax credit certificate is redeemed, the certificate must be attached to the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate.

If the tax credit certificate is redeemed, any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following seven years or until used, whichever is the earlier.

If the tax credit certificate is redeemed, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

This rule is intended to implement Iowa Code section 15E.43 and sections 15E.51, 15E.66, and 422.33(13) as amended by 2010 Iowa Acts, Senate File 2380.
[**ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—52.22(15) New capital investment program tax credits. Effective for tax periods beginning on or after January 1, 2003, a business which qualifies under the new capital investment program is eligible to receive tax credits. An eligible business under the new capital investment program must be approved by the Iowa department of economic development and meet the qualifications of 2003 Iowa Acts, chapter 125, section 4. The new capital investment program was repealed on July 1, 2005, and has been replaced with the high quality job creation program. See rule 701—52.28(15) for information on the tax credits available under the high quality job creation program. Any tax credits earned by businesses approved under the new capital investment program prior to July 1, 2005, remain valid, and can be claimed on tax returns filed after July 1, 2005.

52.22(1) *Research activities credit.* A business approved under the new capital investment program is eligible for an additional research activities credit as described in subrule 52.7(5). This credit for increasing research activities is in lieu of the research activities credit described in subrule 52.7(3).

52.22(2) *Investment tax credit.*

a. General rule. An eligible business can claim an investment tax credit equal to a percentage of the new investment directly related to new jobs created by the location or expansion of an eligible

business. The percentage is equal to the amount provided in paragraph *"b."* New investment directly related to new jobs created by the location or expansion of an eligible business includes the following:

(1) The cost of machinery and equipment, as defined in Iowa Code section 427A.1(1), paragraphs *"e"* and *"j,"* purchased for use in the operation of the eligible business. The purchase price shall be depreciated in accordance with generally accepted accounting principles.

(2) The purchase price of real property and any buildings and structures located on the real property.

(3) The cost of improvements made to real property which is used in the operation of the eligible business.

For eligible businesses approved by the Iowa department of economic development on or after March 17, 2004, certain lease payments made by eligible businesses to a third-party developer will be considered to be new investment for purposes of computing the investment tax credit. The eligible business shall enter into a lease agreement with the third-party developer for a minimum of five years. The investment tax credit is based on the annual base rent paid to a third-party developer by the eligible business for a period not to exceed ten years. The total costs of the annual base rent payments for the ten-year period cannot exceed the cost of the land and the third-party developer's cost to build or renovate the building used by the eligible business. The annual base rent is defined as the total lease payment less taxes, insurance and operating and maintenance expenses.

Any credit in excess of the tax liability for the tax period may be carried forward seven years or until used, whichever is the earlier.

If the business is a partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount of the credit claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust.

b. Tax credit percentage. The amount of tax credit claimed shall be based on the number of high-quality jobs created as determined by the Iowa department of economic development:

(1) If no high-quality jobs are created but economic activity within Iowa is advanced, the eligible business may claim a tax credit of up to 1 percent of the new investment.

(2) If 1 to 5 high-quality jobs are created, the eligible business may claim a tax credit of up to 2 percent of the new investment.

(3) If 6 to 10 high-quality jobs are created, the eligible business may claim a tax credit of up to 3 percent of the new investment.

(4) If 11 to 15 high-quality jobs are created, the eligible business may claim a tax credit of up to 4 percent of the new investment.

(5) If 16 or more high-quality jobs are created, the eligible business may claim a tax credit of up to 5 percent of the new investment.

c. Investment tax credit—value-added agricultural products or biotechnology-related processes. An eligible business whose project primarily involves the production of value-added agricultural products or uses biotechnology-related processes may elect to receive a refund for all or a portion of an unused investment tax credit. An eligible business includes a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol.

Eligible businesses that elect to receive a refund shall apply to the Iowa department of economic development for tax credit certificates between May 1 and May 15 of each fiscal year through the fiscal year ending June 30, 2009. The election to receive a refund of all or a portion of an unused investment tax credit is no longer available beginning with the fiscal year ending June 30, 2010. Only those businesses that have completed projects before the May 1 filing date may apply for a tax credit certificate. The Iowa department of economic development shall not issue tax credit certificates for more than $4 million during a fiscal year to eligible businesses for this program and eligible businesses described in subrule 52.10(4). If applications are received for more than $4 million, the applicants shall receive certificates for a prorated amount.

The Iowa department of economic development shall issue tax credit certificates within a reasonable period of time. Tax credit certificates are valid for the tax year following project completion. The tax credit certificate must be attached to the tax return for the tax year during which the tax credit is claimed. The tax credit certificate shall not be transferred, except for a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol, as provided in subrule 52.10(4). For value-added agricultural projects involving ethanol, the cooperative must submit a list of its members and the share of each member's interest in the cooperative. The Iowa department of economic development shall issue a tax credit certificate to each member on the list.

d. Repayment of benefits. If an eligible business fails to maintain the requirements of the new capital investment program, the taxpayer may be required to repay all or a portion of the tax incentives taken on Iowa returns. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the tax credits may have expired, the department may proceed to collect the tax incentives forfeited by failure to maintain the requirements of the new capital investment program. This is because it is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability.

An eligible business in the new capital investment program may also be required to repay all or a portion of the tax incentives received on Iowa returns if the eligible business experiences a layoff of employees in Iowa or closes any of its facilities in Iowa.

If, within five years of purchase, the eligible business sells, disposes of, razes, or otherwise renders unusable all or a part of the land, buildings, or other existing structures for which a tax credit was claimed under this subrule, the income tax liability of the eligible business shall be increased by one of the following amounts:

(1) One hundred percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within one full year after being placed in service.

(2) Eighty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within two full years after being placed in service.

(3) Sixty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within three full years after being placed in service.

(4) Forty percent of the tax credit claimed if the property ceases to be eligible for the tax credit within four full years after being placed in service.

(5) Twenty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within five full years after being placed in service.

52.22(3) *Corporate tax credit—certain sales taxes paid by developer.* For eligible businesses approved by the Iowa department of economic development on or after March 17, 2004, the eligible business may claim a corporate tax credit for certain sales taxes paid by a third-party developer.

a. Sales taxes eligible for the credit. The sales taxes paid by the third-party developer which are eligible for this credit include the following:

(1) Iowa sales and use tax for gas, electricity, water, or sewer utility services, goods, wares, or merchandise, or on services rendered to, furnished to or performed for a contractor or subcontractor and used in the fulfillment of a written contract relating to the construction or equipping of a facility within the economic development area.

(2) Iowa sales and use tax paid for racks, shelving, and conveyor equipment to be used in a warehouse or distribution center within the economic development area.

Any Iowa sales and use tax paid relating to intangible property, furniture and other furnishings is not eligible for the corporate tax credit.

b. How to claim the credit. The third-party developer must provide to the Iowa department of economic development the amount of Iowa sales and use tax paid as described in paragraph *"a."* The amount of Iowa sales and use tax attributable to racks, shelving, and conveyor equipment must be identified separately.

The Iowa department of economic development will issue a tax credit certificate to the eligible business equal to the Iowa sales and use tax paid by the third-party developer for gas, electricity, water, or sewer utility services, goods, wares, or merchandise, or on services rendered to, furnished to or performed for a contractor or subcontractor and used in the fulfillment of a written contract relating

to the construction or equipping of a facility. In addition, the Iowa department of economic development will also issue a separate tax credit certificate to the eligible business equal to the Iowa sales and use tax paid by the third-party developer for racks, shelving, and conveyor equipment to be used in a warehouse or distribution center.

The tax credit certificate shall contain the name, address, and tax identification number of the eligible business, along with the amount of the tax credit and the year in which the tax credit can be claimed. The tax credit certificate must be attached to the taxpayer's income tax return for the tax year for which the tax credit is claimed. Any tax credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following seven years or until it is used, whichever is the earlier.

For the tax credit certificate relating to Iowa sales and use tax paid by the third-party developer for racks, shelving, and conveyor equipment, the aggregate amount of tax credit certificates and tax refunds for Iowa sales and use tax paid for racks, shelving, and conveyor equipment to eligible businesses under the new jobs and income program, enterprise zone program and new capital investment program cannot exceed $500,000 in a fiscal year. The requests for tax credit certificates or refunds will be processed in the order they are received on a first-come, first-served basis until the amount of credits authorized for issuance has been exhausted. If applications for tax credit certificates or refunds exceed the $500,000 limitation for any fiscal year, the applications shall be considered in succeeding fiscal years.

This rule is intended to implement Iowa Code sections 15.331C, 15.333 as amended by 2010 Iowa Acts, Senate File 2380, and 15.381 to 15.387.
[**ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—52.23(15E,422) Endow Iowa tax credit. Effective for tax years beginning on or after January 1, 2003, a taxpayer who makes an endowment gift to an endow Iowa qualified community foundation may qualify for an endow Iowa tax credit, subject to the availability of the credit. For tax years beginning on or after January 1, 2003, but before January 1, 2010, the credit is equal to 20 percent of a taxpayer's endowment gift to an endow Iowa qualified community foundation approved by the Iowa department of economic development. For tax years beginning on or after January 1, 2010, the credit is equal to 25 percent of a taxpayer's endowment gift to an endow Iowa qualified community foundation approved by the Iowa department of economic development. For tax years beginning on or after January 1, 2010, a taxpayer cannot claim a deduction for charitable contributions under Section 170 of the Internal Revenue Code for the amount of the contribution for which the tax credit is claimed for Iowa tax purposes. The administrative rules for the endow Iowa tax credit for the Iowa department of economic development may be found under 261—Chapter 47.

The total amount of endow Iowa tax credits available is $2 million in the aggregate for the 2003 and 2004 calendar years. The total amount of endow Iowa tax credits is $2 million annually for the 2005-2007 calendar years, and $200,000 of these tax credits on an annual basis is reserved for endowment gifts of $30,000 or less. The maximum amount of tax credit granted to a single taxpayer shall not exceed $100,000 for the 2003-2007 calendar years. The total amount of endow Iowa tax credits annually for the 2008 and 2009 calendar years is $2 million plus a percentage of the tax imposed on the adjusted gross receipts from gambling games in accordance with Iowa Code section 99F.11(3). The total amount of endow Iowa tax credits annually for 2010 is $2.7 million plus a percentage of the tax imposed on the adjusted gross receipts from gambling games in accordance with Iowa Code section 99F.11(3). The total amount of endow Iowa tax credits annually for 2011 and subsequent calendar years is $3.5 million plus a percentage of the tax imposed on the adjusted gross receipts from gambling games in accordance with Iowa Code section 99F.11(3). The maximum amount of tax credit granted to a single taxpayer shall not exceed 5 percent of the total endow Iowa tax credit amount authorized for 2008 and subsequent years. For example, the total amount of endow Iowa tax credits authorized for the 2011 calendar year is $4,551,813, so the maximum amount of tax credit authorized to a single taxpayer is $227,590.65 ($4,551,813 times 5 percent). The endow Iowa tax credit cannot be transferred to any other taxpayer.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

If a taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 15E.305 as amended by 2011 Iowa Acts, Senate File 302, and Iowa Code section 422.33.

[**ARC 8589B**, IAB 3/10/10, effective 4/14/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—52.24(422) Soy-based cutting tool oil tax credit. Effective for tax periods ending after June 30, 2005, and beginning before January 1, 2007, a manufacturer may claim a soy-based cutting tool oil tax credit. A manufacturer, as defined in Iowa Code section 428.20, may claim the credit equal to the costs incurred during the tax year for the purchase and replacement costs relating to the transition from using nonsoy-based cutting tool oil to using soy-based cutting tool oil.

All of the following conditions must be met to qualify for the tax credit.

1. The costs must be incurred after June 30, 2005, and before January 1, 2007.
2. The costs must be incurred in the first 12 months of the transition from using nonsoy-based cutting tool oil to using soy-based cutting tool oil.
3. The soy-based cutting tool oil must contain at least 51 percent soy-based products.
4. The costs of the purchase and replacement must not exceed $2 per gallon of soy-based cutting tool oil used in the transition.
5. The number of gallons used in the transition cannot exceed 2,000 gallons.
6. The manufacturer shall not deduct for Iowa income tax purposes the costs incurred in the transition to using soy-based cutting tool oil which are deductible for federal tax purposes.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

If a taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 422.33 as amended by 2005 Iowa Acts, Senate File 389.

701—52.25(15I,422) Wage-benefits tax credit. Effective for tax years ending on or after June 9, 2006, a wage-benefits tax credit equal to a percentage of the annual wages and benefits paid for a qualified new job created by the location or expansion of the business in Iowa is available for qualified businesses.

52.25(1) *Definitions.* The following definitions are applicable to this rule:

"Average county wage" means the annualized average hourly wage calculated by the Iowa department of economic development using the most current four quarters of wage and employment information as provided in the Quarterly Covered Wage and Employment Data report provided by the department of workforce development. Agricultural/mining and governmental employment categories are deleted in compiling the wage information.

"Benefits" means all of the following:

1. Medical and dental insurance plans.
2. Pension and profit-sharing plans.
3. Child care services.
4. Life insurance coverage.
5. Vision insurance plan.
6. Disability coverage.

"Department" means the Iowa department of revenue.

"Full-time" means the equivalent of employment of one person:

1. For 8 hours per day for a 5-day, 40-hour workweek for 52 weeks per year, including paid holidays, vacations, and other paid leave, or

2. The number of hours or days per week, including paid holidays, vacations, and other paid leave, currently established by schedule, custom or otherwise, as constituting a week of full-time work for the kind of service an individual performs for an employing unit.

"Grow Iowa values fund" means the grow Iowa values fund created in Iowa Code Supplement section 15G.108.

"Nonqualified new job" means any one of the following:

1. A job previously filled by the same employee in Iowa.
2. A job that was relocated from another location in Iowa.
3. A job that is created as a result of a consolidation, merger, or restructuring of a business entity if the job does not represent a new job in Iowa.

"Qualified new job" or *"job creation"* means a job that meets all of the following criteria:

1. Is a new full-time job that has not existed in the business within the previous 12 months in Iowa.
2. Is filled by a new employee for at least 12 months.
3. Is filled by a resident of the state of Iowa.
4. Is not created as a result of a change in ownership.
5. Was created on or after June 9, 2005.

"Retail business" means a business which sells its product directly to a consumer.

"Retained qualified new job" or *"job retention"* means the continued employment, after the first 12 months of employment, of the same employee in a qualified new job for another 12 months.

"Service business" means a business which is not engaged in the sale of tangible personal property, and which provides services to a local consumer market and does not have a significant proportion of its sales coming from outside the state.

52.25(2) *Calculation of credit.* A business which is not a retail or service business may claim the wage-benefits tax credit which is determined as follows:

a. If the annual wages and benefits for the qualified new job equal less than 130 percent of the average county wage, the credit is 0 percent of the annual wage and benefits paid.

b. If the annual wages and benefits for the qualified new job equal at least 130 percent but less than 160 percent of the average county wage, the credit is 5 percent of the annual wage and benefits paid for each qualified new job.

c. If the annual wages and benefits for the qualified new job equal at least 160 percent of the average county wage, the credit is 10 percent of the annual wage and benefits paid for each qualified new job.

If the business is a partnership, S corporation, limited liability company, or estate or trust electing to have the income taxed directly to the individual, an individual may claim the tax credit. The amount claimed by the individual shall be based upon the pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

52.25(3) *Application for the tax credit, tax credit certificate and amount of tax credit available.*

a. In order to claim the wage-benefits tax credit, the business must submit an application to the department along with information on the qualified new job or retained qualified new job. The application cannot be submitted until the end of the twelfth month after the qualified job was filled. For example, if the new job was created on June 9, 2005, the application cannot be submitted until June 9, 2006. The following information must be submitted in the application:

(1) Name, address and federal identification number of the business.

(2) A description of the activities of the business. If applicable, the proportion of the sales of the business which come from outside Iowa should be included.

(3) The amount of wages and benefits paid to each employee for each new job for the previous 12 months.

(4) A computation of the amount of credit being requested.

(5) The address and state of residence of each new employee.

(6) The date that the qualified new job was filled.

(7) An indication of whether the job is a qualified new job or a retained qualified new job for which an application was filed for a previous year.

(8) The type of tax for which the credit will be applied.

(9) If the business is a partnership, S corporation, limited liability company, or estate or trust, a schedule of the partners, shareholders, members or beneficiaries. This schedule shall include the names, addresses and federal identification number of the partners, shareholders, members or beneficiaries, along with their percentage of the pro-rata share of earnings of the partnership, S corporation, limited liability company, or estate or trust.

b. Upon receipt of the application, the department has 45 days either to approve or disapprove the application. If the department does not act on the application within 45 days, the application is deemed to be approved. If the department disapproves the application, the business may appeal the decision to the Iowa economic development board within 30 days of the notice of disapproval.

c. If the application is approved, or if the Iowa economic development board approves the application that was previously denied by the department, a tax credit certificate will be issued by the department to the business, subject to the availability of the amount of credits that may be issued. The tax credit certificate will contain the name, address and tax identification number of the business (or individual, estate or trust, if applicable), the date of the qualified new job(s), the wage and benefits paid for each job(s) for the 12-month period, the amount of the credit, the tax period for which the credit may be applied, and the type of tax for which the credit will be applied.

d. The tax credit certificates that are issued in a fiscal year cannot exceed $10 million for the fiscal year ending June 30, 2007, and shall not exceed $4 million for the fiscal years ending June 30, 2008, through June 30, 2011. The tax credit certificates are issued on a first-come, first-served basis. Therefore, if tax credit certificates have already been issued for the $10 million limit for the fiscal year ending June 30, 2007, any applications for tax credit certificates received after the $10 million limit has been reached will be denied. Similarly, if tax credit certificates have already been issued for the $4 million limit for the fiscal years ending June 30, 2008, through June 30, 2011, any applications for tax credit certificates received after the $4 million limit has been reached will be denied. If a business failed to receive all or a part of the tax credit due to the $10 million or $4 million limitation, the business may reapply for the tax credit for the retained new job for a subsequent tax period.

e. A business which qualifies for the tax credit for the fiscal year ending June 30, 2007, is eligible to receive the tax credit certificate for each of the fiscal years ending June 30, 2008, through June 30, 2011, subject to the $4 million limit for tax credits for the fiscal years ending June 30, 2008, through June 30, 2011, if the business retains the qualified new job during each of the fiscal years ending June 30, 2008, through June 30, 2011. The business must reapply by June 30 of each fiscal year for the tax credit, and the percentage of the wages and benefits allowed for the credit set forth in subrule 52.25(2) for the first year is applicable for each subsequent period. Preference will be given in issuing tax credit certificates for those businesses that retain qualified new jobs, and preference will be given in the order in which applications were filed for the fiscal year ending June 30, 2007. Therefore, those businesses which received the first $4 million of tax credits for the year ending June 30, 2007, in which the qualified jobs were created will automatically receive a tax credit for the fiscal years ending June 30, 2008, through June 30, 2011, as long as the qualified jobs are retained and an application is completed.

f. For the fiscal years ending June 30, 2008, through June 30, 2011, if credits become available because the jobs were not retained by businesses which received the first $4 million of credits for the year ending June 30, 2007, an application which was originally denied will be considered in the order in which the application was received for the fiscal year ending June 30, 2007.

EXAMPLE: Wage-benefits tax credits of $4 million were issued for the fiscal year ending June 30, 2007, relating to applications filed between July 1, 2006, and March 31, 2007. For the next fiscal year ending June 30, 2008, the same businesses that received the $4 million in wage-benefits tax credits filed applications totaling $3 million for the retained jobs for which the application for the prior year was filed on or before March 31, 2007. The first $3 million of the available $4 million will be allowed to these same businesses. The remaining $1 million that is still available for the year ending June 30, 2008, will

be allowed for those retained jobs for which applications for the prior year were filed starting on April 1, 2007, until the remaining $1 million in tax credits is issued.

g. A business may apply in writing to the Iowa economic development board for a waiver of the average wage and benefit requirement. See 261—subrule 68.3(2) for more detail on the procedures to apply for a waiver of the wage and benefit requirement. If a waiver is granted, the business must provide the department with the waiver and it must be attached to the application.

h. A business may receive other federal, state, and local incentives and tax credits in addition to the wage-benefits tax credit. However, a business that receives a wage-benefits tax credit cannot receive tax incentives under the high quality job creation program set forth in Iowa Code chapter 15 as amended by 2005 Iowa Acts, chapter 150, or moneys from the grow Iowa values fund.

52.25(4) *Examples.* The following noninclusive examples illustrate how this rule applies:

EXAMPLE 1: Business A operates a grocery store and hires five new employees, each of whom will earn wages and benefits in excess of 130 percent of the average county wage. Business A would not qualify for the wage-benefits tax credit because Business A is a retail business.

EXAMPLE 2: Business B operates an accounting firm and hires two new accountants, each of whom will earn wages and benefits in excess of 160 percent of the average county wage. The accounting firm provides services to clients wholly within Iowa. Business B would not qualify for the wage-benefits tax credit because it is a service business. The majority of its sales are generated from within the state of Iowa and thus Business B, because it is a service business, is not eligible for the credit.

EXAMPLE 3: Business C operates a software development business and hires two new programmers, each of whom will earn wages and benefits in excess of 160 percent of the average county wage. Over 50 percent of the customers of Business C are located outside Iowa. Business C would qualify for the wage-benefits tax credit because a majority of its sales are coming from outside the state, even though Business C is engaged in the performance of services.

EXAMPLE 4: Business D is a manufacturer that hires a new employee in Clayton County, Iowa, on July 8, 2005. The average county wage for Clayton County for the third quarter of 2005 is $11.86 per hour. If the average county wage per hour for Clayton County is $11.95 for the fourth quarter of 2005, $12.05 for the first quarter of 2006, and $12.14 for the second quarter of 2006, the annualized average county wage for this 12-month period is $12.00 per hour. This wage equates to an average annual wage of $24,960 ($12.00 × 40 hours × 52 weeks). In order to qualify for the 5 percent wage-benefits tax credit, the new employee must receive wages and benefits totaling $32,448 (130 percent of $24,960) for the 12-month period from July 8, 2005, through July 7, 2006. In order to qualify for the 10 percent wage-benefits tax credit, the new employee must receive wages and benefits totaling $39,936 (160 percent of $24,960) for the 12-month period from July 8, 2005, through July 7, 2006.

EXAMPLE 5: Business E is a manufacturer that hires three new employees in Grundy County, Iowa, on July 1, 2005. If the average county wage for the 12-month period from July 1, 2005, through June 30, 2006, is $13.75 per hour in Grundy County, this wage equates to an average county wage of $28,600. The wages and benefits for each of these three new employees is $40,000 for the period from July 1, 2005, through June 30, 2006, which is 140 percent of the average county wage. Business E is entitled to a wage-benefits tax credit of $2,000 for each employee ($40,000 × 5 percent), for a total wage-benefits tax credit of $6,000. If Business E files on a calendar-year basis, the $6,000 wage-benefits tax credit can be claimed on the tax return for the period ending December 31, 2006.

EXAMPLE 6: Business F is a manufacturer that hires ten new employees on July 1, 2005, and qualifies for the wage-benefits tax credit because the wages and benefits paid exceed 130 percent of the average county wage. Business F receives a wage-benefits tax credit in July 2006 for these ten employees, which can be used on the tax return for the period ending December 31, 2006. On August 31, 2006, two of the employees leave the business and are replaced by two new employees. Business F is entitled to a wage-benefits tax credit for only eight employees in July 2007 because only eight employees continued employment for the subsequent 12 months, which meets the definition of a retained qualified new job. Business F cannot request a wage-benefits tax credit for the two employees hired on August 31, 2006. Business F cannot request the wage-benefits tax credit because these two full-time jobs existed in the

business within the previous 12 months in Iowa, and these jobs do not meet the definition of a qualified new job or retained qualified new job.

EXAMPLE 7: Business G is a manufacturer that hires ten new employees on July 1, 2005, and qualifies for the wage-benefits tax credit because the wages and benefits paid exceed 130 percent of the average county wage. Business G receives a wage-benefits tax credit in July 2006 for these ten employees equal to 5 percent of the wages and benefits paid. On October 1, 2006, Business G hires an additional five employees, each of whom receives wages and benefits in excess of 130 percent of the average county wage. Business G can apply for the wage-benefits tax credit on October 1, 2007, for these five employees, since these employees have now been employed for 12 months. However, the credit may not be allowed if more than $4 million of retained job applications is received for the fiscal year ending June 30, 2008.

EXAMPLE 8: Assume the same facts as Example 6, except that the $10 million limit of tax credits has already been met for the fiscal year ending June 30, 2007, and Business F hired five new employees on August 31, 2006. Business F can apply for the wage-benefits tax credit for the three employees on August 31, 2007, a number which is above the ten full-time jobs originally created, but Business F may not receive the tax credit if more than $4 million of retained job applications is received for the fiscal year ending June 30, 2008.

EXAMPLE 9: Assume the same facts as Example 7, except that the ten employees hired on July 1, 2005, by Business G received wages and benefits equal to 155 percent of the average county wage, and the five employees hired on October 1, 2006, by Business G received wages equal to 161 percent of the average county wage. Business G can apply for the tax credit on October 1, 2007, equal to 10 percent of the wages and benefits paid for the employees hired on October 1, 2006. On July 1, 2007, Business G can reapply for the tax credit equal to 5 percent of the wages and benefits paid only for the ten employees originally hired on July 1, 2005, even if the wages and benefits for these ten employees exceed 160 percent of the average county wage for the period from July 1, 2006, through June 30, 2007.

52.25(5) *Repeal of the wage-benefits tax credit.* The wage-benefits tax credit is repealed effective July 1, 2008. However, the wage-benefits tax credit is still available through the fiscal year ending June 30, 2011, as provided in subrule 52.25(3), paragraphs *"d," "e,"* and *"f."* A business is not entitled to a wage-benefits tax credit for a qualified new job created on or after July 1, 2008.

This rule is intended to implement Iowa Code chapter 15I as amended by 2008 Iowa Acts, House File 2700, section 167, and Iowa Code section 422.33(18).

701—52.26(422,476B) Wind energy production tax credit. Effective for tax years beginning on or after July 1, 2006, an owner of a qualified wind energy production facility that has been approved by the Iowa utilities board may claim a wind energy production tax credit for qualified electricity sold by the owner or used for on-site consumption against a taxpayer's Iowa corporation income tax liability. The administrative rules for the certification of eligibility for the wind energy production tax credit for the Iowa utilities board may be found in rule 199—15.18(476B).

52.26(1) *Application and review process for the wind energy production tax credit.* An owner of a wind energy production facility must be approved by the Iowa utilities board in order to qualify for the wind energy production tax credit. The facility must be an electrical production facility that produces electricity from wind, is located in Iowa, and must be placed in service on or after July 1, 2005, but before July 1, 2012. For applications filed on or after March 1, 2008, a facility must consist of one or more wind turbines which have a combined nameplate generating capacity of at least 2 megawatts and no more than 30 megawatts. For applications filed on or after July 1, 2009, by a private college or university, community college, institution under the control of the state board of regents, public or accredited nonpublic elementary and secondary school, or public hospital as defined in Iowa Code section 249J.3, the facility must have a combined nameplate capacity of no less than ¾ of a megawatt.

The maximum amount of nameplate generating capacity for all qualified wind energy production facilities cannot exceed 50 megawatts of nameplate generating capacity. An owner shall not own more than two qualified facilities. A facility that is not operational within 18 months after issuance of the approval from the Iowa utilities board will no longer be considered a qualified facility. However, a

facility that is not operational within 18 months due to the unavailability of necessary equipment shall be granted an additional 12 months to become operational.

An owner of the qualified facility must apply to the Iowa utilities board for the wind energy production tax credit. The application for the tax credit must be filed no later than 30 days after the close of the tax year for which the credit is applied. The information to be included in the application is set forth in 199—subrule 15.20(1).

52.26(2) *Computation of the credit.* The wind energy production credit equals one cent multiplied by the number of kilowatt-hours of qualified electricity sold or used for on-site consumption by the owner during the tax year. For the first tax year in which the credit is applied, the kilowatt-hours of qualified electricity sold may exceed 12 months.

EXAMPLE: A qualified facility was placed in service on April 1, 2006, and the taxpayer files on a calendar-year basis. The first year for which the credit can be claimed is the period ending December 31, 2007, since that is the first tax year that began on or after July 1, 2006. The credit for the 2007 tax year can include electricity sold between April 1, 2006, and December 31, 2007.

The credit is not allowed for any kilowatt-hours of electricity sold to a related person. The definition of "related person" uses the same criteria set forth in Section 45(e)(4) of the Internal Revenue Code relating to the federal renewable electricity production credit. Persons shall be treated as related to each other if such persons are treated as a single employer under Treasury Regulation §1.52-1. In the case of a corporation that is a member of an affiliated group of corporations filing a federal consolidated return, such corporation shall be treated as selling electricity to an unrelated person if such electricity is sold to the person by another member of the affiliated group.

The utilities board will notify the department of the number of kilowatt-hours of electricity sold by the qualified facility or generated and used on site by the qualified facility during the tax year. The department will calculate the credit and issue a tax credit certificate to the owner. The tax credit certificate will include the taxpayer's name, address and federal identification number, the tax type for which the credit will be claimed, the amount of the credit and the tax year for which the credit may be claimed. In addition, the tax credit certificate will include a place for the name and tax identification number of a transferee and the amount of the tax credit certificate, as provided in subrule 52.26(3). If the department refuses to issue the tax credit certificate, the taxpayer shall be notified in writing and the taxpayer will have 60 days from the date of denial to file a protest in accordance with rule 701—7.41(17A). The department will not issue a tax credit certificate if the facility is not operational within 18 months after approval was given by the utilities board, unless a 12-month extension is granted by the utilities board as provided in subrule 52.26(1).

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on the partner's, member's, shareholder's or beneficiary's pro-rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust, except when the taxpayer is eligible to receive renewable electricity production tax credits authorized under Section 45 of the Internal Revenue Code. In cases where the taxpayer is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder. In addition, if a taxpayer is a partnership, limited liability company, S corporation, or estate or trust that is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the taxpayer may distribute the tax credit to an equity holder or beneficiary as a liquidating distribution or portion thereof, of an equity holder's interest in the partnership, limited liability company or S corporation, or the beneficiary's interest in the estate or trust.

The credit can be allowed for a ten-year period beginning on the date the qualified facility was originally placed in service. For example, if a facility was placed in service on April 1, 2006, the credit can be claimed for kilowatt-hours of electricity sold between April 1, 2006, and March 31, 2016.

To claim the tax credit, the taxpayer must attach the tax credit certificate to the tax return for the tax year set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for seven years or until it is used, whichever is the earlier.

52.26(3) *Transfer of the wind energy production tax credit certificate.* The wind energy production tax credit certificate may be transferred to any person or entity.

Within 30 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the wind energy production tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year and the same expiration date as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

This rule is intended to implement Iowa Code section 422.33 and chapter 476B as amended by 2011 Iowa Acts, House File 672.

[**ARC 8589B**, IAB 3/10/10, effective 4/14/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—52.27(422,476C) Renewable energy tax credit. Effective for tax years beginning on or after July 1, 2006, a purchaser or producer of renewable energy whose facility has been approved by the Iowa utilities board may claim a renewable energy tax credit for qualified renewable energy against a taxpayer's Iowa corporation income tax liability. The administrative rules for the certification of eligibility for the renewable energy tax credit for the Iowa utilities board may be found in rule 199—15.19(476C).

52.27(1) *Application and review process for the renewable energy tax credit.* A producer or purchaser of a renewable energy facility must be approved by the Iowa utilities board in order to qualify for the renewable energy credit. The eligible renewable energy facility can be a wind energy conversion facility, biogas recovery facility, biomass conversion facility, methane gas recovery facility, solar energy conversion facility or refuse conversion facility. The facility must be located in Iowa and placed in service on or after July 1, 2005, and before January 1, 2015.

The maximum amount of nameplate generating capacity of all wind energy conversion facilities cannot exceed 363 megawatts of nameplate generating capacity. The maximum amount of energy production capacity for biogas recovery facilities, biomass conversion facilities, methane gas recovery facilities, solar energy conversion facilities and refuse conversion facilities cannot exceed a combined output of 53 megawatts of nameplate generating capacity and 167 billion British thermal units of heat for a commercial purpose. A facility that is not operational within 30 months after issuance of approval from the utilities board will no longer be considered a qualified facility. However, if the facility is a wind energy conversion property and is not operational within 18 months due to the unavailability of necessary equipment, the facility may apply for a 12-month extension of the 30-month limit. Extensions can be renewed for succeeding 12-month periods if the facility applies for the extension prior to expiration of the current extension period. A producer of renewable energy, which is the person who owns the renewable energy facility, cannot own more than two eligible renewable energy facilities. A

person that has an equity interest equal to or greater than 51 percent in an eligible renewable energy facility cannot have an equity interest greater than 10 percent in any other renewable energy facility.

A producer or purchaser of a renewable energy facility must apply to the utilities board for the renewable energy tax credit. The application for the tax credit must be filed no later than 30 days after the close of the tax year for which the credit is applied. The information to be included in the application is set forth in 199—subrule 15.21(1).

52.27(2) *Computation of the credit.* The renewable energy tax credit equals 1½ cents per kilowatt-hour of electricity, or 44 cents per 1000 standard cubic feet of hydrogen fuel, or $4.50 per 1 million British thermal units of methane gas or other biogas used to generate electricity, or $4.50 per 1 million British thermal units of heat for a commercial purpose generated by and purchased from an eligible renewable energy facility or used for on-site consumption by the producer during the tax year. For the first tax year in which the credit is applied, the kilowatt-hours, standard cubic feet or British thermal units generated by and purchased from the facility or used for on-site consumption by the producer may exceed 12 months.

EXAMPLE: A qualified wind energy production facility was placed in service on April 1, 2006, and the taxpayer files on a calendar-year basis. The first year for which the credit can be claimed is the year ending December 31, 2007, since that is the first tax year that began on or after July 1, 2006. The credit for the 2007 tax year can include electricity generated and purchased or used for on-site consumption by the producer between April 1, 2006, and December 31, 2007.

The credit is not allowed for any kilowatt-hours, standard cubic feet or British thermal units that are purchased from an eligible facility by a related person. Persons shall be treated as related to each other if either person owns an 80 percent or more equity interest in the other person.

The utilities board will notify the department of the number of kilowatt-hours, standard cubic feet or British thermal units that are generated and purchased from an eligible facility or used for on-site consumption by the producer during the tax year. The department will calculate the credit and issue a tax credit certificate to the purchaser or producer. The tax credit certificate will include the taxpayer's name, address and federal identification number, the tax type for which the credit will be claimed, the amount of the credit and the tax year for which the credit may be claimed. In addition, the tax credit certificate will include a place for the name and tax identification number of a transferee and the amount of the tax credit certificate, as provided in subrule 52.27(3). If the department refuses to issue the tax credit certificate, the taxpayer shall be notified in writing and the taxpayer will have 60 days from the date of denial to file a protest in accordance with rule 701—7.41(17A). The department will not issue a tax credit certificate if the facility is not operational within 30 months after approval was given by the utilities board, unless a 12-month extension is granted by the utilities board as provided in subrule 52.27(1). In addition, the department will not issue a tax credit certificate to any person who received a wind energy production tax credit in accordance with Iowa Code chapter 476B.

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on the partner's, member's, shareholder's or beneficiary's pro-rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust, except when the taxpayer is eligible to receive renewable electricity production tax credits authorized under Section 45 of the Internal Revenue Code. In cases where the taxpayer is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder. In addition, if a taxpayer is a partnership, limited liability company, S corporation, or estate or trust that is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the taxpayer may distribute the tax credit to an equity holder or beneficiary as a liquidating distribution or portion thereof, of an equity holder's interest in the partnership, limited liability company or S corporation, or the beneficiary's interest in the estate or trust.

The credit can be allowed for a ten-year period beginning on the date the qualified facility was originally placed in service. For example, if a renewable energy facility was placed in service on April 1,

2006, the credit can be claimed for kilowatt-hours, standard cubic feet or British thermal units generated and purchased or used for on-site consumption by the producer between April 1, 2006, and March 31, 2016. Tax credit certificates cannot be issued for renewable energy purchased or produced for on-site consumption after December 31, 2024.

To claim the tax credit, the taxpayer must attach the tax credit certificate to the tax return for the tax period set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for seven years or until it is used, whichever is the earlier.

52.27(3) *Transfer of the renewable energy tax credit certificate.* The renewable energy tax credit certificate may be transferred once to any person or entity. A decision between a producer and purchaser of renewable energy regarding who may claim the tax credit is not considered a transfer.

Within 30 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the renewable energy tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year and the same expiration date as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

52.27(4) *Small wind innovation zones.* Effective for tax years beginning on or after January 1, 2009, an owner of a small wind energy system operating within a small wind innovation zone which has been approved by the Iowa utilities board is eligible for the renewable energy tax credit. The administrative rules of the Iowa utilities board for the certification of eligibility for owners of small wind energy systems operating within a small wind innovation zone may be found in rule 199—15.22(476).

This rule is intended to implement Iowa Code section 422.33 and chapter 476C as amended by 2011 Iowa Acts, House File 672.

[**ARC 8589B**, IAB 3/10/10, effective 4/14/10; **ARC 8605B**, IAB 3/10/10, effective 4/14/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—52.28(15) High quality job creation program. Effective for tax periods ending on or after July 1, 2005, for programs approved on or after July 1, 2005, but before July 1, 2009, a business which qualifies under the high quality job creation program is eligible to receive tax credits. The high quality job creation program replaces the new jobs and income program and the new capital investment program. An eligible business under the high quality job creation program must be approved by the Iowa department of economic development and meet the qualifications of Iowa Code section 15.329. The administrative rules for the high quality job creation program for the Iowa department of economic development may be found at 261—Chapter 68.

The high quality job creation program was repealed on July 1, 2009, and has been replaced with the high quality jobs program. See rule 701—52.40(15) for information on the investment tax credit and additional research activities credit under the high quality jobs program. Any investment tax credit and additional research activities credit earned by businesses approved under the high quality job creation program prior to July 1, 2009, remains valid and can be claimed on tax returns filed after July 1, 2009.

52.28(1) *Research activities credit.* An eligible business approved under the high quality job creation program is eligible for an additional research activities credit as subrule described in 52.7(4).

Research activities allowable for the Iowa research activities credit include expenses related to the development and deployment of innovative renewable energy generation components manufactured or assembled in Iowa; such expenses related to the development and deployment of innovative renewable energy generation components are not eligible for the federal credit for increasing research activities. For purposes of this subrule, innovative renewable energy generation components do not include components with more than 200 megawatts in installed effective nameplate capacity. The research activities credit related to renewable energy generation components under the high quality job creation program and the enterprise zone program shall not exceed $1 million in the aggregate.

These expenses related to the development and deployment of innovative renewable energy generation components are applicable only to the additional research activities credit set forth in this subrule and are not applicable to the research activities credit set forth in subrule 52.7(3). The research activities credit is subject to the threshold amounts of qualifying investment set forth in Iowa department of economic development subrule 261—68.4(7).

52.28(2) *Investment tax credit.*

a. General rule. An eligible business can claim an investment tax credit equal to a percentage of the new investment directly related to new jobs created by the location or expansion of an eligible business. The percentage is equal to the amount provided in Iowa department of economic development 261—subrule 68.4(7). New investment directly related to new jobs created by the location or expansion of an eligible business includes the following:

(1) The cost of machinery and equipment, as defined in Iowa Code section 427A.1(1), paragraphs *"e"* and *"j,"* purchased for use in the operation of the eligible business. The purchase price shall be depreciated in accordance with generally accepted accounting principles.

(2) The purchase price of real property and any buildings and structures located on the real property.

(3) The cost of improvements made to real property which is used in the operation of the eligible business.

In addition, certain lease payments made by eligible businesses to a third-party developer will be considered to be new investment for purposes of computing the investment tax credit. The eligible business shall enter into a lease agreement with the third-party developer for a minimum of five years. The investment tax credit is based on the annual base rent paid to a third-party developer by the eligible business for a period not to exceed ten years. The total costs of the annual base rent payments for the ten-year period cannot exceed the cost of the land and the third-party developer's cost to build or renovate the building used by the eligible business. The annual base rent is defined as the total lease payment less taxes, insurance and operating and maintenance expenses.

The investment tax credit can be claimed in the tax year in which the qualifying assets are placed in service. The investment tax credit will be amortized over a five-year period. Any credit in excess of the tax liability for the tax period may be carried forward seven years or until used, whichever is the earlier.

EXAMPLE: An eligible business which files tax returns on a calendar-year basis earned $100,000 of investment tax credits for new investment made in 2006. The business can claim $20,000 of investment tax credits for each of the years from 2006 through 2010. The $20,000 of investment tax credit that can be claimed in 2006 can be carried forward to the 2007-2013 tax years if the entire credit cannot be claimed on the 2006 return. Similarly, the $20,000 investment tax credit that can be claimed in 2007 can be carried forward to the 2008-2014 tax years if the entire credit cannot be claimed on the 2007 return.

If the business is a partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount of the credit claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust electing to have the income taxed directly to an individual.

b. Investment tax credit—value-added agricultural products or biotechnology-related processes. An eligible business whose project primarily involves the production of value-added agricultural products or uses biotechnology-related processes may elect to receive a refund for all or a portion of an unused investment tax credit. An eligible business includes a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol.

Eligible businesses that elect to receive a refund shall apply to the Iowa department of economic development for tax credit certificates between May 1 and May 15 of each fiscal year through the fiscal year ending June 30, 2009. The election to receive a refund of all or a portion of an unused investment tax credit is no longer available beginning with the fiscal year ending June 30, 2010. Only those businesses that have completed projects before the May 1 filing date may apply for a tax credit certificate. The Iowa department of economic development shall not issue tax credit certificates for more than $4 million during a fiscal year to eligible businesses for this program and the enterprise zone program described in subrule 52.14(2). If applications are received for more than $4 million, the applicants shall receive certificates for a prorated amount.

The Iowa department of economic development shall issue tax credit certificates within a reasonable period of time. Tax credit certificates are valid for the tax year following project completion. The tax credit certificate must be attached to the tax return for the tax year during which the tax credit is claimed. The tax credit certificate shall not be transferred, except for a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol, as provided in subrule 52.10(4). For value-added agricultural projects involving ethanol, the cooperative must submit a list of its members and the share of each member's interest in the cooperative. The Iowa department of economic development shall issue a tax credit certificate to each member on the list.

c. Repayment of benefits. If an eligible business fails to maintain the requirements of the high quality job creation program, the taxpayer may be required to repay all or a portion of the tax incentives taken on Iowa returns. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the tax credits may have expired, the department may proceed to collect the tax incentives forfeited by failure of the eligible business to maintain the requirements of the high quality job creation program because it is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability.

An eligible business in the high quality job creation program may also be required to repay all or a portion of the tax incentives received on Iowa returns if the eligible business experiences a layoff of employees in Iowa or closes any of its facilities in Iowa.

If, within five years of purchase, the eligible business sells, disposes of, razes, or otherwise renders unusable all or a part of the land, buildings, or other existing structures for which a tax credit was claimed under this subrule, the income tax liability of the eligible business shall be increased by one of the following amounts:

(1) One hundred percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within one full year after being placed in service.

(2) Eighty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within two full years after being placed in service.

(3) Sixty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within three full years after being placed in service.

(4) Forty percent of the tax credit claimed if the property ceases to be eligible for the tax credit within four full years after being placed in service.

(5) Twenty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within five full years after being placed in service.

52.28(3) *Determination of tax credit amounts.* The amount of tax credit claimed under the high quality job creation program shall be based on the number of high quality jobs created and the amount of qualifying investment made as determined by the Iowa department of economic development.

a. If the high quality jobs have a starting wage, including benefits, equal to or greater than 130 percent of the average county wage but less than 160 percent of the average county wage, see Iowa department of economic development 261—paragraph 68.4(7)*"a"* for the amount of tax credits that may be claimed.

b. If the high quality jobs have a starting wage, including benefits, equal to or greater than 160 percent of the average county wage, see Iowa department of economic development 261—paragraph 68.4(7)*"b"* for the amount of tax credits that may be claimed.

c. An eligible business approved under the high quality job creation program is not eligible for the wage-benefits tax credit set forth in rule 701—52.25(15H).

This rule is intended to implement Iowa Code Supplement chapter 15.
[**ARC 8589B**, IAB 3/10/10, effective 4/14/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—52.29(15E,422) Economic development region revolving fund tax credit. Effective for tax years ending on or after July 1, 2005, but beginning before January 1, 2010, a taxpayer who makes a contribution to an economic development region revolving fund may claim a tax credit, subject to the availability of the credit. The credit is equal to 20 percent of a taxpayer's contribution to the economic development region revolving fund approved by the Iowa department of economic development. The administrative rules for the economic development region revolving fund tax credit for the Iowa department of economic development may be found at 261—Chapter 32. The tax credit is repealed for tax years beginning on or after January 1, 2010.

The total amount of economic development region revolving fund tax credits available shall not exceed $2 million per fiscal year. The tax credit shall not be carried back to a tax year prior to the year in which the taxpayer redeems the credit. The economic development region revolving fund tax credit is not transferable to any other taxpayer.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following ten years or until used, whichever is the earlier.

If a taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code sections 15E.232 and 422.33 as amended by 2010 Iowa Acts, Senate File 2380.
[**ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—52.30(422) E-85 gasoline promotion tax credit. Effective for tax years beginning on or after January 1, 2006, a retail dealer of gasoline may claim an E-85 gasoline promotion tax credit. "E-85 gasoline" means ethanol blended gasoline formulated with a minimum percentage of between 70 percent and 85 percent of volume of ethanol, if the formulation meets the standards provided in Iowa Code section 214A.2. For purposes of this rule, tank wagon sales are considered retail sales. The credit is calculated on Form IA 135. The credit is calculated by multiplying the total number of E-85 gallons sold by the retail dealer during the tax year by the following designated rates:

Calendar years 2006, 2007 and 2008	25 cents
Calendar years 2009 and 2010	20 cents
Calendar year 2011	10 cents
Calendar years 2012 through 2017	16 cents

A taxpayer may claim the E-85 gasoline promotion tax credit even if the taxpayer also claims the ethanol blended gasoline tax credit provided in rule 701—52.19(422) for gallons sold prior to January 1, 2009, or the ethanol promotion tax credit provided in rule 701—52.36(422) for gallons sold on or after January 1, 2009, for the same tax year for the same ethanol gallons.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

EXAMPLE: A taxpayer operated one retail motor fuel site in 2006 and sold 200,000 gallons of gasoline, of which 160,000 gallons was ethanol blended gasoline. Of these 160,000 gallons, 1,000 gallons was E-85 gasoline. Taxpayer may claim the E-85 gasoline promotion tax credit on the 1,000

gallons of E-85 gasoline sold during 2006. Taxpayer is also entitled to claim the ethanol blended gasoline tax credit of two and one-half cents multiplied by 40,000 gallons, since this constitutes the gallons in excess of 60 percent of the total gasoline gallons sold for the 2006 tax year.

52.30(1) *Fiscal year filers.* For taxpayers whose tax year is not on a calendar-year basis, the taxpayer may compute the tax credit on the gallons of E-85 gasoline sold during the year using the designated rates as shown above. Because the tax credit is repealed on January 1, 2018, a taxpayer whose tax year ends prior to December 31, 2017, can continue to claim the tax credit in the following tax year for any E-85 gallons sold through December 31, 2017. For a retail dealer whose tax year is not on a calendar-year basis and who did not claim the E-85 credit on the previous return, the dealer may claim the credit for the current tax year for the period beginning on January 1 of the previous tax year until the last day of the previous tax year.

EXAMPLE: A taxpayer who is a retail dealer of gasoline has a fiscal year ending March 31, 2009. The taxpayer sold 2,000 gallons of E-85 gasoline for the period from April 1, 2008, through December 31, 2008, and sold 500 gallons of E-85 gasoline for the period from January 1, 2009, through March 31, 2009. The taxpayer is entitled to a total E-85 gasoline promotion tax credit of $600 for the fiscal year ending March 31, 2009, which consists of a $500 credit (2,000 gallons multiplied by 25 cents) for the period from April 1, 2008, through December 31, 2008, and a credit of $100 (500 gallons multiplied by 20 cents) for the period from January 1, 2009, through March 31, 2009.

EXAMPLE: A taxpayer who is a retail dealer of gasoline has a fiscal year ending April 30, 2006. The taxpayer sold 800 gallons of E-85 gasoline for the period from January 1, 2006, through April 30, 2006. The taxpayer is entitled to claim an E-85 gasoline promotion tax credit of $200 (800 gallons times 25 cents) on the taxpayer's Iowa income tax return for the period ending April 30, 2006. In lieu of claiming the credit on the return for the period ending April 30, 2006, the taxpayer can claim the E-85 gasoline promotion tax credit on the tax return for the period ending April 30, 2007, including all E-85 gallons sold for the period from January 1, 2006, through April 30, 2007.

52.30(2) *Allocation of credit to owners of a business entity.* If a taxpayer claiming the E-85 gasoline promotion tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 422.33 as amended by 2011 Iowa Acts, Senate File 531.

[**ARC 9821B**, IAB 11/2/11, effective 12/7/11]

701—52.31(422) Biodiesel blended fuel tax credit. Effective for tax years beginning on or after January 1, 2006, a retail dealer of biodiesel blended fuel may claim a biodiesel blended fuel tax credit. "Biodiesel blended fuel" means a blend of biodiesel with petroleum-based diesel fuel which meets the standards provided in Iowa Code section 214A.2. The biodiesel blended fuel must be formulated with a minimum percentage of 2 percent by volume of biodiesel, if the formulation meets the standards provided by Iowa Code section 214A.2, to qualify for the tax credit for gallons sold on or after January 1, 2006, but before January 1, 2013. For gallons sold on or after January 1, 2013, but before January 1, 2018, the biodiesel blended fuel must be formulated with a minimum percentage of 5 percent by volume of biodiesel, if the formulation meets the standards provided by Iowa Code section 214A.2, to qualify for the tax credit. In addition, of the total gallons of diesel fuel sold by the retail dealer, 50 percent or more must be biodiesel blended fuel to be eligible for the tax credit for tax years beginning prior to January 1, 2009. For tax years beginning on or after January 1, 2009, but before January 1, 2012, the biodiesel blended fuel tax credit is calculated separately for each retail motor fuel site for which 50 percent or more of the total gallons of diesel fuel sold at the motor fuel site was biodiesel blended fuel. For tax years beginning on or after January 1, 2012, the requirement that 50 percent of all diesel fuel gallons sold be biodiesel gallons to be eligible for the tax credit is eliminated.

The tax credit equals three cents multiplied by the qualifying number of biodiesel blended fuel gallons sold by the taxpayer during the tax year for gallons sold through December 31, 2011. For

gallons sold during the 2012 calendar year, the tax credit equals the sum of two cents multiplied by the qualifying number of biodiesel blended fuel gallons that have a minimum percentage of 2 percent by volume of biodiesel but less than 5 percent by volume of biodiesel and four and one-half cents multiplied by the qualifying number of biodiesel blended fuel gallons that have a minimum percentage of 5 percent by volume of biodiesel. For gallons sold during the 2013 to 2017 calendar years, the tax credit equals four and one-half cents multiplied by the qualifying number of biodiesel blended fuel gallons that have a minimum percentage of 5 percent by volume of biodiesel. In determining the minimum percentage by volume of biodiesel, the department will taken into account reasonable variances due to testing and other limitations. For purposes of this rule, tank wagon sales are considered retail sales. The credit is calculated on Form IA 8864.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

EXAMPLE: A taxpayer operated four retail motor fuel sites during 2006 and sold a combined total at all four sites of 100,000 gallons of diesel fuel, of which 55,000 gallons was biodiesel blended fuel containing a minimum percentage of 2 percent by volume of biodiesel. Because 50 percent or more of the diesel fuel sold was biodiesel blended fuel, the taxpayer may claim the biodiesel blended fuel tax credit totaling $1,650, which is 55,000 gallons multiplied by three cents.

EXAMPLE: A taxpayer operated two retail motor fuel sites during 2006, and each site sold 40,000 gallons of diesel fuel. One site sold 25,000 gallons of biodiesel blended fuel, and the other site sold 10,000 gallons of biodiesel blended fuel. The taxpayer would not be eligible for the biodiesel blended fuel tax credit because only 35,000 gallons of the total 80,000 gallons, or 43.75 percent of the total diesel fuel gallons sold, was biodiesel blended fuel. The 50 percent requirement is based on the aggregate number of diesel fuel gallons sold by the taxpayer, and the fact that one retail motor fuel site met the 50 percent requirement does not allow the taxpayer to claim the biodiesel blended fuel tax credit for the 2006 tax year. If the facts in this example had occurred during the 2009 tax year, the taxpayer could claim a biodiesel blended fuel tax credit totaling $750, which is 25,000 gallons multiplied by three cents, since one of the retail motor fuel sites met the 50 percent biodiesel blended fuel requirement.

52.31(1) *Fiscal year filers.* For taxpayers whose tax year is not on a calendar-year basis and whose tax year ends before December 31, 2006, the taxpayer may compute the tax credit on the gallons of biodiesel blended fuel sold during the period from January 1, 2006, through the end of the tax year, provided that 50 percent of all diesel fuel sold during that period was biodiesel blended fuel. Because the tax credit is repealed on January 1, 2018, a taxpayer whose tax year ends prior to December 31, 2017, may continue to claim the tax credit in the following tax year for any biodiesel blended fuel sold through December 31, 2017.

EXAMPLE: A taxpayer who operates one retail motor fuel site has a fiscal year ending April 30, 2006. The taxpayer sold 60,000 gallons of diesel fuel for the period from May 1, 2005, through April 30, 2006, of which 28,000 gallons was biodiesel blended fuel. However, for the period from January 1, 2006, through April 30, 2006, the taxpayer sold 20,000 gallons of diesel fuel, of which 12,000 gallons was biodiesel blended fuel. The taxpayer is entitled to claim the biodiesel blended fuel tax credit of $360 (12,000 gallons times 3 cents) on the taxpayer's Iowa income tax return for the period ending April 30, 2006, since more than 50 percent of all diesel fuel sold during the period from January 1, 2006, through April 30, 2006, was biodiesel blended fuel.

EXAMPLE: A taxpayer who operates one retail motor fuel site has a fiscal year ending June 30, 2006. The taxpayer sold 80,000 gallons of diesel fuel for the period from July 1, 2005, through June 30, 2006, of which 42,000 gallons was biodiesel blended fuel. However, for the period from January 1, 2006, through June 30, 2006, the taxpayer sold 40,000 gallons of diesel fuel, of which 19,000 gallons was biodiesel blended fuel. The taxpayer is not entitled to claim the biodiesel blended fuel tax credit on the taxpayer's Iowa income tax return for the period ending June 30, 2006, since less than 50 percent of all diesel fuel sold during the period from January 1, 2006, through June 30, 2006, was biodiesel blended fuel, even though more than 50 percent of all diesel fuel sold during the period from July 1, 2005, through June 30, 2006, was biodiesel blended fuel.

EXAMPLE: A taxpayer who operates one retail motor fuel site has a fiscal year ending February 28, 2012. The taxpayer sold 100,000 gallons of diesel fuel for the period from March 1, 2011, through February 28, 2012, of which 60,000 gallons was biodiesel blended fuel. For the period from March 1, 2011, through December 31, 2011, the taxpayer sold 85,000 gallons of diesel fuel, of which 50,000 gallons was biodiesel fuel. The taxpayer is entitled to claim the biodiesel blended fuel tax credit of $1,500 (50,000 gallons times 3 cents) on the taxpayer's Iowa income tax return for the period ending February 12, 2012, since the credit is computed only on gallons sold through December 31, 2011.

52.31(2) *Allocation of credit to owners of a business entity.* If a taxpayer claiming the biodiesel blended fuel tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 422.33 as amended by 2011 Iowa Acts, Senate File 531.

[**ARC 9821B**, IAB 11/2/11, effective 12/7/11]

701—52.32(422) Soy-based transformer fluid tax credit. Effective for tax periods ending after June 30, 2006, and beginning before January 1, 2009, an electric utility may claim a soy-based transformer fluid tax credit. An electric utility, which is a public utility, city utility, or electric cooperative which furnishes electricity, may claim a credit equal to the costs incurred during the tax year for the purchase and replacement costs relating to the transition from using nonsoy-based transformer fluid to using soy-based transformer fluid.

52.32(1) *Eligibility requirements for the tax credit.* All of the following conditions must be met for the electric utility to qualify for the soy-based transformer fluid tax credit.

a. The costs must be incurred after June 30, 2006, and before January 1, 2009.

b. The costs must be incurred in the first 18 months of the transition from using nonsoy-based transformer fluid to using soy-based transformer fluid.

c. The soy-based transformer fluid must be dielectric fluid that contains at least 98 percent soy-based products.

d. The costs of the purchase and replacement must not exceed $2 per gallon of soy-based transformer fluid used in the transition.

e. The number of gallons used in the transition must not exceed 20,000 gallons per electric utility, and the total number of gallons eligible for the credit must not exceed 60,000 gallons in the aggregate.

f. The electric utility shall not deduct for Iowa income tax purposes the costs incurred in the transition to using soy-based transformer fluid which are deductible for federal income tax purposes.

52.32(2) *Applying for the tax credit.* An electric utility must apply to the department for the soy-based transformer fluid tax credit. The application for the tax credit must be filed no later than 30 days after the close of the tax year for which the credit is claimed. The application must include the following information:

a. A copy of the signed purchase agreement or other agreement to purchase soy-based transformer fluid.

b. The number of gallons of soy-based transformer fluid purchased during the tax year, along with the cost per gallon of each purchase made during the tax year.

c. The name, address, and tax identification number of the electric utility.

d. The type of tax for which the credit will be claimed, and the first year in which the credits will be claimed.

e. If the application is filed by a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, a list of the partners, members, shareholders or beneficiaries of the entity. This list shall include the name, address, tax identification number and pro-rata share of earnings from the entity for each of the partners, members, shareholders or beneficiaries.

52.32(3) *Claiming the tax credit.* After the application is reviewed, the department will issue a tax credit certificate to the electric utility. The tax credit certificate will include the taxpayer's name, address and federal identification number, the tax type for which the credit will be claimed, the amount of the credit and the tax year for which the credit may be claimed. Once the tax credit certificate is issued, the credit may be claimed only against the type of tax reflected on the certificate. If the department refuses to issue the tax credit certificate, the taxpayer shall be notified in writing; and the taxpayer will have 60 days from the date of denial to file a protest in accordance with rule 701—7.41(17A).

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on the partner's, member's, shareholder's or beneficiary's pro-rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

This rule is intended to implement Iowa Code Supplement section 422.33 as amended by 2008 Iowa Acts, Senate File 572.

701—52.33(175,422) Agricultural assets transfer tax credit. Effective for tax years beginning on or after January 1, 2007, an owner of agricultural assets that rents assets to qualified beginning farmers may claim an agricultural assets transfer tax credit for Iowa corporation income tax. The credit is equal to 5 percent of the rental income received by the owner for cash rental agreements, and the credit is equal to 15 percent of the rental income received by the owner for commodity share agreements. The administrative rules for the agricultural assets transfer tax credit for the Iowa agricultural development authority may be found under 25—Chapter 6.

To qualify for the tax credit, an owner of agricultural assets must enter into a lease or rental agreement with a beginning farmer for a term of at least two years, but not more than five years. Both the owner of agricultural assets and the beginning farmer must meet certain qualifications set forth by the Iowa agricultural development authority, and the beginning farmer must be eligible to receive financial assistance under Iowa Code section 175.12.

The Iowa agricultural development authority will issue a tax credit certificate to the owner of agricultural assets which will include the name, address and tax identification number of the owner, the amount of the credit, and the tax period for which the credit may be applied. To claim the tax credit, the owner must attach the tax credit certificate to the tax return for the tax period set forth on the certificate. For fiscal years beginning on or after July 1, 2009, the amount of tax credit certificates issued by the Iowa agricultural development authority cannot exceed $6 million, and the credit certificates will be issued on a first-come, first-served basis.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier. The tax credit shall not be carried back to a tax year prior to the year in which the owner redeems the credit. The credit is not transferable to any other person other than the taxpayer's estate or trust upon the death of the taxpayer.

If an owner of agricultural assets is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

The lease or rental agreement may be terminated by either the owner or the beginning farmer. If the agricultural development authority determines that the owner is not at fault for the termination, the authority will not issue a tax credit certificate for subsequent years, but any prior tax credit certificates issued will be allowed. If the authority determines that the owner is at fault for the termination, any prior tax credit certificates will be disallowed. The amount of tax credits previously allowed will be

recaptured, and the owner will be required to repay the entire amount of tax credits previously claimed on Iowa returns.

This rule is intended to implement Iowa Code section 175.37 as amended by 2009 Iowa Acts, Senate File 473, and section 422.33.
[**ARC 8589B**, IAB 3/10/10, effective 4/14/10]

701—52.34(15,422) Film qualified expenditure tax credit. Effective for tax years beginning on or after January 1, 2007, a film qualified expenditure tax credit is available for corporation income tax. The tax credit cannot exceed 25 percent of the taxpayer's qualified expenditures in a film, television, or video project registered with the film office of the Iowa department of economic development (IDED). The film office may negotiate the amount of the tax credit. The administrative rules for the film qualified expenditure tax credit for IDED may be found at 261—Chapter 36.

52.34(1) *Qualified expenditures.* A qualified expenditure is a payment to an Iowa resident or an Iowa-based business for the sale, rental or furnishing of tangible personal property or services directly related to the registered project. The qualified expenditures include, but are not limited to, the following:

1. Aircraft.
2. Vehicles.
3. Equipment.
4. Materials.
5. Supplies.
6. Accounting services.
7. Animals and animal care services.
8. Artistic and design services.
9. Graphics.
10. Construction.
11. Data and information services.
12. Delivery and pickup services.
13. Labor and personnel. For limitations on the amount of labor and personnel expenditures, see Iowa department of economic development 261—paragraph 36.7(2)*"b."*
14. Lighting services.
15. Makeup and hairdressing services.
16. Film.
17. Music.
18. Photography.
19. Sound.
20. Video and related services.
21. Printing.
22. Research.
23. Site fees and rental.
24. Travel related to Iowa distant locations.
25. Trash removal and cleanup.
26. Wardrobe.

A detailed list of all qualified expenditures for each of these categories is available from the film office of IDED.

52.34(2) *Claiming the tax credit.* Upon completion of the registered project in Iowa, the taxpayer must submit, in a format approved by IDED prior to production, a listing of the qualified expenditures. Upon verification of the qualified expenditures, IDED will issue a tax credit certificate to the taxpayer. The certificate will list the taxpayer's name, address, and tax identification number; the date of project completion; the amount of the credit; the tax period for which the credit may be applied; and the type of tax for which the credit will be applied.

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners,

members, shareholders or beneficiaries based on each partner's, member's, shareholder's or beneficiary's pro-rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust.

To claim the tax credit, the taxpayer must attach the tax credit certificate to the tax return for the tax period set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for five years or until the tax credit is used, whichever is the earlier. The tax credit cannot be carried back to a tax year prior to the year in which the taxpayer claimed the tax credit.

52.34(3) *Transfer of the film qualified expenditure tax credit.* The film qualified expenditure tax credit may be transferred no more than two times to any person or entity.

Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department of revenue will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the film qualified expenditure tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

This rule is intended to implement Iowa Code section 15.393 as amended by 2009 Iowa Acts, Senate File 480, and Iowa Code section 422.33.

[**ARC 8589B**, IAB 3/10/10, effective 4/14/10]

701—52.35(15,422) Film investment tax credit. Effective for tax years beginning on or after January 1, 2007, a film investment tax credit is available for corporation income tax. The tax credit cannot exceed 25 percent of the taxpayer's investment in a film, television, or video project registered with the film office of the Iowa department of economic development (IDED). The film office may negotiate the amount of the tax credit. The administrative rules for the film investment tax credit for IDED may be found at 261—Chapter 36.

52.35(1) *Claiming the tax credit.* Upon completion of the project in Iowa and verification of the investment in the project, IDED will issue a tax credit certificate to the taxpayer. The certificate will list the taxpayer's name, address, and tax identification number; the date of project completion; the amount of the credit; the tax period for which the credit may be applied; and the type of tax for which the credit will be applied.

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on each partner's, member's, shareholder's or beneficiary's pro-rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust.

To claim the tax credit, the taxpayer must attach the tax credit certificate to the tax return for the tax period set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for five years or until the tax credit is used, whichever is the earlier. The tax credit cannot be carried back to a tax year prior to the year in which the taxpayer claimed the tax credit. In addition, a taxpayer cannot claim the film investment tax credit for qualified expenditures for which the film expenditure tax credit set forth in rule 701—52.34(15,422) is claimed.

The total of all film investment tax credits for a particular project cannot exceed 25 percent of the qualified expenditures as set forth in subrule 52.34(1) for the particular project. If the amount of investment exceeds the qualified expenditures, the tax credit will be allocated proportionately. For example, if three investors each invested $100,000 in a project but the qualified expenditures in Iowa only totaled $270,000, each investor would receive a tax credit based on a $90,000 investment amount.

52.35(2) *Transfer of the film investment tax credit.* The film investment tax credit may be transferred no more than two times to any person or entity.

Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department of revenue will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the film investment tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

This rule is intended to implement Iowa Code section 15.393 as amended by 2009 Iowa Acts, Senate File 480, section 4, and Iowa Code section 422.33.
[**ARC 8589B**, IAB 3/10/10, effective 4/14/10]

701—52.36(422) Ethanol promotion tax credit. Effective for tax years beginning on or after January 1, 2009, a retail dealer of gasoline may claim an ethanol promotion tax credit. For purposes of this rule, tank wagon sales are considered retail sales. The ethanol promotion tax credit is computed on Form IA 137.

52.36(1) *Definitions.* The following definitions are applicable to this rule:

"Biodiesel gallonage" means the total number of gallons of biodiesel which the retail dealer sells from motor fuel pumps during a determination period. For example, 5,000 gallons of biodiesel blended fuel with a 2 percent by volume of biodiesel sold during a determination period results in a biodiesel gallonage of 100 (5,000 times 2%).

"Biofuel distribution percentage" means the sum of the retail dealer's total ethanol gallonage plus the retail dealer's total biodiesel gallonage expressed as a percentage of the retail dealer's total gasoline gallonage.

"Biofuel threshold percentage" is dependent on the aggregate number of gallons of motor fuel sold by a retail dealer during a determination period, as set forth below:

Determination Period	More than 200,000 Gallons Sold by Retail Dealer	200,000 Gallons or Less Sold by Retail Dealer
2009	10%	6%
2010	11%	6%
2011	12%	10%
2012	13%	11%
2013	14%	12%
2014	15%	13%

2015	17%	14%
2016	19%	15%
2017	21%	17%
2018	23%	19%
2019	25%	21%
2020	25%	25%

"Biofuel threshold percentage disparity" means the positive percentage difference between the retail dealer's biofuel threshold percentage and the retail dealer's biofuel distribution percentage. For example, if a retail dealer that sells more than 200,000 gallons of motor fuel in 2009 has a biofuel distribution percentage of 8 percent, the biofuel threshold percentage disparity equals 2 percent (10% minus 2%).

"Determination period" means any 12-month period beginning on January 1 and ending on December 31.

"Ethanol gallonage" means the total number of gallons of ethanol which the retail dealer sells from motor fuel pumps during a determination period. For example, 10,000 gallons of ethanol blended gasoline formulated with a 10 percent by volume of ethanol sold during a determination period results in an ethanol gallonage of 1,000 (10,000 gallons times 10%).

"Gasoline gallonage" means the total number of gallons of gasoline sold by the retail dealer during a determination period.

52.36(2) *Calculation of tax credit.*

a. The tax credit is calculated by multiplying the retail dealer's total ethanol gallonage by the tax credit rate, which is adjusted based upon the retail dealer's biofuel threshold percentage disparity. The tax credit rate is set forth below:

Biofuel Threshold Percentage Disparity	Tax Credit Rate per Gallon 2009-2010	Tax Credit Rate per Gallon 2011	Tax Credit Rate per Gallon 2012-2020
0%	6.5 cents	8 cents	8 cents
0.01% to 2.00%	4.5 cents	6 cents	6 cents
2.01% to 4.00%	2.5 cents	2.5 cents	4 cents
4.01% or more	0 cents	0 cents	0 cents

b. For use in calculating a retail dealer's total ethanol gallonage, the department is required to establish a schedule regarding the average amount of ethanol contained in E-85 gasoline.

c. A taxpayer may claim the ethanol promotion tax credit even if the taxpayer also claims the E-85 gasoline promotion tax credit provided in rule 701—52.30(422) or the E-15 plus gasoline promotion tax credit provided in rule 701—52.43(422) for the same tax year for the same ethanol gallons.

d. The tax credit must be calculated separately for each retail motor fuel site operated by the taxpayer for tax years beginning prior to January 1, 2011. The biofuel threshold percentage disparity of the taxpayer is computed on a statewide basis based on the total ethanol gallonage sold in Iowa. The taxpayer must determine the ethanol gallonage sold at each retail motor fuel site and multiply this ethanol gallonage by the applicable tax credit rate based on the biofuel threshold percentage disparity to calculate the ethanol promotion tax credit.

e. For tax years beginning on or after January 1, 2011, the taxpayer may elect to compute the biofuel threshold percentage disparity and the tax credit on either a site-by-site basis or on a companywide basis. The election made on the first return beginning on or after January 1, 2011, for either the site-by-site method or the companywide method is binding on the taxpayer for subsequent tax years unless the taxpayer petitions the department for a change in the method. Any petition for a change in the method should be made within a reasonable period of time prior to the due date of the return for which the change is requested. For example, if a change is requested for the tax return beginning January 1, 2012, the petition should be made by January 31, 2013, which is 90 days prior to the due date of the return.

The mere fact that a change in the method will result in a larger tax credit for subsequent years is not, of itself, sufficient grounds for changing the method for computing the credit. An example of a case for which the department may grant a change in the method is if the taxpayer has a significant change in the type of fuel sold at the taxpayer's retail sites in Iowa. For example, if a retail dealer opted to start selling E-85 gasoline at all the taxpayer's retail sites in Iowa for a subsequent tax year, the department may grant a change in the method.

If a taxpayer chooses the site-by-site method to compute the biofuel threshold percentage disparity, the gallons sold at all sites in Iowa must be considered in determining if the biofuel threshold percentage as defined in subrule 52.36(1) is based on more than 200,000 gallons, or 200,000 gallons or less. For example, if a taxpayer operates three motor fuel sites in Iowa and each site sells 80,000 gallons of motor fuel during 2011, the biofuel threshold percentage of 12 percent must be used for each retail site if the tax credit is computed on a site-by-site basis, even though each retail site sold less than 200,000 gallons of motor fuel.

f. Any tax credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming a refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

52.36(3) *Fiscal year filers.* or taxpayers whose tax year is not on a calendar year basis, the taxpayer may compute the ethanol promotion tax credit on the total ethanol gallonage sold during the year using the designated tax credit rates as shown in subrule 52.36(2), paragraph *"a."* Because the tax credit is repealed on January 1, 2021, a taxpayer whose tax year ends prior to December 31, 2020, may continue to claim the tax credit in the following tax year for the total ethanol gallonage sold through December 31, 2020. For a taxpayer whose tax year is not on a calendar year basis and that did not claim the ethanol promotion tax credit on the previous return, the taxpayer may claim the tax credit for the current tax year for the period beginning on January 1 of the previous tax year until the last day of the previous tax year.

52.36(4) *Allocation of tax credit to owners of a business entity.* If a taxpayer claiming the ethanol promotion tax credit is a partnership, limited liability company, S corporation, estate, or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by the individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, estate, or trust.

52.36(5) *Examples.* The following noninclusive examples illustrate how this rule applies:

EXAMPLE 1. A taxpayer that is a retail dealer of gasoline operates only one motor fuel site in Iowa. The number of gallons of gasoline sold at this site in 2009 equals 100,000 gallons. This consisted of 5,000 gallons of E-85 gasoline, 80,000 gallons of E-10 (10% ethanol blended gasoline) and 15,000 gallons not containing ethanol. The average ethanol content of E-85 gasoline is assumed to be 79%. The taxpayer also sold at this site during 2009 15,000 gallons of diesel fuel, of which 5,000 gallons was B-2 (2% biodiesel). The ethanol gallonage is 11,950 (5,000 E-85 gallons times 79% equals 3,950; 80,000 E-10 gallons times 10% equals 8,000; and thus 3,950 plus 8,000 equals 11,950). The biodiesel gallonage sold is 100, or 5,000 times 2%. The sum of 11,950 and 100, or 12,050, is divided by the total gasoline gallonage of 100,000 to arrive at a biofuel distribution percentage of 12.05%. Since this exceeds the biofuel threshold percentage of 6% for a retail dealer selling 200,000 gallons or less, the biofuel threshold disparity percentage is 0%. This results in an ethanol promotion tax credit of 6.5 cents times 11,950, or $776.75.

In addition, the taxpayer is entitled to claim the E-85 gasoline promotion tax credit equal to 20 cents multiplied by 5,000 gallons, or $1,000.

EXAMPLE 2. A taxpayer that is a retail dealer of gasoline operates only one motor fuel site in Iowa. The number of gallons of gasoline sold at this site in 2010 equals 300,000 gallons. This consisted of 10,000 gallons of E-85 gasoline, 230,000 gallons of E-10 (10% ethanol blended gasoline) and 60,000 gallons not containing ethanol. The average ethanol content of E-85 gasoline is assumed to be 79%. The taxpayer also sold at this site during 2010 60,000 gallons of diesel fuel, of which 25,000 gallons was B-2 (2% biodiesel). The ethanol gallonage is 30,900 (10,000 E-85 gallons times 79% equals 7,900; 230,000 E-10 gallons times 10% equals 23,000; and thus 7,900 plus 23,000 equals 30,900). The biodiesel gallonage sold is 500, or 25,000 times 2%. The sum of 30,900 and 500, or 31,400, is divided by the total gasoline gallonage of 300,000 to arrive at a biofuel distribution percentage of 10.47%. Since this is less

than the biofuel threshold percentage of 11% for a retail dealer selling more than 200,000 gallons, the biofuel threshold disparity percentage is .53%. This results in an ethanol promotion tax credit of 4.5 cents times 30,900, or $1,390.50.

In addition, the taxpayer is entitled to claim the E-85 gasoline promotion tax credit equal to 20 cents multiplied by 10,000 gallons, or $2,000.

EXAMPLE 3. A taxpayer that is a retail dealer of gasoline operates three motor fuel sites in Iowa during 2009, and each site sold 80,000 gallons of gasoline. Sites A and B each sold 70,000 gallons of E-10 (10% ethanol blended gasoline) and 10,000 gallons not containing ethanol. Site C sold 60,000 gallons of E-10, 10,000 gallons of E-85, and 10,000 gallons not containing ethanol. The average ethanol content of E-85 gasoline is assumed to be 79%. The retail dealer did not sell any diesel fuel at any of the motor fuel sites. The ethanol gallonage is 27,900, as shown below:

Site A – 70,000 times 10% equals	7,000
Site B – 70,000 times 10% equals	7,000
Site C – 60,000 times 10% equals	6,000
Site C – 10,000 times 79% equals	7,900
Total	27,900

The ethanol gallonage of 27,900 is divided by the gasoline gallonage of 240,000 to arrive at a biofuel distribution percentage of 11.63%. Since this exceeds the biofuel threshold percentage of 10% for a retail dealer selling more than 200,000 gallons, the biofuel threshold disparity percentage is 0%. The credit is computed separately for each motor fuel site, and the ethanol promotion credit equals $1,813.50, as shown below:

Site A – 7,000 times 6.5 cents equals	$455.00
Site B – 7,000 times 6.5 cents equals	$455.00
Site C – 13,900 times 6.5 cents equals	$903.50
Total	$1,813.50

Since the biofuel distribution percentage and the biofuel threshold percentage disparity are computed on a statewide basis for all gallons sold in Iowa, the 6.5 cent tax credit rate is applied to the total ethanol gallonage, even if Sites A and B did not meet the biofuel threshold percentage of 10% for 2009.

In addition, the taxpayer is entitled to claim the E-85 gasoline promotion tax credit equal to 20 cents multiplied by 10,000 gallons, or $2,000.

EXAMPLE 4. A taxpayer that is a retail dealer of gasoline has a fiscal year ending March 31, 2011, and operates one motor fuel site in Iowa. The taxpayer sold more than 200,000 gallons of gasoline during the 2010 calendar year and expects to sell more than 200,000 gallons of gasoline during the 2011 calendar year. The ethanol gallonage is 30,000 for the period from April 1, 2010, through December 31, 2010, and the ethanol gallonage is 8,000 for the period from January 1, 2011, through March 31, 2011. The biofuel distribution percentage is 11.5% for the period from April 1, 2010, through December 31, 2010, and the biofuel distribution percentage is 11.8% for the period from January 1, 2011, through March 31, 2011. This results in a biofuel threshold percentage disparity of 0% (11.0 minus 11.5) for the period from April 1, 2010, through December 31, 2010, and a biofuel threshold percentage disparity of .2% (12.0 minus 11.8) for the period from January 1, 2011, through March 31, 2011. The taxpayer is entitled to an ethanol promotion tax credit of $2,310 for the fiscal year ending March 31, 2011, as shown below:

30,000 times 6.5 cents equals	$1,950
8,000 times 4.5 cents equals	360
Total	$2,310

EXAMPLE 5. A taxpayer that is a retail dealer of gasoline has a fiscal year ending April 30, 2009, and operates one motor fuel site in Iowa. The taxpayer expects to sell more than 200,000 gallons of gasoline

during the 2009 calendar year. The ethanol gallonage is 50,000 gallons for the period from January 1, 2009, through April 30, 2009. The biofuel distribution percentage is 7.7% for the period from January 1, 2009, through April 30, 2009, which results in a biofuel threshold percentage disparity of 2.3% (10.0 minus 7.7). The taxpayer is entitled to claim an ethanol promotion tax credit of $1,250 (50,000 gallons times 2.5 cents) on the taxpayer's Iowa income tax return for the period ending April 30, 2009.

In lieu of claiming the credit on the return for the period ending April 30, 2009, the taxpayer may claim the ethanol promotion tax credit on the tax return for the period ending April 30, 2010, including the ethanol gallonage for the period from January 1, 2009, through April 30, 2010. In this case, the taxpayer will compute the biofuel distribution percentage for the period from January 1, 2009, through December 31, 2009, to determine the proper tax credit rate to be applied to the ethanol gallonage for the period from January 1, 2009, through December 31, 2009.

EXAMPLE 6. Assume the same facts as Example 3, except that the gallons were sold in 2011. The taxpayer chose the companywide method to compute the biofuel threshold percentage disparity and the tax credit. The biofuel distribution percentage is 11.63%, and since the biofuel threshold percentage is 12% for retailers selling more than 200,000 gallons of motor fuel, the biofuel threshold percentage disparity is 0.37%. This results in an ethanol promotion tax credit on a companywide basis of 6 cents multiplied by the ethanol gallonage of 27,900 or $1,674.

EXAMPLE 7. Assume the same facts as Example 3, except that the gallons were sold in 2011. The taxpayer chose the site-by-site method to compute the biofuel threshold percentage disparity and the tax credit. The biofuel threshold percentage is still 12% since the retailer sold more than 200,000 gallons of motor fuel at all sites in Iowa. The biofuel distribution percentage for Site A and Site B is 7,000 divided by 80,000, or 8.75%. The biofuel threshold percentage disparity for Site A and Site B is 3.25%, or 12% less 8.75%. The biofuel distribution percentage for Site C is 13,900 divided by 80,000, or 17.38%. The biofuel threshold percentage disparity for Site C is 0% since the biofuel distribution percentage exceeds the biofuel threshold percentage. This results in an ethanol promotion tax credit on a site-by-site basis of $1,462, as shown below:

Site A – 7,000 times 2.5 cents equals	$175
Site B – 7,000 times 2.5 cents equals	$175
Site C – 13,900 times 8 cents equals	$1,112
Total	$1,462

This rule is intended to implement Iowa Code section 422.33 as amended by 2011 Iowa Acts, Senate File 531.
[**ARC 9821B**, IAB 11/2/11, effective 12/7/11]

701—52.37(422) Charitable conservation contribution tax credit. Effective for tax years beginning on or after January 1, 2008, a charitable conservation contribution tax credit is available for corporation income tax which is equal to 50 percent of the fair market value of a qualified real property interest located in Iowa that is conveyed as an unconditional charitable donation in perpetuity by a taxpayer to a qualified organization exclusively for conservation purposes.

52.37(1) *Definitions.* The following definitions are applicable to this rule:

"Conservation purpose" means the same as defined in Section 170(h)(4) of the Internal Revenue Code, with the exception that a conveyance of land for open space for the purpose of fulfilling density requirements to obtain subdivision or building permits is not considered a conveyance for a conservation purpose.

"Qualified organization" means the same as defined in Section 170(h)(3) of the Internal Revenue Code.

"Qualified real property interest" means the same as defined in Section 170(h)(2) of the Internal Revenue Code. Conservation easements and bargain sales are examples of a qualified real property interest.

52.37(2) *Computation of the credit.* The credit equals 50 percent of the fair market value of the qualified real property interest. There are numerous federal revenue regulations, rulings, court cases and other provisions relating to the determination of the value of a qualified real property interest, and these are equally applicable in determining the amount of the charitable conservation contribution tax credit.

The maximum amount of the tax credit is $100,000. The amount of the contribution for which the tax credit is claimed shall not be claimed as a deduction for charitable contributions for Iowa income tax purposes.

52.37(3) *Claiming the tax credit.* The tax credit is claimed on Form IA 148, Tax Credits Schedule. The taxpayer must attach a copy of federal Form 8283, Noncash Charitable Contributions, which reflects the calculation of the fair market value of the real property interest, to the Iowa return for the year in which the contribution is made. If a qualified appraisal of the property or other relevant information is required to be attached to federal Form 8283 for federal tax purposes, the appraisal and other relevant information must also be attached to the Iowa return.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following 20 years or until used, whichever is the earlier.

If the taxpayer claiming the credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

52.37(4) *Examples.* The following noninclusive examples illustrate how this rule applies:

EXAMPLE 1: A taxpayer conveys a real property interest with a fair market value of $150,000 to a qualified organization during 2008. The tax credit is equal to $75,000, or 50 percent of the $150,000 fair market value of the real property. The taxpayer cannot claim the $150,000 as a deduction for charitable contributions on the Iowa corporation income tax return for 2008.

EXAMPLE 2: A taxpayer conveys a real property interest with a fair market value of $500,000 to a qualified organization during 2009. The tax credit is limited to $100,000, which equates to $200,000 of the contribution being eligible for the tax credit. The remaining amount of $300,000 ($500,000 less $200,000) can be claimed as a deduction for charitable contributions on the Iowa corporation income tax return for 2009.

This rule is intended to implement Iowa Code Supplement section 422.33 as amended by 2008 Iowa Acts, House File 2700, section 63.

701—52.38(422) School tuition organization tax credit. Effective for tax years beginning on or after July 1, 2009, a school tuition organization tax credit is available which is equal to 65 percent of the amount of the voluntary cash or noncash contribution made by a corporation taxpayer to a school tuition organization. The credit is not available for S corporations, partnerships and limited liability companies where the income is taxed directly to the individual shareholders, partners or members. For information on the initial registration, participation forms and reporting requirements for school tuition organizations, see rule 701—42.30(422).

52.38(1) *Amount of tax credit authorized.* Of the $7.5 million of school tuition organization tax credits authorized for the 2009 through 2011 calendar years, no more than 25 percent, or $1,875,000, can be authorized for corporation income tax taxpayers. Of the $8.75 million of school tuition organization tax credits authorized for 2012 and subsequent calendar years, no more than 25 percent, or $2,187,500, can be authorized for corporation income tax taxpayers.

52.38(2) *Issuance of tax credit certificates.* The school tuition organization shall issue tax credit certificates to each taxpayer who made a cash or noncash contribution to the school tuition organization. The tax credit certificate will contain the name, address and tax identification number of the taxpayer, the amount and date that the contribution was made, the amount of the credit, the tax year that the credit may be applied, the school tuition organization to which the contribution was made, and the tax credit certificate number.

52.38(3) *Claiming the tax credit.* The taxpayer must attach the tax credit certificate to the tax return for which the credit is claimed. Any credit in excess of the tax liability for the tax year may be credited to

the tax liability for the following five years or until used, whichever is the earlier. The taxpayer may not claim a deduction for charitable contributions for Iowa corporation income tax purposes for the amount of the contribution made to the school tuition organization.

This rule is intended to implement Iowa Code section 422.33.

[**ARC 8589B**, IAB 3/10/10, effective 4/14/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—52.39(15,422) Redevelopment tax credit. Effective for tax years beginning on or after July 1, 2009, a taxpayer whose project has been approved by the Iowa brownfield redevelopment advisory council may claim a redevelopment tax credit. The credit is based on the taxpayer's qualifying investment in a brownfield or grayfield site. The administrative rules for a redevelopment project for the brownfield redevelopment authority which qualifies for the tax credit, including definitions of brownfield and grayfield sites, may be found in rules 261—65.11(15) and 261—65.12(15).

52.39(1) *Eligibility for the credit.* The economic development authority is responsible for developing a system for registration and authorization of projects receiving redevelopment tax credits. For the fiscal year beginning July 1, 2009, the maximum amount of tax credits allowed was $1 million, and the amount of credits authorized for any one redevelopment project could not exceed $100,000. For fiscal years beginning July 1, 2011, and subsequent fiscal years, the maximum amount of tax credits allowed cannot exceed $5 million, and the amount of credit authorized for any one redevelopment project cannot exceed $500,000.

52.39(2) *Computation and claiming of the credit.*

a. The amount of the tax credit shall equal one of the following:

(1) Twelve percent of the taxpayer's qualifying investment in a grayfield site.

(2) Fifteen percent of the taxpayer's qualifying investment in a grayfield site if the qualifying redevelopment project meets the requirements of green development as defined in rule 261—65.2(15).

(3) Twenty-four percent of the taxpayer's qualifying investment in a brownfield site.

(4) Thirty percent of the taxpayer's qualifying investment in a brownfield site if the qualifying redevelopment project meets the requirements of green development as defined in rule 261—65.2(15).

b. Upon completion of the project, the Iowa department of economic development will issue a tax credit certificate to the taxpayer. The tax credit certificate shall include the taxpayer's name, address and federal identification number, the tax type for which the credit will be claimed, the amount of the credit, the tax year for which the credit may be claimed and the tax credit certificate number. In addition, the tax credit certificate will include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 52.39(3).

c. If a taxpayer claiming the tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

d. The increase in the basis of the redevelopment property that would otherwise result from the qualified redevelopment costs shall be reduced by the amount of the redevelopment tax credit. For example, if a qualifying investment in a grayfield site totaled $100,000 for which a $12,000 redevelopment tax credit was issued, the increase in the basis of the property would total $88,000 for Iowa tax purposes ($100,000 less $12,000).

e. To claim the tax credit, the taxpayer must attach the tax credit certificate to the tax return for the tax period set forth on the certificate. Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier. The tax credit shall not be carried back to a tax year prior to the year in which the taxpayer redeems the credit.

52.39(3) *Transfer of the credit.* The redevelopment tax credit can be transferred to any person or entity.

Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the

department of revenue will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information describing how the redevelopment tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income tax, corporation income tax, or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income tax, corporation income tax, or franchise tax purposes.

This rule is intended to implement Iowa Code section 15.293A as amended by 2011 Iowa Acts, Senate File 514, and section 422.33.

[**ARC 8589B**, IAB 3/10/10, effective 4/14/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—52.40(15) High quality jobs program. Effective for tax periods beginning on or after July 1, 2009, a business which qualifies under the high quality jobs program is eligible to receive tax credits. The high quality jobs program replaces the high quality job creation program. An eligible business under the high quality jobs program must be approved by the Iowa department of economic development and meet the qualifications of Iowa Code section 15.329. The tax credits available under the high quality jobs program are based upon the number of jobs created or retained that pay a qualifying wage threshold and the amount of qualifying investment. The administrative rules for the high quality jobs program for the Iowa department of economic development may be found at 261—Chapter 68.

52.40(1) *Research activities credit.* An eligible business approved under the high quality jobs program is eligible for an additional research activities credit as described in subrule 52.7(4) for awards issued by the Iowa department of economic development prior to July 1, 2010. The eligible business is eligible for the research activities credit as described in subrule 52.7(6) for awards issued by the Iowa department of economic development on or after July 1, 2010.

Research activities allowable for the Iowa research activities credit include expenses related to the development and deployment of innovative renewable energy generation components manufactured or assembled in Iowa; such expenses related to the development and deployment of innovative renewable energy generation components are not eligible for the federal credit for increasing research activities. For purposes of this subrule, innovative renewable energy generation components do not include components with more than 200 megawatts in installed effective nameplate capacity. The research activities credit related to renewable energy generation components under the high quality jobs program and the enterprise zone program shall not exceed $2 million for the fiscal year ending June 30, 2010, and $1 million for the fiscal year ending June 30, 2011.

These expenses related to the development and deployment of innovative renewable energy generation components are applicable only to the additional research activities credit set forth in this subrule and in subrule 52.7(5) for businesses in enterprise zones, and are not applicable to the research activities credit set forth in subrule 52.7(3).

52.40(2) *Investment tax credit.* An eligible business can claim an investment tax credit equal to a percentage of the new investment directly related to new jobs created or retained by the location or expansion of an eligible business. The percentage is equal to the amount provided in Iowa department of economic development 261—subrule 68.4(7).

The determination of the new investment eligible for the investment tax credit, the eligibility of a refundable investment tax credit for value-added agricultural product or biotechnology-related projects

and the repayment of investment tax credits for the high quality jobs program is the same as set forth in subrule 52.28(2) for the high quality job creation program.

This rule is intended to implement Iowa Code chapter 15.
[**ARC 8589B**, IAB 3/10/10, effective 4/14/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—52.41(15) Aggregate tax credit limit for certain economic development programs. Effective for the fiscal year beginning July 1, 2009, awards made under certain economic development programs cannot exceed $185 million during a fiscal year. These programs include the assistive device tax credit program, the enterprise zone program, the housing enterprise zone program, the film, television and video project promotion program, and the high quality jobs program. Effective for fiscal years beginning on or after July 1, 2010, awards made under these economic development programs cannot exceed $120 million during a fiscal year. The administrative rules for the aggregate tax credit limit for the Iowa department of economic development may be found at 261—Chapter 76.

This rule is intended to implement 2009 Iowa Code Supplement section 15.119 as amended by 2010 Iowa Acts, Senate File 2380.
[**ARC 8589B**, IAB 3/10/10, effective 4/14/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—52.42(16,422) Disaster recovery housing project tax credit. For tax years beginning on or after January 1, 2011, a disaster recovery housing project tax credit is available for corporation income tax. The credit is equal to 75 percent of the taxpayer's qualifying investment in a disaster recovery housing project, and is administered by the Iowa finance authority. Qualifying investments are costs incurred on or after May 12, 2009, and prior to July 1, 2010, related to a disaster recovery housing project. Eligible properties must have applied for and received an allocation of federal low-income housing tax credits under Section 42 of the Internal Revenue Code to be eligible for the tax credit. The administrative rules of the Iowa finance authority for the disaster recovery housing project tax credit may be found at 265—Chapter 34.

52.42(1) *Issuance of tax credit certificates.* Upon completion of the project and verification of the amount of investment made in the disaster recovery housing project, the Iowa finance authority will issue a tax credit certificate to the taxpayer. The tax credit certificate shall include the taxpayer's name, address, tax identification number, amount of credit, and the tax year for which the credit may be claimed. The tax credit certificates will be issued on a first-come, first-served basis. The tax credit cannot be transferred to any other person or entity.

52.42(2) *Limitation of tax credits.* The tax credit shall not exceed 75 percent of the taxpayer's qualifying investment in a disaster recovery housing project. The maximum amount of tax credits issued by the Iowa finance authority shall not exceed $3 million in each of the five consecutive years beginning in the 2011 calendar year. A tax credit certificate shall be issued by the Iowa finance authority for each year that the credit can be claimed.

52.42(3) *Claiming the tax credit.* The amount of the tax credit earned by the taxpayer will be divided by five and an amount equal thereto will be claimed on the Iowa corporation income tax return commencing with the tax year beginning on or after January 1, 2011. A taxpayer is not entitled to a refund of the excess tax for any tax credit in excess of the tax liability, and also is not entitled to carry forward any excess credit to a subsequent tax year.

If the taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

The increase in the basis of the property that would otherwise result from the disaster recovery housing investment shall be reduced by the amount of the tax credit allowed.

EXAMPLE: A corporation whose tax year ends on December 31 incurs $100,000 of costs related to an eligible disaster recovery housing project. The taxpayer receives a tax credit of $75,000, and $15,000 of credit can be claimed on each Iowa corporation income tax return for the periods ending December 31, 2011, through December 31, 2015. If the tax liability for the corporation for the period ending December 31, 2011, is $10,000, the credit is limited to $10,000, and the remaining $5,000 credit cannot be used.

If the tax liability for the corporation for the period ending December 31, 2012, is $25,000, the credit is limited to $15,000, and the remaining $5,000 credit from 2011 cannot be used to reduce the tax for 2012.

52.42(4) *Potential recapture of tax credits.* If the taxpayer fails to comply with the eligibility requirements of the project or violates local zoning and construction ordinances, the Iowa finance authority can void the tax credit and the department of revenue shall seek recovery of the value of any tax credit claimed on a corporation income tax return.

This rule is intended to implement Iowa Code Supplement sections 16.211 and 16.212 and Iowa Code section 422.33 as amended by 2009 Iowa Acts, Senate File 457.
[**ARC 8605B**, IAB 3/10/10, effective 4/14/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—52.43(422) E-15 plus gasoline promotion tax credit. Effective for eligible gallons sold on or after July 1, 2011, a retail dealer of gasoline may claim an E-15 plus gasoline promotion tax credit. "E-15 plus gasoline" means ethanol blended gasoline formulated with a minimum percentage of between 15 percent and 69 percent of volume of ethanol, if the formulation meets the standards provided in Iowa Code section 214A.2. For purposes of this rule, tank wagon sales are considered retail sales. The credit is calculated on Form IA138. The tax credit is calculated by multiplying the total number of E-15 plus gallons sold by the retail dealer during the tax year by the following designated rates:

Gallons sold from July 1, 2011, through December 31, 2014	3 cents
Gallons sold from January 1, 2015, through December 31, 2017	2 cents

A taxpayer may claim the E-15 plus gasoline promotion tax credit even if the taxpayer also claims the ethanol promotion tax credit provided in rule 701—52.36(422) for gallons sold for the same tax year for the same ethanol gallons.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

52.43(1) *Fiscal year filers.* For taxpayers whose tax year is not on a calendar-year basis, the taxpayer may compute the tax credit on the gallons of E-15 plus gasoline sold during the year using the designated rates as shown above. Because the tax credit is repealed on January 1, 2018, a taxpayer whose tax year ends prior to December 31, 2017, may continue to claim the tax credit in the following tax year for any E-15 plus gallons sold through December 31, 2017. For a retail dealer whose tax year is not on a calendar-year basis and who did not claim the E-15 plus credit on the previous return, the dealer may claim the credit for the current tax year for gallons sold for the period beginning on July 1 of the previous tax year until the last day of the previous tax year. However, for taxpayers whose fiscal year ends before December 31, 2011, the dealer must claim the credit for the current tax year for gallons sold for the period beginning on July 1 of the previous tax year until the last day of the previous tax year.

EXAMPLE 1: A taxpayer who is a retail dealer of gasoline has a fiscal year ending October 31, 2011. The taxpayer sold 2,000 gallons of E-15 plus gasoline for the period from July 1, 2011, through October 31, 2011, and sold 7,000 gallons of E-15 plus gasoline for the period from November 1, 2011, through October 31, 2012. The taxpayer is entitled to a total E-15 plus gasoline promotion tax credit of $270 for the fiscal year ending October 31, 2012, which consists of a $60 credit (2,000 gallons multiplied by 3 cents) for the period from July 1, 2011, through October 31, 2011, and a credit of $210 (7,000 gallons multiplied by 3 cents) for the period from November 1, 2011, through October 31, 2012.

EXAMPLE 2: A taxpayer who is a retail dealer of gasoline has a fiscal year ending April 30, 2012. The taxpayer sold 4,000 gallons of E-15 plus gasoline between July 1, 2011, and April 30, 2012. The taxpayer sold 9,000 gallons of E-15 plus gasoline between May 1, 2012, and April 30, 2013. The taxpayer is entitled to claim an E-15 plus gasoline promotion tax credit of $120 (4,000 gallons times 3 cents) for the fiscal year ending April 30, 2012. In lieu of claiming the credit on the return for the period ending April 30, 2012, the taxpayer can claim the E-15 plus gasoline promotion tax credit on the tax return for the period ending April 30, 2013, for all E-15 plus gasoline gallons sold for the period from July 1, 2011, through April 30, 2013.

EXAMPLE 3: A taxpayer who is a retail dealer of gasoline has a fiscal year ending February 28, 2018. The taxpayer sold 20,000 gallons of E-15 plus gasoline for the period from March 1, 2017, through February 28, 2018, of which 16,000 gallons were sold between March 1, 2017, and December 31, 2017. The taxpayer is entitled to claim an E-15 plus gasoline promotion tax credit of $320 (16,000 gallons times 2 cents) on the taxpayer's Iowa income tax return for the period ending February 28, 2018.

52.43(2) *Allocation of credit to owners of a business entity.* If a taxpayer claiming the E-15 plus gasoline promotion tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 422.33 as amended by 2011 Iowa Acts, Senate File 531.

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◊ Two or more ARCs

CHAPTER 58
FILING RETURNS, PAYMENT OF TAX, PENALTY AND INTEREST, AND TAX CREDITS

[Prior to 12/17/86, Revenue Department[730]]

701—58.1(422) Who must file. Every financial institution as defined in 701—subrule 57.1(2), regardless of net income, shall file a true and accurate return of its income or loss for the taxable period. The return shall be signed by the president or other duly authorized officer. If the financial institution was inactive or not doing business within Iowa, although qualified to do so, during the taxable year, the return must contain a statement to that effect.

58.1(1) *Income tax of financial institutions in liquidation.* When a financial institution is in the process of liquidation, or in the hands of a receiver, the franchise tax returns must be made under oath or affirmation of the persons responsible for the conduct of the affairs of such financial institutions, and must be filed at the same time and in the same manner as required of other financial institutions.

58.1(2) *Franchise tax returns for financial institutions dissolved.* Financial institutions which have been dissolved during the income year must file franchise tax returns for the period prior to dissolution which has not already been covered by previous returns. Officers and directors are responsible for the filing of the returns and for the payment of taxes, if any, for the audit period provided by law.

Where a financial institution dissolves and disposes of its assets without making provision for the payment of its accrued Iowa franchise tax, liability for the tax follows the assets so distributed and upon failure to secure the unpaid amount, suit to collect the tax may be instituted against the stockholders and other persons receiving the property, to the extent of the property received, except bona fide purchasers or others as provided by law.

This rule is intended to implement Iowa Code sections 422.60 and 422.61.

701—58.2(422) Time and place for filing return.

58.2(1) *Returns of financial institutions.* A return of income for all financial institutions must be filed on or before the delinquency date. The delinquency date for all financial institutions is the day following the last day of the fourth month following the close of the taxpayer's taxable year, whether the return is made on the basis of the calendar year or the fiscal year; or the day following the last day of the period covered by an extension of time granted by the director. When the last day prior to the delinquency date falls on a Saturday, Sunday or a legal holiday, the return will be timely if it is filed on the first business day following the Saturday, Sunday or legal holiday. If a return is placed in the mails, properly addressed and postage paid in ample time to reach the department on or before the delinquency date for filing, no penalty will attach should the return not be received until after that date. Mailed returns should be addressed to Franchise Tax Processing, P.O. Box 10413, Des Moines, Iowa 50306.

58.2(2) *Short period returns.* Where under a provision of the Internal Revenue Code, a financial institution is required to file a tax return for a period of less than 12 months, a short period Iowa franchise tax return must be filed for the same period. The delinquency date for the short period return is 45 days after the federal due date not considering any federal extension of time to file.

58.2(3) *Extension of time for filing returns for tax years beginning on or after January 1, 1991.* See 701—subrule 39.2(4).

58.2(4) *Extension of time for filing returns for tax years beginning on or after January 1, 1986.* Rescinded IAB 3/15/95, effective 4/19/95.

This rule is intended to implement Iowa Code sections 422.24, 422.62, and 422.66.

701—58.3(422) Form for filing.

58.3(1) *Use and completeness of prescribed forms.* Returns shall be made by financial institutions on forms supplied by the department. Taxpayers not supplied with the proper forms shall make application for same to the department in ample time to have their returns made, verified and filed on or before the delinquency date. Taxpayers shall carefully prepare their returns so as to fully and clearly set forth the data required. For lack of a prescribed form, a statement made by a taxpayer disclosing the taxpayer's

gross income and the deductions therefrom may be accepted as a tentative return, and if verified and filed within the prescribed time, will relieve the taxpayer from liability to penalties, provided that without unnecessary delay such a tentative return is replaced by a return made on the proper form. Each question shall be answered and each direction complied with in the same manner as if the forms and instructions were embodied in these rules.

Failure to receive the proper forms does not relieve the taxpayer from the obligation of making any return required by the statute.

Returns received which are not completed, but merely state "see schedule attached" are not considered to be a properly filed return and may be returned to the taxpayer for proper completion. This may result in the imposition of penalties and interest due to the return being filed after the due date.

58.3(2) *Form for filing—financial institutions.* Financial institutions as defined by Iowa Code section 422.61(1) shall include a true and accurate copy of their federal corporation income tax return as filed with the Internal Revenue Service with the filing of their Iowa return. At a minimum this return includes the following federal schedules: income statement, balance sheet, reconciliation of income per books with income per return, analysis of unappropriated retained earnings per books, dividend income and special deductions, capital gains, tax computation and tax deposits, work opportunity credit computation, foreign tax credit computation, alternative minimum tax computation, and statements detailing other income and other deductions.

When a financial institution whose income is included in a consolidated federal income tax return files an Iowa return, federal consolidating income statements as properly computed for federal income tax purposes showing the income and expenses of each member of the consolidated group shall be required together with the following additional schedules on a separate basis:

a. Capital gains.
b. Dividend income and special deductions.
c. Work opportunity credit computation.
d. Foreign tax credit computation.
e. Holding company tax computation.
f. Alternative minimum tax computation.
g. Schedules detailing other income and other deductions.

58.3(3) *Amended returns.* If it becomes known to the taxpayer that the amount of income reported to be federal net income or Iowa taxable income subject to franchise tax was erroneously stated on the Iowa return, or changed by Internal Revenue Service audit, or otherwise, the taxpayer shall file an amended Iowa return along with supporting schedules, to include the amended federal return and a copy of the federal revenue agent's report if applicable. A copy of the federal revenue agent's report and notification of final federal adjustments provided by the taxpayer will be acceptable in lieu of an amended return. The assessment or refund of tax shall be dependent on the statute of limitations as set forth in 701—subrule 57.2(1) and rule 701—60.3(422).

This rule is intended to implement Iowa Code sections 422.62, 422.66 and 422.73.

701—58.4(422) Payment of tax.

58.4(1) *Quarterly estimated payments.* Effective for taxable years beginning on or after July 1, 1977, financial institutions are required to make quarterly payments of estimated franchise tax. Rules pertaining to the estimated tax are contained in 701—Chapter 61.

58.4(2) *Full estimated payment prior to original delinquency date.* Rescinded IAB 3/15/95, effective 4/19/95.

58.4(3) *Penalty and interest on unpaid tax.* See rule 701—10.6(421) for penalty for tax periods beginning on or after January 1, 1991. See rule 701—10.8(421) for statutory exemptions to penalty for tax periods beginning on or after January 1, 1991.

Interest shall accrue on tax due from the original due date of the return. Interest on refunds of any portion of the tax imposed by statute which has been erroneously refunded and which is recoverable by the department shall bear interest as provided by law from the date of payment of the refund, with each

fraction of a month considered to be an entire month. See rule 701—10.2(421) for the statutory interest rate.

All payments shall be first applied to the penalty and then to the interest, and the balance, if any, to the amount of tax due.

58.4(4) *Payment of tax by uncertified checks.* The department will accept uncertified checks in payment of franchise taxes, provided such checks are collectible for their full amount without any deduction for exchange or other charges. The date on which the department receives the check will be considered the date of payment, so far as the taxpayer is concerned, unless the check is dishonored. If one check is remitted to cover two or more financial institutions' taxes, the remittance must be accompanied by a letter of transmittal stating:

a. The name of the drawer of the check;

b. The amount of the check;

c. The amount of any cash, money order or other instrument included in the same remittance;

d. The name of each financial institution whose tax is to be paid by the remittance; and

e. The amount of payment on account of each financial institution.

58.4(5) *Procedure with respect to dishonored checks.* If any check is returned unpaid, all expenses incidental to the collection thereof will be charged to the taxpayer. If any taxpayer whose check has been returned by the depository bank uncollected should fail at once to make the check good, the director will proceed to collect the tax as though no check had been given. A taxpayer who tenders a certified check in payment for taxes is not relieved from the taxpayer's obligation until the check has been paid.

This rule is intended to implement Iowa Code chapter 422.

701—58.5(422) Minimum tax.

58.5(1) Rescinded IAB 11/24/04, effective 12/29/04.

58.5(2) For tax years beginning after 1997, a small business corporation or a new corporation, that is a financial institution, for its first year of existence, that through the operation of Internal Revenue Code Section 55(e) is exempt from the federal alternative minimum tax, is not subject to Iowa alternative minimum tax. A small business corporation that is a financial institution may apply any alternative minimum tax credit carryforward to the extent of its regular Iowa franchise tax liability.

For tax years beginning on or after January 1, 1987, the minimum tax is imposed only to the extent that it exceeds the taxpayer's regular tax liability computed under Iowa Code section 422.63. The minimum tax rate is 60 percent of the maximum franchise tax rate rounded to the nearest one-tenth of 1 percent or 3 percent. Minimum taxable income is computed as follows:

	State taxable income as adjusted by Iowa Code sections 422.35 and 422.61(4)
Plus:	Tax preference items, adjustments and losses added back
Less:	Allocable income including allocable preference items
	Subtotal
Times:	Apportionment percentage
	Result
Plus:	Income allocable to Iowa including allocable preference items
Less:	Iowa alternative tax net operating loss deduction $40,000 exemption amount
Equals:	Iowa alternative minimum taxable income

For taxable years beginning on or after January 1, 1987, the items of tax preference are the same items of tax preference under Section 57 except for subsections (a)(1) and (a)(5) of the Internal Revenue Code used to compute federal alternative minimum taxable income. The adjustments to state taxable income are those adjustments required by Section 56 except for subsections (a)(4), (c)(1), (d), and (g) of the Internal Revenue Code used to compute federal alternative minimum taxable income computed without adjustments and the $40,000 exemption. The state alternative tax net operating loss deduction shall be

substituted for the amounts in Section 56(g)(1)(B) of the Internal Revenue Code. For tax years beginning on or after January 1, 1988, in making the adjustment under Section 56(c)(1) of the Internal Revenue Code, interest and dividends from state and other political subdivisions and from regulated investment companies exempt from federal income tax under the Internal Revenue Code shall be subtracted net of amortization of any discount or premium. Losses to be added are those losses required to be added by Section 58 of the Internal Revenue Code in computing federal alternative minimum taxable income.

a. Tax preference items are:

1. Intangible drilling costs;
2. Incentive stock options;
3. Reserves for losses on bad debts of financial institutions;
4. Appreciated property charitable deductions;
5. Accelerated depreciation or amortization on certain property placed in service before January 1, 1987.

b. Adjustments are:

1. Depreciation;
2. Mining exploration and development;
3. Long-term contracts;
4. Iowa alternative minimum net operating loss deduction;
5. Book income or adjusted earnings and profits.

c. Losses added back are:

1. Farm losses;
2. Passive activity losses.

Computation of Iowa alternative minimum tax net operating loss deduction.

Net operating losses computed under rule 701—59.2(422) carried forward from tax years beginning before January 1, 1987, are deductible without adjustment.

Net operating losses from tax years beginning after December 31, 1986, which are carried back or carried forward to the current tax year shall be reduced by the amount of tax preferences and adjustments taken into account in computing the net operating loss prior to applying allocation and apportionment. The deduction for a net operating loss from a tax year beginning after December 31, 1986, which is carried back or carried forward shall not exceed 90 percent of the alternative minimum taxable income computed without regard for the net operating loss deduction.

The exemption amount shall be reduced by 25 percent of the amount that the alternative minimum taxable income computed without regard to the $40,000 exemption exceeds $150,000. The exemption shall not be reduced below zero.

EXAMPLE: The following example shows the computation of the alternative minimum tax when there are net operating loss carryforwards and carrybacks including an alternative minimum tax net operating loss.

For tax year 1987, the following information is available:

Federal taxable income before NOL	$ 35,000
Interest exempt from federal tax	5,000
Tax preferences and adjustments	53,400
Iowa income tax expensed on federal	878
Iowa NOL carryforward	<25,000>

For tax year 1988, the following information is available:

Federal taxable income before NOL	$ <90,000>
Interest exempt from federal tax	4,000
Tax preferences and adjustments	20,000
Iowa franchise tax refund reported on federal	878

The alternative minimum tax for 1987 before the 1988 net operating loss carryback should be computed as follows:

Regular Iowa Tax	
Federal taxable income	$ 35,000
Add interest exempt from federal tax	5,000
Add Iowa franchise tax expensed	878
Iowa taxable income before NOL carryforward	$ 40,878
Less NOL carryforward	<25,000>
Iowa taxable income	$ 15,878
Iowa income tax	$ 794
Alternative Minimum Tax	
Iowa taxable income before NOL	$ 40,878
Add preferences and adjustments	53,400
Total	$ 94,278
Less NOL carryforward*	<25,000>
Iowa alternative taxable income	$ 69,278
Less exemption amount	<40,000>
Total	$ 29,278
Times 3%	878
Less regular tax	794
Alternative minimum tax	$ 84

*Net operating loss carryforwards from tax years beginning before January 1, 1987, are deductible at 100 percent without reduction for items of tax preference or adjustments arising in the tax year.

The alternative minimum tax for 1987 after the 1988 net operating loss carryback should be computed as follows:

Regular Iowa Tax	
Federal taxable income	$ 35,000
Add interest exempt from federal tax	5,000
Add Iowa franchise tax expensed	878
Iowa taxable income before NOL carryforward	$ 40,878
Less NOL carryforward	<25,000>
	$ 15,878
Less NOL carryback from 1988[1]	<86,878>
NOL carryforward	$ <71,000>
Alternative Minimum Tax	
Iowa taxable income before NOL	$ 40,878
Add preferences and adjustments	53,400
Total	$ 94,278
Less NOL carryforward from pre-1987 tax year	<25,000>
Total	$ 69,278
Less alternative minimum tax NOL[2]	<62,350>
Total	$ 6,928
Less exemption	<40,000>
Alternative minimum taxable income after NOL	$ -0-

[1]Computation of 1988 Iowa NOL	
Federal NOL	$ <90,000>
Add interest exempt from federal tax	4,000
Less Iowa refund in federal income	<878>
Iowa NOL	$ <86,878>
[2]Computation of 1988 Alternative Minimum Tax NOL	
Iowa NOL	$ <86,878>
Add preferences and adjustments	20,000
Total	$ <66,878>
NOL carryback limited to 90% of alternative minimum income before NOL and exemption*	$ <62,350>
Alternative minimum tax NOL carryforward	$ 4,528

*For purposes of the alternative minimum tax, net operating loss carryforward or carryback from tax years beginning after December 31, 1986, must be reduced by items of tax preference and adjustments, and are limited to 90 percent of alternative minimum taxable income before deduction of the post-1986 NOL and the $40,000 exemption amount ($69,278 × 90% = $62,350).

58.5(3) Effective for tax years beginning on or after January 1, 1986, estimated payments are required for minimum tax.

58.5(4) Alternative minimum tax credit for minimum tax paid in a prior tax year. Minimum tax paid in prior tax years commencing with tax years beginning on or after January 1, 1987, by a taxpayer can be claimed as a tax credit against the taxpayer's regular income tax liability in a subsequent tax year. Therefore, 1988 is the first tax year that the minimum tax credit is available for use and the credit is based on the minimum tax paid by the taxpayer for 1987. However, only the portion of the minimum tax which is attributable to those adjustments and tax preferences which are "deferral items" qualifies for the minimum tax credit for tax years beginning prior to January 1, 1990. "Deferral items" are those tax preferences and adjustments which result in a temporary change in a taxpayer's tax liability. An example of a "deferral item" is the tax preference for accelerated depreciation of real property placed in service before 1987. On the other hand, the portion of the minimum tax which is attributable to the "exclusion item" for appreciated property charitable deduction does not qualify for the minimum tax credit. The appreciated property charitable deduction tax preference is the only state "exclusion item," although there are several "exclusion items" which are used to compute federal minimum tax. For tax years beginning on or after January 1, 1990, the entire amount of minimum tax paid qualifies for the minimum tax credit, and there is no longer any distinction between "deferral items" and "exclusion items." The minimum tax credit may only be used against regular income tax for a tax year to the extent that the regular tax is greater than the tentative minimum tax for the tax year. If the minimum tax credit is not used up against the regular tax for a tax year the remaining credit is carried to the following tax year to be applied against the regular income tax liability for that period.

a. Computation of minimum tax credit on Form IA 8801C. The minimum tax credit is computed on Form IA 8801C from information on Form IA 4626 for the prior tax year, Form IA 1120 and Form IA 4626 for the current year and from Form IA 8801C for the prior year (applies in 1989 and in subsequent tax years).

Form IA 8801C is in three parts. In the first part, a calculation is made to determine the portion of the minimum tax paid in the prior year, if any, which is attributable to the exclusion item for appreciated property charitable deduction. In the second portion of Form IA 8801C, the minimum tax attributable to the appreciated property charitable deduction from Part I is subtracted from the total minimum tax paid for the prior year. The remaining amount of minimum tax is attributable to the deferral tax preference items and adjustment items. This remaining amount, if any, is added to the minimum tax carryover credit from Form IA 8801C for the prior tax year, if any. This total is compared to the regular income

tax liability less nonrefundable credits, less the tentative minimum tax for the current year and the lesser amount is the allowable minimum tax credit for the current year.

The final part of Form IA 8801C is used to compute the minimum tax credit, if any, which will be carried over to the next tax year. The carryover credit is computed by subtracting the allowable credit for the current tax year from the total of the minimum tax credit attributable to deferral items and the carryover credit from the prior tax years.

b. Example. The taxpayer had a 1989 taxable income of $450,000 and an accelerated depreciation tax preference of $280,000. In 1988 the taxpayer had taxable income of $500,000 and tax preferences of $370,000 which consisted of $320,000 of accelerated property charitable deduction and $50,000 of appreciated property charitable deduction. The minimum tax credit for 1989 was computed on Form IA 8801C using data from Form IA 4626F for 1988 and from Form IA 4626F for 1989 and Form IA 1120 for 1989.

Form IA 8801C

Part I.		Computation of Minimum Tax on Exclusion Items	
Line 11	-	Gross tax on exclusion items	-0-
Line 12	-	Less regular tax minus credits	$33,900
Line 13	-	Net minimum tax on exclusion items	-0-
Part II.		Computation of Allowable Credit for 1989	
Line 14	-	Enter amount from line 18 IA 4626F for 1988	$ 1,100
Line 15	-	Enter amount from line 13 part I	-0-
Line 16	-	Subtract line 15 from line 14	$ 1,100
Line 17	-	Enter credit carryforward from 1987	-0-
Line 18	-	Add lines 16 and 17	$ 1,100
Line 19	-	Enter 1989 regular tax liability	$22,500
Line 20	-	Enter 1989 tentative minimum tax	$21,600
Line 21	-	Subtract line 20 from line 19	$ 900
Line 22	-	Allowable minimum tax credit for 1989. Enter smaller of line 18 or line 21	$ 900
Part III.		Computation of Minimum Tax Credit Carryovers	
Line 23	-	Enter amount from line 18 part II	$ 1,100
Line 24	-	Enter amount from line 22 part II	900
Line 25	-	Carryforward of minimum tax credit to 1990. Subtract line 24 from line 23	$ 200

This rule is intended to implement Iowa Code section 422.60.

701—58.6(422) Refunds and overpayments.

58.6(1) to **58.6(6)** Reserved.

58.6(7) *Computation of interest on refunds resulting from net operating losses or net capital losses for tax years or periods beginning on or after January 1, 1974, and ending after July 1, 1980.* Rescinded IAB 11/24/04, effective 12/29/04.

58.6(8) *Computation of interest on refunds resulting from net operating losses for tax years ending on or after April 30, 1981.* Rescinded IAB 11/24/04, effective 12/29/04.

58.6(9) *For refund claims received by the department after June 11, 1984.* If the amount of tax is reduced as a result of a net operating loss or net capital loss, interest shall accrue on the refund resulting from the loss carryback beginning on the date a claim for refund or amended return carrying back the net operating loss or net capital loss is filed with the department or the first day of the second calendar month following the actual payment date, whichever is later.

58.6(10) *Overpayment—interest accruing before July 1, 1980.* Rescinded IAB 11/24/04, effective 12/29/04.

58.6(11) *Interest commencing on or after January 1, 1982.* See rule 701—10.2(421) regarding the rate of interest charged by the department on delinquent taxes and the rate paid by the department on refunds commencing on or after January 1, 1982.

58.6(12) *Overpayment—interest accruing on or after July 1, 1980, and before April 30, 1981.* Rescinded IAB 11/24/04, effective 12/29/04.

58.6(13) *Overpayment—interest accruing on overpayments resulting from returns due on or after April 30, 1981.* If the amount of tax determined to be due by the department is less than the amount paid, the excess to be refunded will accrue interest from the first day of the second calendar month following the date of payment or the date the return was due to be filed or was filed, whichever is the later.

701—58.7(422) Allocation of franchise tax revenues. For fiscal years prior to July 1, 2004, each quarterly distribution shall be made up of the tax shown due on the franchise tax returns received during that quarter, net of all refunds of franchise tax established during that quarter. In determining the portion of franchise tax revenues to be distributed to cities and counties for fiscal years prior to July 1, 2004, each financial institution, as defined by Iowa Code section 422.61, is required to submit the appropriate allocation data with the filing of its Iowa franchise tax return. Each financial institution shall accumulate or maintain data to properly determine the business activity ratios as prescribed in subrules 58.7(1) and 58.7(2). The allocation shall be made on the basis of business activity for each office location. The word "office" shall mean a branch office, a drive-in bank depository or any other establishment whereby the business pertaining to the financial institution is carried on.

58.7(1) *Business activity determination for a production credit association.* A production credit association shall measure its business activity on the basis of loan volume. "Loan volume" shall mean total loans originated during the taxable period. The business activity for each office location shall be that percentage of loans originated by each office to total loans originated for all office locations during the taxable period.

58.7(2) *Business activity determination for a financial institution other than a production credit association.* A financial institution, other than a production credit association, shall measure its business activity on a basis of net deposits. The business activity of each office shall be that percentage of average "savings and demand deposits net of withdrawals" for each office location to the total average "savings and demand deposits net of withdrawals" for all office locations.

This rule is intended to implement Iowa Code section 422.61.

701—58.8(15E) Eligible housing business tax credit. For tax years beginning on or after January 1, 2000, a financial institution may claim on the franchise tax return the pro-rata share of the Iowa eligible housing business tax credit from a partnership, limited liability company, estate or trust which has been approved as an eligible housing business by the Iowa department of economic development.

An eligible housing business may receive a tax credit of up to 10 percent of the new investment which is directly related to the building or rehabilitating of homes in an enterprise zone. The tax credit may be taken on the tax return for the tax year in which the home is ready for occupancy. The portion of the credit claimed by the taxpayer shall be in the same ratio as the taxpayer's pro-rata share of the earnings of the partnership, limited liability company, estate or trust, except for projects beginning on or after July 1, 2005, which used low-income housing tax credits authorized under Section 42 of the Internal Revenue Code to assist in the financing of the housing development. For these projects, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder. Any eligible housing business tax credit in excess of the franchise tax liability must be carried forward for seven years or until it is used, whichever is the earlier.

Prior to January 1, 2001, the tax credit cannot exceed 10 percent of $120,000 for each home or individual unit in a multiple dwelling unit building. Effective January 1, 2001, the tax credit cannot exceed 10 percent of $140,000 for each home or individual unit in a multiple dwelling unit building.

58.8(1) *Computation of credit.* New investment which is directly related to the building or rehabilitating of homes includes but is not limited to the following costs: land, surveying, architectural services, building permits, inspections, interest on a construction loan, building materials, roofing,

plumbing materials, electrical materials, amounts paid to subcontractors for labor and materials provided, concrete, labor, landscaping, appliances normally provided with a new home, heating and cooling equipment, millwork, drywall and drywall materials, nails, bolts, screws, and floor coverings.

New investment does not include the machinery, equipment, hand or power tools necessary to build or rehabilitate homes.

If the eligible housing business fails to maintain the requirements of Iowa Code section 15E.193B, as amended by 2003 Iowa Acts, Senate File 441, to be an eligible housing business, the taxpayer may be required to repay all or a part of the tax incentives the business received. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the income tax credit may have expired, the department may proceed to collect the tax incentives forfeited by failure to maintain the requirements of Iowa Code section 15E.193B as amended by 2003 Iowa Acts, Senate File 441. This is because it is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability.

Effective for tax periods beginning on or after January 1, 2003, the taxpayer must receive a tax credit certificate from the Iowa department of economic development to claim the eligible housing business tax credit. The tax credit certificate shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the date the project was completed, the amount of the eligible housing business tax credit, and the tax year for which the credit may be claimed. In addition, the tax credit certificate shall include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 58.8(2). The tax credit certificate must be attached to the income tax return for the tax period in which the home is ready for occupancy. The administrative rules for the eligible housing business tax credit for the Iowa department of economic development may be found under 261—Chapter 59.

58.8(2) *Transfer of the eligible housing business tax credit.* For tax periods beginning on or after January 1, 2003, the eligible housing business tax credit certificates may be transferred to any person or entity if low-income housing tax credits authorized under Section 42 of the Internal Revenue Code are used to assist in the financing of the housing development. In addition, the eligible housing business tax credit certificates may be transferred to any person or entity for projects beginning on or after July 1, 2005, if the housing development is located in a brownfield site as defined in Iowa Code section 15.291, or if the housing development is located in a blighted area as defined in Iowa Code section 403.17. No more than $3 million of tax credits for housing developments located in brownfield sites or blighted areas may be transferred in a calendar year, with no more than $1.5 million being transferred for any one eligible housing business in a calendar year.

Within 90 days of transfer of the tax credit certificate for transfers prior to July 1, 2006, the transferee must submit the transferred tax credit certificate to the Iowa department of economic development, along with a statement which contains the transferee's name, address and tax identification number, and the amount of the tax credit being transferred. For transfers on or after July 1, 2006, the transferee must submit the transferred tax credit certificate to the department of revenue. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee for transfers prior to July 1, 2006, the Iowa department of economic development will issue a replacement tax credit certificate to the transferee. For transfers on or after July 1, 2006, the department of revenue will issue the replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company or S corporation, the transferee shall provide a list of the partners, members or shareholders and information on how the housing business tax credit should be divided among the partners, members or shareholders. The transferee shall also provide the tax identification numbers and addresses of the partners, members or shareholders. The replacement tax credit certificate must contain the same information that was on the original certificate and must have the same expiration date as the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax period for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes.

Any consideration paid for the transfer of the tax credit shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

This rule is intended to implement Iowa Code Supplement section 15E.193B as amended by 2006 Iowa Acts, chapter 1158.

701—58.9(15E) Eligible development business investment tax credit. Effective for tax years beginning on or after January 1, 2001, a business which qualifies as an eligible development business may receive a tax credit of up to 10 percent of the new investment which is directly related to the construction, expansion or rehabilitation of building space to be used for manufacturing, processing, cold storage, distribution, or office facilities.

An eligible development business must be approved by the Iowa department of economic development prior to March 17, 2004, and meet the qualifications of Iowa Code section 15E.193C. Effective March 17, 2004, the eligible development business program is repealed.

New investment includes the purchase price of land and the cost of improvements made to real property. The tax credit may be claimed by an eligible development business in the tax year in which the construction, expansion or rehabilitation is completed.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following seven years or until used, whichever is the earlier.

If the business is a partnership, S corporation, limited liability company, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

If the eligible development business fails to meet and maintain any one of the requirements to be an eligible business, the business shall be subject to repayment of all or a portion of the amount of tax incentives received. For example, if within five years of project completion the development business sells or leases any space to any retail business, the development business shall proportionally repay the value of the investment credit. The proportion of the investment credit that would be due for repayment by an eligible development business for selling or leasing space to a retail business would be determined by dividing the square footage of building space occupied by the retail business by the square footage of the total building space.

An eligible business, which is not a development business, which operates in an enterprise zone cannot claim an investment tax credit if the property is owned, or was previously owned, by an approved development business that has already received an investment tax credit. An eligible business, which is not a development business, can claim an investment tax credit only on additional, new improvements made to real property that was not included in the development business's approved application for the investment tax credit.

This rule is intended to implement Iowa Code section 15E.193C.

701—58.10(422) Historic preservation and cultural and entertainment district tax credit. For tax years beginning on or after January 1, 2001, a historic preservation and cultural and entertainment district tax credit, subject to the availability of the credit, may be claimed against a taxpayer's Iowa franchise tax liability for 25 percent of the qualified rehabilitation costs to the extent the costs were incurred for the rehabilitation of eligible property in Iowa. For information on those types of property that are eligible for the historic preservation and cultural and entertainment district tax credit, how to file applications for the credit, how the historic preservation and cultural and entertainment district tax credit is computed, how the historic preservation and cultural and entertainment district tax credit can be transferred for tax periods beginning on or after January 1, 2003, and other details about the credit, see rule 701—52.18(422). See also the administrative rules for the historic preservation and cultural and entertainment district tax credit for the historical division of the department of cultural affairs under 223—Chapter 48.

This rule is intended to implement Iowa Code chapter 404A as amended by 2005 Iowa Acts, House File 868, sections 20 through 26, and Iowa Code section 422.60.

701—58.11(15E,422) Venture capital credits.

58.11(1) *Investment tax credit for an equity investment in a community-based seed capital fund or qualifying business.* See rule 123—2.1(15E) for the discussion of the investment tax credit for an equity investment in a community-based seed capital fund or an equity investment made on or after January 1, 2004, in a qualifying business, along with the issuance of tax credit certificates by the Iowa capital investment board.

The department of revenue will be notified by the Iowa capital investment board when the tax credit certificates are issued. The tax credit certificate must be attached to the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

For equity investments made in a community-based seed capital fund and equity investments made on or after January 1, 2004, in a qualifying business, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

58.11(2) *Investment tax credit for an equity investment in a venture capital fund.* See rule 123—3.1(15E) for the discussion of the investment tax credit for an equity investment in a venture capital fund, along with the issuance of tax credit certificates by the Iowa capital investment board. This credit is repealed for investments in venture capital funds made after July 1, 2010.

The department of revenue will be notified by the Iowa capital investment board when the tax credit certificates are issued. The tax credit certificate must be attached to the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

For equity investments made in a venture capital fund, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

58.11(3) *Contingent tax credit for investments in Iowa fund of funds.* See rule 123—4.1(15E) for the discussion of the contingent tax credit available for investments made in the Iowa fund of funds organized by the Iowa capital investment corporation. Tax credit certificates related to the contingent tax credits will be issued by the Iowa capital investment board.

The department of revenue will be notified by the Iowa capital investment board when these tax credit certificates are issued and, if applicable, when they are redeemed. If the tax credit certificate is redeemed, the certificate must be attached to the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate.

If the tax credit certificate is redeemed, any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following seven years or until used, whichever is the earlier.

If the tax credit certificate is redeemed, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

This rule is intended to implement Iowa Code section 15E.43 and sections 15E.51, 15E.66, and 422.60(5) as amended by 2010 Iowa Acts, Senate File 2380.

[**ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—58.12(15) New capital investment program tax credits. Effective for tax periods beginning on or after January 1, 2003, a business which qualifies under the new capital investment program is

eligible to receive tax credits. An eligible business under the new capital investment program must be approved by the Iowa department of economic development and meet the qualifications of 2003 Iowa Acts, chapter 125, section 4. The new capital investment program was repealed on July 1, 2005, and has been replaced with the high quality job creation program. See rules 701—52.28(15) and 701—58.17(15) for information on the tax credits available under the high quality job creation program. Any tax credits earned by businesses approved under the new capital investment program prior to July 1, 2005, remain valid, and can be claimed on tax returns filed after July 1, 2005.

This rule is intended to implement 2003 Iowa Acts, House File 677, sections 1 to 7, and Iowa Code section 15.333 as amended by 2003 Iowa Acts, House File 677, section 8.

701—58.13(15E,422) Endow Iowa tax credit. Effective for tax years beginning on or after January 1, 2003, a taxpayer who makes an endowment gift to an endow Iowa qualified community foundation may qualify for an endow Iowa tax credit, subject to the availability of the credit. For tax years beginning on or after January 1, 2003, but before January 1, 2010, the credit is equal to 20 percent of a taxpayer's endowment gift to an endow Iowa qualified community foundation approved by the Iowa department of economic development. For tax years beginning on or after January 1, 2010, the credit is equal to 25 percent of a taxpayer's endowment gift to an endow Iowa qualified community foundation approved by the Iowa department of economic development. For tax years beginning on or after January 1, 2010, a taxpayer cannot claim a deduction for charitable contributions under Section 170 of the Internal Revenue Code for the amount of the contribution for which the tax credit is claimed for Iowa tax purposes. The administrative rules for the endow Iowa tax credit for the Iowa department of economic development may be found under 261—Chapter 47.

The total amount of endow Iowa tax credits available is $2 million in the aggregate for the 2003 and 2004 calendar years. The total amount of endow Iowa tax credits is $2 million annually for the 2005-2007 calendar years, and $200,000 of these tax credits on an annual basis is reserved for endowment gifts of $30,000 or less. The maximum amount of tax credit granted to a single taxpayer shall not exceed $100,000 for the 2003-2007 calendar years. The total amount of endow Iowa tax credits annually for the 2008 and 2009 calendar years is $2 million plus a percentage of the tax imposed on the adjusted gross receipts from gambling games in accordance with Iowa Code section 99F.11(3). The total amount of endow Iowa tax credits annually for 2010 is $2.7 million plus a percentage of the tax imposed on the adjusted gross receipts from gambling games in accordance with Iowa Code section 99F.11(3). The total amount of endow Iowa tax credits annually for 2011 and subsequent calendar years is $3.5 million plus a percentage of the tax imposed on the adjusted gross receipts from gambling games in accordance with Iowa Code section 99F.11(3). The maximum amount of tax credit granted to a single taxpayer shall not exceed 5 percent of the total endow Iowa tax credit amount authorized for 2008 and subsequent years. For example, the total amount of endow Iowa tax credits authorized for the 2011 calendar year is $4,551,813, so the maximum amount of tax credit authorized to a single taxpayer is $227,590.65 ($4,551,813 times 5 percent). The endow Iowa tax credit cannot be transferred to any other taxpayer.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

If a taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro-rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 15E.305 as amended by 2011 Iowa Acts, Senate File 302, and section 422.60.

[**ARC 8589B**, IAB 3/10/10, effective 4/14/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12]

701—58.14(15I,422) Wage-benefits tax credit. Effective for tax years ending on or after June 9, 2006, a wage-benefits tax credit, subject to the availability of the credit, equal to a percentage of the annual wages and benefits paid for a qualified new job created by the location or expansion of the business in Iowa is available for eligible financial institutions. For information on the eligibility for the wage-benefits

tax credit, how to file applications for the wage-benefits tax credit, how the wage-benefits tax credit is computed, the repeal of the wage-benefits credit effective July 1, 2008, and other details about the credit, see rule 701—52.25(15I,422).

This rule is intended to implement Iowa Code chapter 15I as amended by 2008 Iowa Acts, House File 2700, section 167, and Iowa Code Supplement section 422.60(10) as amended by 2008 Iowa Acts, House File 2700, section 164.

701—58.15(422,476B) Wind energy production tax credit. Effective for tax years beginning on or after July 1, 2006, owners of qualified wind energy production facilities approved by the Iowa utilities board may claim a wind energy production tax credit for qualified electricity sold by the owner against a taxpayer's Iowa franchise tax liability. For information on the application and review process for the wind energy production tax credit, how the wind energy production tax credit is computed, how the wind energy production tax credit can be transferred and other details about the credit, see rule 701—52.26(422,476B). See also the administrative rules for the wind energy production tax credit for the Iowa utilities board in rules 199—15.18(476B) and 199—15.20(476B).

This rule is intended to implement Iowa Code section 422.60 and chapter 476B.

701—58.16(422,476C) Renewable energy tax credit. Effective for tax years beginning on or after July 1, 2006, a purchaser or producer of renewable energy whose facility has been approved by the Iowa utilities board may claim a renewable energy tax credit for qualified renewable energy against a taxpayer's Iowa franchise tax liability. For information on the application and review process for the renewable energy tax credit, how the renewable energy tax credit is computed, how the renewable energy tax credit can be transferred and other details about the credit, see rule 701—52.27(422,476C). See also the administrative rules for the renewable energy tax credit for the Iowa utilities board in rules 199—15.19(476C) and 199—15.21(476C).

This rule is intended to implement Iowa Code section 422.60 and chapter 476C.

701—58.17(15) High quality job creation program. Effective for tax periods ending on or after July 1, 2005, for programs approved on or after July 1, 2005, but before July 1, 2009, a business which qualifies under the high quality job creation program is eligible to receive tax credits. The high quality job creation program replaces the new jobs and income program and the new capital investment program. An eligible business under the high quality job creation program must be approved by the Iowa department of economic development and meet the qualifications of Iowa Code section 15.329.

The high quality job creation program was repealed on July 1, 2009, and has been replaced with the high quality jobs program. See rule 701—52.40(15) for information on the investment tax credit under the high quality jobs program. Any investment tax credit earned by businesses approved under the high quality job creation program prior to July 1, 2009, remains valid, and can be claimed on tax returns filed after July 1, 2009. The administrative rules for the high quality jobs program for the Iowa department of economic development may be found at 261—Chapter 68.

For information on what credits can be taken under this program, how the investment tax credit is computed and other details about this program, see rule 701—52.28(15). However, the research credit described in subrule 52.28(1) is not available for franchise tax filers.

This rule is intended to implement Iowa Code Supplement chapter 15.

[**ARC 8589B**, IAB 3/10/10, effective 4/14/10]

701—58.18(15E,422) Economic development region revolving fund tax credit. Effective for tax years ending on or after July 1, 2005, but beginning before January 1, 2010, a taxpayer who makes a contribution to an economic development region revolving fund may claim a tax credit, subject to the availability of the credit. The credit is equal to 20 percent of a taxpayer's contribution to the economic development region revolving fund approved by the Iowa department of economic development. The administrative rules for the economic development region revolving fund tax credit for the Iowa department of economic development may be found at 261—Chapter 32. The tax credit is repealed for tax years beginning on or after January 1, 2010.

The total amount of economic development region revolving fund tax credits available shall not exceed $2 million per fiscal year. The tax credit shall not be carried back to a tax year prior to the year in which the taxpayer redeems the credit. The economic development region revolving fund tax credit is not transferable to any other taxpayer.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following ten years or until used, whichever is the earlier.

This rule is intended to implement Iowa Code sections 15E.232 and 422.60 as amended by 2010 Iowa Acts, Senate File 2380.

[**ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—58.19(15,422) Film qualified expenditure tax credit. Effective for tax years beginning on or after January 1, 2007, a film qualified expenditure tax credit is available for franchise tax. The tax credit is equal to 25 percent of the taxpayer's qualified expenditures in a film, television, or video project registered with the film office of the Iowa department of economic development (IDED). For information on the qualified expenditures eligible for the credit, how the film qualified expenditure tax credit is claimed, how the film qualified expenditure tax credit can be transferred and other details about the credit, see rule 701—52.34(15,422). See also the administrative rules for the film qualified expenditure tax credit for IDED at 261—Chapter 36.

This rule is intended to implement 2007 Iowa Acts, House File 892, section 3, and Iowa Code section 422.60 as amended by 2007 Iowa Acts, House File 892, section 9.

701—58.20(15,422) Film investment tax credit. Effective for tax years beginning on or after January 1, 2007, a film investment tax credit is available for franchise tax. The tax credit is equal to 25 percent of the taxpayer's qualified expenditures in a film, television, or video project registered with the film office of the Iowa department of economic development (IDED). For information on how the film investment tax credit is claimed, how the film investment tax credit can be transferred and other details about the credit, see rule 701—52.35(15,422). See also the administrative rules for the film investment tax credit for IDED at 261—Chapter 36.

This rule is intended to implement 2007 Iowa Acts, House File 892, section 3, and Iowa Code section 422.60 as amended by 2007 Iowa Acts, House File 892, section 9.

701—58.21(15) High quality jobs program. Effective for tax periods beginning on or after July 1, 2009, a business which qualifies under the high quality jobs program is eligible to receive tax credits. The high quality jobs program replaces the high quality job creation program. An eligible business under the high quality jobs program must be approved by the Iowa department of economic development and meet the qualifications of Iowa Code section 15.329. The tax credits available under the high quality jobs program are based upon the number of jobs created or retained that pay a qualifying wage threshold and the amount of qualifying investment. The administrative rules for the high quality jobs program for the Iowa department of economic development may be found at 261—Chapter 68.

For information on the credits that may be taken under this program, how the investment tax credit is computed and other details about the program, see rule 701—52.40(15). NOTE: The research credit described in 701—subrule 52.40(1) is not available for franchise tax filers.

This rule is intended to implement Iowa Code chapter 15.

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◊ Two or more ARCs

CHAPTER 71
ASSESSMENT PRACTICES AND EQUALIZATION
[Prior to 12/17/86, Revenue Department[730]]

701—71.1(405,427A,428,441,499B) Classification of real estate.

71.1(1) *Responsibility of assessors.* All real estate subject to assessment by city and county assessors shall be classified as provided in this rule. It shall be the responsibility of city and county assessors to determine the proper classification of real estate. There can be only one classification per property. An assessor shall not assign one classification to the land and a different classification to the building or separate classifications to the land or separate classifications to the building (dual classification). A building or structure on leased land is considered a separate property and may be classified differently than the land upon which it is located. The determination shall be based upon the best judgment of the assessor following the guidelines set forth in this rule and the status of the real estate as of January 1 of the year in which the assessment is made. The assessor shall classify property according to its present use and not according to its highest and best use. See subrule 71.1(8) for an exception to the general rule that property is to be classified according to its use. The classification shall be utilized on the abstract of assessment submitted to the department of revenue pursuant to Iowa Code section 441.45. See rule 701—71.8(428,441).

71.1(2) *Responsibility of boards of review, county auditors, and county treasurers.* Whenever local boards of review, county auditors, and county treasurers exercise assessment functions allowed or required by law, they shall classify property as provided in this rule and adhere to the requirements of this rule.

71.1(3) *Agricultural real estate.* Agricultural real estate shall include all tracts of land and the improvements and structures located on them which are in good faith used primarily for agricultural purposes except buildings which are primarily used or intended for human habitation as defined in subrule 71.1(4). Land and the nonresidential improvements and structures located on it shall be considered to be used primarily for agricultural purposes if its principal use is devoted to the raising and harvesting of crops or forest or fruit trees, the rearing, feeding, and management of livestock, or horticulture, all for intended profit.

Vineyards and any buildings located on a vineyard and used in connection with the vineyard shall be classified as agricultural real estate if the primary use of the land and buildings is an activity related to the production or sale of wine.

Agricultural real estate shall also include woodland, wasteland, and pastureland, but only if that land is held or operated in conjunction with agricultural real estate as defined in this subrule.

71.1(4) *Residential real estate.* Residential real estate shall include all lands and buildings which are primarily used or intended for human habitation, including those buildings located on agricultural land. Buildings used primarily or intended for human habitation shall include the dwelling as well as structures and improvements used primarily as a part of, or in conjunction with, the dwelling. This includes but is not limited to garages, whether attached or detached, tennis courts, swimming pools, guest cottages, and storage sheds for household goods. Residential real estate located on agricultural land shall include only buildings as defined in this subrule. Buildings for human habitation that are used as commercial ventures, including but not limited to hotels, motels, rest homes, and structures containing three or more separate living quarters shall not be considered residential real estate. However, regardless of the number of separate living quarters, multiple housing cooperatives organized under Iowa Code chapter 499A and land and buildings owned and operated by organizations that have received tax-exempt status under Section 501(c)(3) of the Internal Revenue Code, if the rental income from the property is not taxed as unrelated business income under Iowa Code section 422.33(1A), shall be considered residential real estate.

An apartment in a horizontal property regime (condominium) referred to in Iowa Code chapter 499B which is used or intended for use for human habitation shall be classified as residential real estate regardless of who occupies the apartment. Existing structures shall not be converted to a horizontal property regime unless building code requirements have been met.

71.1(5) *Commercial real estate.* Commercial real estate shall include all lands and improvements and structures located thereon which are primarily used or intended as a place of business where goods, wares, services, or merchandise is stored or offered for sale at wholesale or retail. Commercial realty shall also include hotels, motels, rest homes, structures consisting of three or more separate living quarters and any other buildings for human habitation that are used as a commercial venture. Commercial real estate shall also include data processing equipment as defined in Iowa Code section 427A.1(1)*"j,"* except data processing equipment used in the manufacturing process. However, regardless of the number of separate living quarters or any commercial use of the property, single- and two-family dwellings, multiple housing cooperatives organized under Iowa Code chapter 499A, and land and buildings used primarily for human habitation and owned and operated by organizations that have received tax-exempt status under Section 501(c)(3) of the Internal Revenue Code, if the rental income from the property is not taxed as unrelated business income under Iowa Code section 422.33(1A), shall be classified as residential real estate.

An apartment in a horizontal property regime (condominium) referred to in Iowa Code chapter 499B which is used or intended for use as a commercial venture, other than leased for human habitation, shall be classified as commercial real estate. Existing structures shall not be converted to a horizontal property regime unless building code requirements have been met.

71.1(6) *Industrial real estate.*

a. Land and buildings.

(1) Industrial real estate includes land, buildings, structures, and improvements used primarily as a manufacturing establishment. A manufacturing establishment is a business entity in which the primary activity consists of adding to the value of personal property by any process of manufacturing, refining, purifying, the packing of meats, or the combination of different materials with the intent of selling the product for gain or profit. Industrial real estate includes land and buildings used for the storage of raw materials or finished products and which are an integral part of the manufacturing establishment, and also includes office space used as part of a manufacturing establishment.

(2) Whether property is used primarily as a manufacturing establishment and, therefore, assessed as industrial real estate depends upon the extent to which the property is used for the activities enumerated in subparagraph 71.1(6)*"a"*(1). Property in which the performance of these activities is only incidental to the property's primary use for another purpose is not a manufacturing establishment. For example, a grocery store in which bakery goods are prepared would be assessed as commercial real estate since the primary use of the grocery store premises is for the sale of goods not manufactured by the grocery and the industrial activity, i.e., baking, is only incidental to the store premises' primary use. However, property which is used primarily as a bakery would be assessed as industrial real estate even if baked goods are sold at retail on the premises since the bakery premises' primary use would be for an industrial activity to which the retail sale of baked goods is merely incidental. See *Lichty v. Board of Review of Waterloo,* 230 Iowa 750, 298 N.W. 654 (1941).

Similarly, a facility which has as its primary use the mixing and blending of products to manufacture feed would be assessed as industrial real estate even though a portion of the facility is used solely for the storage of grain, if the use for storage is merely incidental to the property's primary use as a manufacturing establishment. Conversely, a facility used primarily for the storage of grain would be assessed as commercial real estate even though a part of the facility is used to manufacture feed. In the latter situation, the industrial use of the property — the manufacture of feed — is merely incidental to the property's primary use for commercial purposes — the storage of grain.

(3) Property used primarily for the extraction of rock or mineral substances from the earth is not a manufacturing establishment if the only processing performed on the substance is to change its size by crushing or pulverizing. See *River Products Company v. Board of Review of Washington County,* 332 N.W.2d 116 (Iowa Ct. App. 1982).

b. Machinery.

(1) Machinery includes equipment and devices, both automated and nonautomated, which is used in manufacturing as defined in Iowa Code section 428.20. See *Deere Manufacturing Co. v. Beiner,* 247 Iowa 1264, 78 N.W.2d 527 (1956).

(2) Machinery owned or used by a manufacturer but not used within the manufacturing establishment is not assessed as industrial real estate. For example, "X" operates a factory which manufactures building materials for sale. In addition, "X" uses some of these building materials in construction contracts. The machinery which "X" would primarily use at the construction site would not be used in a manufacturing establishment and, therefore, would not be assessed as industrial real estate.

(3) Machinery used in manufacturing but not used in or by a manufacturing establishment is not assessed as industrial real estate. See *Associated General Contractors of Iowa v. State Tax Commission,* 255 Iowa 673, 123 N.W.2d 922 (1963).

(4) Where the primary function of a manufacturing establishment is to manufacture personal property that is consumed by the manufacturer rather than sold, the machinery used in the manufacturing establishment is not assessed as industrial real estate. See *Associated General Contractors of Iowa v. State Tax Commission,* 255 Iowa 673, 123 N.W.2d 922 (1963).

71.1(7) *Point-of-sale equipment.* As used in Iowa Code section 427A.1(1)*"j,"* the term "point-of-sale equipment" means input, output, and processing equipment used to consummate a sale and to record or process information pertaining to a sale transaction at the time the sale takes place and which is located at the counter, desk, or other specific point at which the transaction occurs. As used in this subrule, the term "sale" means the sale or rental of goods or services and includes both retail and wholesale transactions. Point-of-sale equipment does not include equipment used primarily for depositing or withdrawing funds from financial institution accounts.

71.1(8) *Housing development property.* A county board of supervisors may adopt an ordinance providing that property acquired and subdivided for development of housing be classified the same as it was prior to its acquisition until the property is sold or, depending on a county's population, for a specified number of years from the date of subdivision, whichever is shorter. The applicable time period is five years in counties with a population of less than 20,000 and three years in counties with a population of 20,000 or more. The property is to be classified as residential or commercial, whichever is applicable, in the assessment year following the year in which it is sold or the applicable time period has expired. For purposes of this subrule, "subdivided" means to divide a tract of land into three or more lots.

This rule is intended to implement Iowa Code sections 405.1, 427A.1, 428.4 and 441.22 and chapter 499B and Iowa Code Supplement section 441.21 as amended by 2002 Iowa Acts, House File 2584.
[**ARC 8559B**, IAB 3/10/10, effective 4/14/10]

701—71.2(421,428,441) Assessment and valuation of real estate.

71.2(1) *Responsibility of assessor.* The valuation of real estate as established by city and county assessors shall be the actual value of the real estate as of January 1 of the year in which the assessment is made. New parcels of real estate created by the division of existing parcels of real estate shall be assessed separately as of January 1 of the year following the division of the existing parcel of real estate.

71.2(2) *Responsibility of other assessing officials.* Whenever local boards of review, county auditors, and county treasurers exercise assessment functions allowed or required by law, they shall follow the provisions of subrule 71.2(1) and rules 71.3(421,428,441) to 71.7(421,427A,428,441).

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.

701—71.3(421,428,441) Valuation of agricultural real estate. Agricultural real estate shall be assessed at its actual value as defined in Iowa Code section 441.21 by giving exclusive consideration to its productivity and net earning capacity. In determining the actual value of agricultural real estate, city and county assessors shall use the Iowa Real Property Appraisal Manual and any other guidelines issued by the department of revenue pursuant to Iowa Code section 421.17(18).

71.3(1) *Productivity.* In determining the productivity and net earning capacity of agricultural real estate, the assessor shall also use available data from Iowa State University, the United States Department of Agriculture (USDA) National Agricultural Statistics Service, the USDA Farm Service Agency, the Iowa department of revenue, or other reliable sources. The assessor shall also consider the results of a modern soil survey, if completed. The assessor shall determine the actual valuation of agricultural real

estate within the assessing jurisdiction and spread such valuation throughout the jurisdiction so that each parcel of real estate is assessed at its actual value as defined in Iowa Code section 441.21.

71.3(2) *Agricultural factor.* In order to determine a productivity value for agricultural buildings and structures, assessors must make an agricultural adjustment to the market value of these buildings and structures by developing an "agricultural factor" for the assessors' jurisdictions. The agricultural factor for each jurisdiction is the product of the ratio of the productivity and net earning capacity value per acre as determined under subrule 71.12(1) over the market value of agricultural land within the assessing jurisdiction. The resulting ratio is then applied to the actual value of the agricultural buildings and structures as determined under the Iowa Real Property Appraisal Manual prepared by the department. The agricultural factor must be applied uniformly to all agricultural buildings and structures in the assessing jurisdiction. As an example, if a building's actual value is $500,000 and the agricultural factor is 30 percent, the productivity value of that building is $150,000. See *H & R Partnership v. Davis County Board of Review,* 654 N.W.2d 521 (Iowa 2002). The 2007, 2008, and 2009 average of the market value of land will be used in determining the agricultural factor for assessment year 2011. A five-year market value average of land for years used to determine the productivity formula will be used to determine the agricultural factor for assessment year 2013 and subsequent assessment years.

71.3(3) *Classification.* Land classified as agricultural real estate includes the land beneath any dwelling and appurtenant structures located on that land and shall be valued by the assessor pursuant to rule 701—71.3(421,428,441). An assessor shall not value a part of the land as agricultural real estate and a part of the land as if it is residential real estate.

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.

[**ARC 8542B**, IAB 2/24/10, effective 3/31/10; **ARC 9478B**, IAB 4/20/11, effective 5/25/11]

701—71.4(421,428,441) Valuation of residential real estate. Residential real estate shall be assessed at its actual value as defined in Iowa Code section 441.21.

In determining the actual value of residential real estate, city and county assessors shall use the appraisal manual issued by the department of revenue pursuant to Iowa Code section 421.17(18) as well as a locally conducted assessment/sales ratio study, an analysis of sales of comparable properties, and any other relevant data available.

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.

701—71.5(421,428,441) Valuation of commercial real estate. Commercial real estate shall be assessed at its actual value as defined in Iowa Code section 441.21. In determining the actual value of commercial real estate, city and county assessors shall use the appraisal manual issued by the department of revenue pursuant to Iowa Code section 421.17(18) as well as a locally conducted assessment/sales ratio study, an analysis of sales of comparable properties, and any other relevant data available.

71.5(1) *Property of long distance telephone companies.* The director of revenue shall assess the property of long distance telephone companies as defined in Iowa Code section 476.1D(10) which property is first assessed for taxation on or after January 1, 1996, in the same manner as commercial real estate.

71.5(2) *Low-income housing subject to Section 42 of the Internal Revenue Code.*

a. Productive and earning capacity. In assessing property that is rented or leased to low-income individuals and families as authorized by Section 42 of the Internal Revenue Code which limits the amount that the individual or family pays for the rental or lease of units in the property, the assessor shall use the productive and earning capacity from the actual rents received as a method of appraisal and shall take into account the extent to which that use and limitation reduces the market value of the property.

b. Direct capitalization method. The income approach to valuation shall be applied using the direct capitalization method. The assessor may use the discounted cash flow method as a test of the reasonableness of the results produced by the direct capitalization method. The direct capitalization method of the income approach involves dividing the Net Operating Income (NOI) on a cash basis by an overall capitalization rate to derive an indication of the value of the property for the assessment year.

In applying the direct capitalization method, the assessor shall develop a normalized measure of annual NOI based on the productive and earning capacity of the development utilizing (1) the actual rent schedule applicable for each of the available units as of January 1 of the year of assessment indicating the actual rent to be paid by the resident plus any Section 8 rental assistance or other direct cash rental subsidy provided to the resident by federal, state or local rent subsidy programs as limited pursuant to Section 42 of the Internal Revenue Code, (2) a normal vacancy/collection allowance, (3) the prior year's actual and current year's projected annual operating expenses associated with the property, excluding noncash items such as depreciation and amortization, but including property taxes and those actual costs expected to be incurred and paid as required by Internal Revenue Code Section 42 regulations, provisions, and restrictions as applicable to the assessment year, and (4) an appropriate provision for replacement reserves.

If no separate line item is included for reserves for replacement in the historic income and expense data, then the maintenance and repair categories of the historic expense data must be itemized. For properties that have attained a normalized operating history, the NOI results of the prior three years (as represented in the statements variously named as the Income and Loss Statement, the Profit and Loss Statement, the Income Statement, the Actual to Budget Comparison Statement, Balance Sheet, or some name variation of these) may be used to provide the basis for determining the normalized NOI used for purposes of applying the direct capitalization method for the year of assessment, provided an appropriate replacement reserve is included in the NOI determination and provided any additional costs required as a result of Section 42 regulation or compliance changes for the assessment year are included as an operating expense in the NOI determination. In addition, the assessor may utilize the current year operating budget to develop a measure of NOI for the assessment year. The assessor, in developing the measure of annual NOI on a cash basis, shall not consider as income any potential rental income differential that could otherwise be received from the property if the rents were not limited pursuant to Section 42 of the Internal Revenue Code, any tax credit equity, any tax credit value, or other subsidized financing.

c. Filing of reports. It shall be the responsibility of the property owner to file income and expense data with the local assessor by March 1 of each year. The assessor may require the filing of additional information if deemed necessary.

d. Capitalization rate. The overall capitalization rate to be used in applying the direct capitalization method for a Section 42 property is developed through the band-of-investment technique. The capitalization rate will be calculated annually by the Iowa department of revenue and distributed to all Iowa assessors by March 1. The capitalization rate is a composite rate weighted by the proportions of total property investment represented by debt and equity. The capital structure weights equity at 80 percent and debt at 20 percent unless actual market capital structure can be verified to the assessor. The yield, or market rate of return, for equity is calculated using the capital asset pricing model (CAPM). The yield for debt is equivalent to the average yield on 25-year Treasury bonds referred to as the Treasury long-term average rate. An example of the band-of-investment technique to be utilized is as follows:

	% to Total	Yield	Composite
Equity	80%	11.05%	8.84%
Debt	20%	5.94%	1.19%
	100%		10.03%

e. Capital asset pricing model. The capital asset pricing model (CAPM) is utilized to develop the equity rate. The formula is:

	Re	=	B (Rm - Rf) + Rf
Where:	Re	=	return on equity
	B	=	beta
	Rm	=	return on the market
	Rf	=	risk-free rate of return
	Rm - Rf	=	market-risk premium

The beta is assumed to be 1 which indicates the risk level to be consistent with the market as a whole. The risk-free rate is calculated by finding the average of the three-month and six-month Treasury bill. The return on the market is calculated by taking the average of the return on the market for the Merrill Lynch Universe and Standard and Poor's 500 or by reference to other published secondary sources.

f. Properties under construction. For Section 42 properties under construction, the assessor may value the property by applying the percentage of completion to the replacement cost new (RCN) as calculated from the Iowa Real Property Appraisal Manual and adding the fair market value of the land. Alternatively, projected income and expense data may be utilized if available.

g. Negative or minimal NOI. If the Section 42 property shows a negative or minimal net operating income (NOI), the indicator of value as set forth in these rules shall not be utilized.

h. Eligibility withdrawn. The property owner shall notify the assessor when property is withdrawn from Section 42 eligibility under the Internal Revenue Code. The notification must be provided by March 1 of the assessment year or the owner is subject to a penalty of $500.

This rule is intended to implement Iowa Code sections 421.17, 428.4, 441.21 as amended by 2004 Iowa Acts, Senate File 2296, and 476.1D(10).

701—71.6(421,428,441) Valuation of industrial land and buildings. Industrial real estate shall be assessed at its actual value as defined in Iowa Code section 441.21.

In determining the actual value of industrial land and buildings, city and county assessors shall use the appraisal manual issued by the department of revenue pursuant to Iowa Code subsection 421.17(18), and any other relevant data available.

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.

701—71.7(421,427A,428,441) Valuation of industrial machinery. Industrial machinery as referred to in Iowa Code section 427A.1(1)*"e"* shall include all machinery used in manufacturing establishments and shall be assessed as real estate even though such machinery might be assessed as personal property if not used in a manufacturing establishment.

In determining the actual value of industrial machinery assessed as real estate, the assessor shall give consideration to the "Industrial Machinery and Equipment Valuation Guide" issued by the department of revenue and any other relevant data available.

This rule is intended to implement Iowa Code sections 421.17, 427A.1, 428.4 and 441.21.

701—71.8(428,441) Abstract of assessment. Each city and county assessor shall submit annually to the director of revenue at the times specified in Iowa Code section 441.45 an abstract of assessment for the current year. The assessor shall use the form of abstract prescribed and furnished by the department of revenue, and shall enter on the abstract all information required by the department. However, the department may approve the use of a computer-prepared abstract if the data is essentially the same format as on the form prescribed by the department. The information entered on the abstract of assessment shall be reviewed and considered by the director of revenue in equalizing the valuations of classes of properties.

This rule is intended to implement Iowa Code sections 428.4 and 441.45.

701—71.9(428,441) Reconciliation report. The assessor's report of any revaluation required by Iowa Code section 428.4 shall be made on the reconciliation report prescribed and furnished by the department of revenue. The assessor shall enter on the report all information required by the department. The reconciliation report shall be a part of the abstract of assessment required by Iowa Code section 441.45 and shall be reviewed and considered by the director in equalizing valuations of classes of property.

This rule is intended to implement Iowa Code sections 428.4 and 441.45.

701—71.10(421) Assessment/sales ratio study.

71.10(1) *Basic data.* Basic data shall be that submitted to the department of revenue by county recorders and city and county assessors on forms prescribed and provided by the department, information furnished by parties to real estate transactions, and information obtained by field investigations made by the department of revenue.

71.10(2) *Responsibility of recorders and assessors.* County recorders and city and county assessors shall complete the prescribed forms as required by Iowa Code subsection 421.17(6) and rule 701—79.3(428A) in accordance with instructions issued by the department. Assessed values entered on the prescribed form shall be those established as of January 1 of the year in which the sale takes place.

71.10(3) *Normal sales.* All real estate transfers shall be considered by the department of revenue to be normal sales unless there exists definite information which would indicate the transfer was not an arms-length transaction or is of an excludable nature as provided in Iowa Code section 441.21.

This rule is intended to implement Iowa Code section 421.17.

701—71.11(441) Equalization of assessments by class of property. Commencing in 1977 and every two years thereafter, the director of revenue shall order the equalization of the levels of assessment of each class of property as provided in rule 701—71.12(441) by adding to or deducting from the valuation of each class of property, as reported to the department on the abstract of assessment and reconciliation report which is a part of the abstract, the percentage in each case as may be necessary to bring the level of assessment to its actual value as defined in Iowa Code section 441.21. Valuation adjustments shall be ordered if the director determines that the aggregate valuation of a class of property as reported on the abstract of assessment submitted by the assessor is at least 5 percent above or below the aggregate valuation for that class of property as determined by the director pursuant to rule 701—71.12(441). Equalization orders of the director shall be restricted to equalizing the aggregate valuations of entire classes of property among the several assessing jurisdictions. All classifications of real estate shall be applied uniformly throughout the state of Iowa.

Equalization percentage adjustments determined for residential realty located outside incorporated areas and not located on agricultural land shall apply to buildings located on agricultural land outside incorporated areas, which are primarily used or intended for human habitation, as defined in subrule 71.1(4).

Equalization percentage adjustments determined for residential realty located within incorporated cities and not located on agricultural land shall apply to buildings located on agricultural land within incorporated cities which are primarily used or intended for human habitation as defined in subrule 71.1(4).

This rule is intended to implement Iowa Code sections 441.21, 441.47, 441.48 and 441.49.

701—71.12(441) Determination of aggregate actual values.

71.12(1) *Agricultural real estate.*

a. Use of income capitalization study. The equalized valuation of agricultural realty shall be based upon its productivity and net earning capacity and shall be determined in accordance with the provisions of this subrule. Data used shall pertain to crops harvested during the five-year period ending with the calendar year in which assessments were last equalized. The equalized valuation of agricultural realty shall be determined for each county as follows:

(1) Computation of county acres. This information shall be obtained from the USDA National Agricultural Statistics Service.

1. Total acres in farms: Total acreage used for agricultural purposes.

2. Corn acres: Sum of corn acres harvested including silage, popcorn and acres planted for sorghum.

3. Oats and wheat acres: Sum of oats and wheat acres harvested.

4. Soybean acres: Soybean acres harvested.

5. Hay acres: All hay acres harvested.

6. Pasture acres: All pasture acres. Total pasture acres shall be determined by multiplying the total acres in farms reported by the USDA National Agricultural Statistics Service by the percentage which total pasture land as reported in the most recent U.S. Census of Agriculture bears to the total acreage in farmland also reported in the most recent U.S. Census of Agriculture. The amount of tillable and nontillable pasture acres shall be determined as follows:

1.	From the most recent U.S. Census of Agriculture obtain the following:		
	Cropland used only for pasture and grazing	_____	acres
	Woodland pasture	_____	acres
	Pasture land and rangeland (other than cropland and woodland pasture)	_____	acres
	TOTAL PASTURE LAND (total of above):	_____	acres
2.	Determine what percentage of the total pasture land is cropland used only for pasture:	_____	%
3.	Apply the percentage in "2" above to the 5-year average total acres of pasture as determined above to determine the pasture acres to be classified as tillable pasture. The remainder of the 5-year average shall be classified as nontillable pasture land.	_____	acres

7. Government programs: Determine the 5-year average acres participating in applicable government programs. Obtain data from the USDA Farm Service Agency, including but not limited to acreage devoted to the Payment-In-Kind (PIK), diverted and deficiency programs.

8. Other acres: The difference between the total acreage for land uses listed above and the total of all land in farms. Add the total of the corn, oats, soybeans, hay, tillable and nontillable pasture and diverted acres. Subtract this total from total acres in farms. The residual is classified as other acres.

(2) Computation of county yields. This information shall be obtained for each county from the USDA National Agricultural Statistics Service.

1. Corn yield (including silage): Number of bushels of corn harvested for grain per acre.

2. Oat yield (including wheat): Number of bushels of oats harvested per acre.

3. Soybean yield: Number of bushels per acre harvested.

4. Hay yield in tons: Number of tons per acre harvested.

(3) Computation of county gross income.

1. Corn: One-half of the 5-year average production multiplied by the 5-year average price received for corn.

2. Silage: One-half of the 5-year average number of acres devoted to the production of silage multiplied by the 5-year average production per acre for corn. The amount of production so determined shall be added to the 5-year average production for corn and included in the determination of the gross income for corn.

3. Soybeans: One-half of the 5-year average production multiplied by the 5-year average price received.

4. Oats: One-half of the 5-year average production of oats and wheat multiplied by the 5-year average price received for oats.

5. Price adjustment: For corn, soybeans, hay, and oats, the prices used shall be as obtained from the USDA National Agricultural Statistics Service and shall be adjusted to reflect any individual county price conditions prior to the 2007 crop year. For the 2007 crop year and later, the USDA National Agricultural Statistics Service district prices shall be used and shall be adjusted to reflect any individual county price conditions.

6. Government programs: Gross income shall be one-half of the 5-year average amount of cash payments or equivalent (such as PIK bushels) including but not limited to diverted, deficiency and PIK programs as reported by the USDA Farm Service Agency.

7. Hay: Gross income shall be a cash rent amount determined by multiplying the 5-year average number of acres devoted to hay by the product obtained by multiplying one-fourth of the 5-year average hay yield by the 5-year average price received for all types of hay.

8. Tillable pasture: Gross income shall be a cash rent amount determined by multiplying the 5-year average number of acres devoted to tillable pasture by the product obtained in "hay" above.

9. Nontillable pasture: Gross income shall be a cash rent amount determined by multiplying the 5-year average number of acres devoted to nontillable pasture by one-half the product obtained in "hay" above.

10. Other acres: Income shall be the product of the number of other acres multiplied by 17 percent of the net income per acre for all other land uses.

(4) Computation of county production costs. The following data and procedures shall be used to determine specific county production costs.

1. Basic average landlord production costs. Landlord production costs for corn, soybeans, oats, diverted acres, hay, tillable pasture, nontillable pasture, fertilizer costs, and facilities' costs shall be obtained for each year from Iowa State University.

2. Production cost adjustment. The production costs for corn, soybeans, oats, and hay are adjusted for each county by multiplying the difference between the 5-year state average yield per acre and the 5-year county average yield per acre by the 5-year average facilities' costs. If a county's yield exceeds the state yield, production costs are increased by this amount. If a county's yield is less than the state yield, production costs are reduced by this amount.

3. Fertilizer cost adjustment. The adjustment for fertilizer costs is determined as follows: Multiply the difference between the 5-year state average corn yield per acre and the 5-year county average corn yield per acre obtained from the USDA National Agricultural Statistics Service by the fertilizer cost amount per bushel determined by dividing the statewide average cost of landlord's share of fertilizer cost per acre from Iowa State University by the statewide average corn yield per acre to produce the corn fertilizer cost per bushel adjustment. This amount is then multiplied by the 5-year county average corn acres determined in (2) above.

4. Expense adjustments. If a county's 5-year average corn yield is greater than the state 5-year average corn yield, this amount is allowed as an additional expense. If the county's average is less than the state average, this amount is an expense reduction.

5. Liability insurance cost adjustment. The 5-year average per acre cost of obtaining tort liability insurance shall be determined.

(5) Computation of county net income. From the total gross income, subtract the total expenses. Divide the resulting total by the total number of acres.

(6) Computation of dwelling adjustment factor. The amount determined in (5) above shall be reduced by 10.6 percent.

(7) Computation of county tax adjustment. Subtract the 5-year average per acre real estate taxes levied for land and structures including drainage and levee district taxes but excluding those levied against agricultural dwellings from the amount determined in (6) above. Taxes shall be the tax levied for collection during the 5-year period as reported by county auditors, and reduced by the amount of the agricultural land tax credit.

(8) Calculation of county valuation per acre. Divide the net income per acre ((7) above) for each county as determined above by the capitalization rate specified in Iowa Code section 441.21. The

quotient shall be the actual per acre equalized valuation of agricultural land and structures for the current equalization year.

b. Use of other relevant data. The director may also consider other relevant data, including field investigations conducted by representatives of the department of revenue, to determine the level of assessment of agricultural real estate.

c. Determination of value. The aggregate actual value of agricultural real estate in each county shall be determined by multiplying the equalized per acre value by the number of acres of agricultural real estate reported on the abstract of assessment for the current year, adjusted where necessary by the results of any field investigations conducted by the department of revenue and any other relevant data available.

71.12(2) *Residential real estate outside and within incorporated cities.*

a. Use of assessment/sales ratio study. Basic data shall be that set forth in rule 701—71.10(421) refined by eliminating any sales determined to be abnormal or by adjusting the sales to eliminate the effects of factors which resulted in the sales having been determined to be abnormal. The basic data used shall be the assessment/sales ratio study conducted for sales taking place during the calendar year immediately preceding the year in which the equalization order is issued. The director may also supplement the assessment/sales ratio study with appraisals made by department of revenue appraisal personnel for the year immediately preceding the year in which the equalization order is issued. The assessment/sales ratio study including relevant appraisals, if any, shall be used to determine the aggregate actual valuation of residential real estate in each assessing jurisdiction. The director of revenue may consider sales and appraisal data for prior years if it is determined the use of the sales and appraisal data for the year immediately preceding the year in which the equalization order is issued is insufficient to determine market value. If such sales and appraisal data for prior years is used, consideration shall be given for any subsequent changes in either assessed value or market value.

Assessors shall provide any known facts or circumstances regarding reported sales transactions and department appraisals which would indicate abnormal or unusual conditions or reporting discrepancies which would necessitate exclusion or adjustment of sales or appraisals from the determination of aggregate actual values. Assessors shall provide those facts within 45 days of receipt from the department of information concerning sales and appraisal data proposed for assessment/sales ratio and equalization purposes.

b. Use of other relevant data. The director may also consider other relevant data, including field investigations conducted by representatives of the department of revenue to determine the level of assessment of residential real estate.

c. Equalization appraisal selection procedures for residential real estate. Residential properties to be appraised by department of revenue personnel for use in supplementing the assessment/sales ratio study shall be selected for each jurisdiction in the following manner:

(1) The department appraiser assigned to the jurisdiction shall determine a systematic random sequence of numbers equal to the number of appraisals required and document the following steps.

1. The department appraiser assigned to the jurisdiction shall compute the interval number by dividing the total number of improved properties in the classification to be sampled by the number of appraisals to be performed.

EXAMPLE: In this example, ten appraisals are needed with a total of 1,397 improved residential units. Dividing 1,397 by 10, 139.7 is arrived at, which is rounded down to 139. This is the interval number.

2. The selection of the first sequence number shall be accomplished by having an available disinterested person randomly select a number from one through the interval number.

EXAMPLE: In this example a number from 1 to 139 is to be selected. The person randomly selected number 20.

3. The department appraiser shall develop a systematic sequence of numbers equal to the number of appraisals required. Starting with the randomly selected number previously picked by the disinterested person, add the interval number to this number and to each resulting number until a systematic sequence of numbers is obtained.

EXAMPLE: In this example ten appraisals are needed, so a sequence of ten numbers must be developed. Starting with number 20 and adding the interval number of 139 to it, each resulting number provides the following systematic sequence: 20, 159, 298, 437, 576, 715, 854, 993, 1,132, 1,271.

(2) Number of improved properties.

County jurisdictions—Put the name of each city or township having improved units in the classification to be sampled into a hat. Draw each one out of the hat and record its name in the order of its draw. Likewise, record the respective number of improved units for each. Then consecutively number all the improved units and document the procedure.

EXAMPLE:

City or Township	Number of Improved Residential Units	Code Numbers
Franklin Twp.	57	1-57
Pleasant View	160	58-217
Jackson Twp.	56	218-273
Johnston	300	274-573
Polk Twp.	110	574-683
Washington Twp.	114	684-797
Maryville	306	798-1103
Camden Twp.	110	1104-1213
Salem	184	1214-1397
Total	1,397	

(3) Determine the location of the improved properties selected for appraisal and document the procedure.

EXAMPLE:

City or Township	Number of Improved Residential Units	Code Numbers	Sequence Number	Entry on Rolls
Franklin Twp.	57	1-57	20	20
Pleasant View	160	58-217	159	102
Jackson Twp.	56	218-273		
Johnston	300	274-573	298,437	25,164
Polk Twp.	110	574-683	576	3
Washington Twp.	114	684-797	715	32
Maryville	306	798-1103	854,993	57,196
Camden Twp.	110	1104-1213	1132	29
Salem	184	1214-1397	1271	58
Total	1,397			

1. The department appraiser shall locate the property to be appraised by finding the relationship between the sequence numbers and the code numbers and identify the property.

EXAMPLE: The first sequence number is 20. Since the improved residential properties in Franklin Township have been assigned code numbers 1 to 57, sequence number 20 is in that location.

To identify this property, examine the Franklin Township assessment roll book and stop at the twentieth improved residential entry.

Document the parcel number, owner's name, and legal description of this property.

2. The department appraiser shall appraise the property selected unless it is ineligible because of any of the following restrictions:

Current year sale
Partial assessment
Prior equalization appraisal
Tax-exempt
Value established by court action
Value is not more than $10,000
Building on leased land

3. The department appraiser shall determine a substitute property if the originally selected one is ineligible. In ascending order, select code numbers until an eligible property is found.

EXAMPLE: If code number 20 is ineligible, use code number 21 as a substitute. If code number 21 is ineligible, use code number 22, etc., until an eligible property is found.

If the procedure described in 71.12(2)*"c"*(3)"3" moves the substitute property to another city or township, select substitute code numbers in descending order until an eligible property is found.

If the procedure described in the previous paragraph moves the substitute property to a preceding city or township, go back to the procedure of 71.12(2)*"c"*(3)"3" even if it moves the substitute property to a subsequent city or township.

4. Select an alternate property for the originally selected property which also would be eligible. This is necessary because at the time of appraisal the property may be found to be ineligible due to one of the restrictions in 71.12(2)*"c"*(3)"2." Alternate properties are selected by using the same procedure described in 71.12(2)*"c"*(3)"3."

5. Follow procedures 71.12(2)*"c"*(3), items "1" to "4," for each of the other originally selected sequence numbers.

71.12(3) *Commercial real estate.*

a. Use of assessment/sales ratio study. Basic data shall be that set forth in rule 71.10(421), refined by eliminating any sales determined to be abnormal or by adjusting same to eliminate the effects of factors which resulted in the sales having been determined to be abnormal. The basic data used shall be the assessment/sales ratio study conducted for sales taking place during the calendar year immediately preceding the year in which the equalization order is issued. The director may also supplement the assessment/sales ratio study with appraisals made by department of revenue appraisal personnel for the year immediately preceding the year in which the equalization order is issued. The assessment/sales ratio study including relevant appraisals, if any, shall be used to determine the aggregate actual valuation of commercial real estate in each assessing jurisdiction. The director of revenue may consider sales and appraisal data for prior years if it is determined the use of sales and appraisal data for the year immediately preceding the year in which the equalization order is issued is insufficient to determine market value. If such sales and appraisal data for prior years is used, consideration shall be given for any subsequent changes in either assessed value or market value.

b. Use of other relevant data. The director may also consider other relevant data, including field investigations conducted by representatives of the department of revenue to determine the level of assessment of commercial real estate. The diverse nature of commercial real estate precludes the use of a countywide or citywide income capitalization study.

Assessors shall provide any known facts or circumstances regarding reported sales transactions and department appraisals which would indicate abnormal or unusual conditions or reporting discrepancies which would necessitate exclusion or adjustment of sales or appraisals from the determination of aggregate actual values. Assessors shall provide those facts within 45 days of receipt from the department of information concerning sales and appraisal data proposed for assessment/sales ratio and equalization purposes.

c. Equalization appraisal selection procedures for commercial real estate. Commercial properties to be appraised by department of revenue personnel for use in supplementing the assessment/sales ratio study shall be selected for each jurisdiction in the following manner:

(1) The department appraiser assigned to the jurisdiction shall determine a systematic random sequence of numbers equal to the number of appraisals required and document the following steps.

1. The department appraiser shall compute the interval number by dividing the total number of improved properties in the classification to be sampled by the number of appraisals to be performed.

EXAMPLE: In this example, ten appraisals are needed with a total of 397 improved commercial units. Dividing 397 by 10, 39.7 is arrived at, which is rounded down to 39. This is the interval number.

2. The selection of the first sequence number shall be accomplished by having an available disinterested person randomly select a number from one through the interval number.

EXAMPLE: In this example a number from 1 to 39 is to be selected. The person randomly selected number 2.

3. The department appraiser shall develop a systematic sequence of numbers equal to the number of appraisals required. Starting with the randomly selected number previously picked by the disinterested person, add the interval number to this number and to each resulting number until a systematic sequence of numbers is obtained.

EXAMPLE: In this example ten appraisals are needed, so a sequence of ten numbers must be developed. Starting with number 2 and adding the interval number of 39 to it, each resulting number provides the following systematic sequence: 2, 41, 80, 119, 158, 197, 236, 275, 314, 353.

(2) Number of improved properties.

1. City jurisdictions—Utilizing the assessment book or a computer printout which follows the same order as the assessment book, consecutively number all the improved units and document the procedure.

2. County jurisdictions—Put the name of each city or township having improved units in the classification to be sampled into a hat. Draw each one out of the hat and record its name in the order of its draw. Likewise, record the respective number of improved units for each. Then consecutively number all the improved units and document the procedure.

EXAMPLE:

City or Township	Number of Improved Commercial Units	Code Numbers
Franklin Twp.	4	1-4
Pleasant View	60	5-64
Jackson Twp.	9	65-73
Johnston	100	74-173
Polk Twp.	10	174-183
Washington Twp.	14	184-197
Maryville	106	198-303
Camden Twp.	10	304-313
Salem	84	314-397
Total	397	

(3) The department appraiser shall determine the location of the improved properties selected for appraisal and document the procedure.

EXAMPLE:

City or Township	Number of Improved Commercial Units	Code Numbers	Sequence Number	Entry on Rolls
Franklin Twp.	4	1-4	2	2
Pleasant View	60	5-64	41	37
Jackson Twp.	9	65-73		
Johnston	100	74-173	80,119,158	7,46,85
Polk Twp.	10	174-183		

City or Township	Number of Improved Commercial Units	Code Numbers	Sequence Number	Entry on Rolls
Washington Twp.	14	184-197	197	14
Maryville	106	198-303	236,275	39,78
Camden Twp.	10	304-313		
Salem	84	314-397	314,353	1,40
Total	397			

1. The department appraiser shall locate the property to be appraised by finding the relationship between the sequence numbers and the code numbers and identify the property.

EXAMPLE: The first sequence number is 2. Since the improved commercial properties in Franklin Township have been assigned code numbers 1 to 4, sequence number 2 is in that location.

To identify this property, examine the Franklin Township assessment roll book and stop at the second improved commercial entry.

The department appraiser shall document the parcel number, owner's name, and legal description of this property.

2. The department appraiser shall appraise the property selected unless it is ineligible because of any of the following restrictions:

Vacant building
Current year sale
Partial assessment
Prior equalization appraisal
Tax-exempt
Only one portion of a total property unit (example—a parking lot of a grocery store)
Value established by court action
Value is not more than $5,000
Building on leased land

3. The department appraiser shall determine a substitute property if the originally selected one is ineligible. In ascending order, select code numbers until an eligible property is found.

EXAMPLE: If code number 2 is ineligible, use code number 3 as a substitute. If code number 3 is ineligible, use code number 4, etc., until an eligible property is found.

If the procedure described in 71.12(3)*"c"*(3)"3" moves the substitute property to a city or township, select substitute code numbers in descending order until an eligible property is found.

If the procedure described in the previous paragraph moves the substitute property to a preceding city or township, go back to the procedure of 71.12(3)*"c"*(3)"3" even if it moves the substitute property to a subsequent city or township.

4. Select an alternate property for the originally selected property which also would be eligible. This is necessary because at the time of appraisal the property may be found to be ineligible due to one of the restrictions in 71.12(3)*"c"*(3)"2." Alternate properties are selected by using the same procedure described in 71.12(3)*"c"*(3)"3."

5. Follow procedures 71.12(3)*"c"*(3), items "1" to "4," for each of the other originally selected sequence numbers.

71.12(4) *Industrial real estate.* It is not possible to determine the level of assessment of industrial real estate by using accepted equalization methods. The lack of sales data precludes the use of an assessment/sales ratio study, the diverse nature of industrial real estate precludes the use of a countywide or citywide income capitalization study, and the limited number of industrial properties precludes the use of sample appraisals. The level of assessment of industrial real estate can only be determined by the valuation of individual parcels of industrial real estate. Any attempt to equalize industrial valuations by using accepted equalization methods would create an arbitrary result. However, under the circumstances

set forth in Iowa Code subsection 421.17(10), the director may correct any errors in such assessments which are brought to the director's attention.

71.12(5) *Personal property.* Rescinded IAB 10/25/95, effective 11/29/95.

71.12(6) *Centrally assessed property.* Property assessed by the director of revenue pursuant to Iowa Code chapters 428 and 433 to 438, inclusive, is equalized internally by the director in the making of the assessments. Further, the assessments are equalized with the aggregate valuations of other classes of property as a result of actions taken by the director of revenue pursuant to rule 701—71.11(441).

71.12(7) *Miscellaneous real estate.* Since it is not possible to use accepted equalization methods to determine the level of assessment of mineral rights and interstate railroad and toll bridges, these classes of property shall not be subject to equalization by the director of revenue. However, under the circumstances set forth in Iowa Code section 421.17(10), the director may correct any errors in assessments which are brought to the director's attention.

This rule is intended to implement Iowa Code sections 441.21, 441.47, 441.48 and 441.49.
[**ARC 7726B**, IAB 4/22/09, effective 5/27/09; **ARC 9478B**, IAB 4/20/11, effective 5/25/11]

701—71.13(441) Tentative equalization notices. Prior to the issuance of the final equalization order to each county auditor, a tentative equalization notice providing for proposed percentage adjustments to the aggregate valuations of classes of property as set forth in rule 701—71.12(441) shall be mailed to the county auditor whose valuations are proposed to be adjusted. The tentative equalization notice constitutes the ten days' notice required by Iowa Code section 441.48.

This rule is intended to implement Iowa Code sections 441.47 and 441.48.

701—71.14(441) Hearings before the director.

71.14(1) *Protests.* Written or oral protest against the proposed percentage adjustments as set forth in the tentative equalization notice issued by the director of revenue shall be made only on behalf of the affected assessing jurisdiction. The protests shall be made only by officials of the assessing jurisdiction, including, but not limited to, an assessing jurisdiction's city council or board of supervisors, assessor, or city or county attorney. An assessing jurisdiction may submit a written protest in lieu of making an oral presentation before the director, or may submit an oral protest supported by written documentation. Protests against the adjustments in valuation contained in the tentative equalization notices shall be limited to a statement of the error or errors complained of and shall include such facts as might lead to their correction. No other factors shall be considered by the director in reviewing the protests. Protests and hearings on tentative equalization notices before the director are excluded from the provisions of the Iowa Administrative Procedure Act governing contested case proceedings.

71.14(2) *Conduct of hearing.* The director shall schedule each hearing so as to allow the same amount of time within which each assessing jurisdiction can make its presentation. During the hearing each assessing jurisdiction shall be afforded the opportunity to present evidence relevant to its protest. The director or the director's designated representative shall preside at the hearing which shall be held at the time and place designated by the director or such other time and place as may be mutually agreed upon by the director and the protesting assessing jurisdiction.

This rule is intended to implement Iowa Code section 441.48.

701—71.15(441) Final equalization order. After the tentative equalization notice has been issued and an opportunity for a hearing described in rule 701—71.14(441) has been afforded, the director shall issue a final equalization order by mail to the county auditor. The order shall specify any percentage adjustments in the aggregate valuations of any class of property to be made effective for the county as of January 1 of the year in which the order is issued. The final equalization order shall be issued on or before October 1 unless for good cause it cannot be issued until after October 1. The final equalization order shall be implemented by the county auditor.

An assessing jurisdiction may appeal a final equalization order to the state board of tax review. The protest must be filed or postmarked not later than ten days after the date the final equalization order is issued.

This rule is intended to implement Iowa Code sections 441.48 and 441.49.

701—71.16(441) Alternative method of implementing equalization orders.

71.16(1) *Application for permission to use an alternative method.* A request by an assessing jurisdiction for permission to use an alternative method of applying the final equalization order must be made in writing to the director of revenue within ten days from the date the county auditor receives the final equalization order. The written request shall include the following information:

a. Facts evidencing the need to use an alternative method of implementing the final equalization order. Such facts shall clearly show that the proposed method is essential to ensure compliance with the provisions of Iowa Code section 441.21.

b. The exact methods to be employed in implementing the requested alternative method for each class of property.

c. The specific method of notifying affected property owners of the valuation changes.

d. Evidence that the alternative method will result in an aggregate property class valuation adjustment equivalent to that prescribed in the director's final equalization order.

The director of revenue shall review each written request for an alternative method and shall notify the assessing jurisdiction of acceptance or rejection of the proposed method by October 15. The assessing jurisdiction shall immediately inform the county auditor of the director's decision. The county auditor shall include a description of any approved alternative method in the required newspaper publication of the final equalization order. In those instances where the approved alternative method includes individual property owner notification, the publication shall not be considered proper notice to the affected property owners.

71.16(2) *Implementation of alternative method.* If an alternative method is approved by the director of revenue, any individual notification of property owners shall be completed by the assessor by not later than October 25.

71.16(3) *Appeal by property owners.* If an alternative method is approved by the director of revenue, the special session of the local board of review to hear equalization protests shall be extended to November 30. In such instances, protests may be filed up to and including November 4.

This rule is intended to implement Iowa Code section 441.49.

701—71.17(441) Special session of boards of review.

71.17(1) *Grounds for protest.* The only ground for protesting to the local board of review reconvened in special session pursuant to Iowa Code section 441.49 is that the application of the director's final equalization order results in a value greater than that permitted under Iowa Code section 441.21.

71.17(2) *Authority of board of review.* When in special session to hear protests resulting from equalization adjustments, the local board of review shall only act upon protests for those properties for which valuations have been increased as a result of the application of the director of revenue's final equalization order.

The local board of review may adjust valuations of those properties it deems warranted, but under no circumstance shall the adjustment result in a value less than that which existed prior to the application of the director's equalization order. The local board of review shall not adjust the valuation of properties for which no protests have been filed.

71.17(3) *Report of board of review.* In the report to the director of revenue of action taken by the local board of review in special session, the board of review shall report the aggregate valuation adjustments by class of property as well as all other information required by the director of revenue to determine if such actions may have substantially altered the equalization order.

71.17(4) *Meetings of board of review.* If the final equalization order does not increase the valuation of any class of property, the board of review is not required to meet during the special session. If the final equalization order increases the valuation of one or more classes of property but no protests are filed by

the times specified in Iowa Code section 441.49, the board of review is not required to meet during the special session.

This rule is intended to implement Iowa Code sections 421.17(10) and 441.49.

701—71.18(441) Judgment of assessors and local boards of review. Nothing stated in these rules should be construed as prohibiting the exercise of honest judgment, as provided by law, by the assessors and local boards of review in matters pertaining to valuing and assessing of individual properties within their respective jurisdictions.

This rule is intended to implement Iowa Code sections 441.17 and 441.35.

701—71.19(441) Conference boards.

71.19(1) *Establishment and abolition of office.*

a. As referred to in Iowa Code section 441.1, the term "federal census" includes any special census conducted by the Bureau of the Census of the U.S. Department of Commerce as well as the Bureau's decennial census.

b. Within 60 days of receiving the certified results of a federal census indicating the population of a city having its own assessor has fallen below 10,000, the city council of the city shall repeal the ordinance providing for its own assessor.

c. Whenever the office of city assessor is abolished, all moneys in the assessment expense fund and the special appraiser fund shall be transferred to the appropriate accounts in the county assessor's office, and all equipment and supplies shall be transferred to the county assessor's office. Employees of the city assessor's office may, at the discretion of the county assessor, become employees of the county assessor. However, any deputy assessor of the city may not be appointed a deputy county assessor unless certified as eligible for appointment pursuant to Iowa Code sections 441.5 and 441.10.

71.19(2) *Membership.*

a. County conference boards. A county conference board consists of the county board of supervisors, the mayor of each incorporated city in the county whose property is assessed by the county assessor, and one member of the board of directors of each high school district in the county, provided the member is a resident of the county. Members representing school districts serve one-year terms, and the board of directors each year must notify the clerk of the conference board of its representative on the conference board. A member of the board of directors of a school district may serve on the county conference board even though the member lives in a city having its own assessor (1978 O.A.G. 466).

b. City conference boards. A city conference board consists of the county board of supervisors, the city council, and the entire board of directors of each school district whose property is assessed by the city assessor.

71.19(3) *Voting.*

a. Votes on matters before a conference board shall be by units as provided in Iowa Code section 441.2. At least two members of each voting unit must be present in order for the unit to cast a vote (1960 O.A.G. 226). In the event the vote of the members of a voting unit ends in a tie, that unit shall not cast a vote on the particular matter before the conference board.

b. If a member of a conference board is absent from a meeting, the member's vote may not be cast by another person, except that a mayor pro tem as provided in Iowa Code section 372.14(3) may vote for the mayor when the mayor is absent from or unable to perform official duties.

This rule is intended to implement Iowa Code section 441.2.

701—71.20(441) Board of review.

71.20(1) *Membership.*

a. Occupation of members. One member of the county board of review must be actively engaged in farming as that member's primary occupation. However, it is not necessary for a board of review to have as a member one licensed real estate broker and one registered architect or person experienced in the building and construction field if the person cannot be located after a good faith effort to do so has been made by the conference board (1966 O.A.G. 416). In determining eligibility for membership on

a board of review, a retired person is not considered to be employed in the occupation pursued prior to retirement, unless that person remains in reasonable contact with the former occupation, including some participation in matters associated with that occupation.

b. Residency of members. A person must be a resident of the assessor jurisdiction served to qualify for appointment as a member of the board of review. However, a member changing assessing jurisdiction residency after appointment to the board may continue to serve on the board until the member's current term of office expires.

c. Term of office. The term of office of members of boards of review shall be for six years and shall be staggered as provided in Iowa Code section 441.31. In the event of the death, resignation, or removal from office of a member of a board of review, the conference board or city council shall appoint a successor to serve the unexpired term of the previous incumbent.

d. Membership on other boards. A member of a board of review shall not at the same time serve on either the conference board or the examining board, or be an employee of the assessor's office (1948 O.A.G. 120, 1960 O.A.G. 226).

e. Number of members. A conference board or city council may at any time change the composition of a board of review to either three or five members. To reduce membership from five members to three members, the conference board or city council shall not appoint successors to fill the next two vacancies which occur (1970 O.A.G. 342). To increase membership from three members to five members, the conference board or city council shall appoint two additional members whose initial terms shall expire at such times so that no two board members' terms expire at the end of the same year. Also, the conference board or city council may increase the membership of the board of review by an additional two members if it determines that a large number of protests warrant the emergency appointments. If the board of review has ten members, not more than four additional members may be appointed by the conference board. The terms of the emergency members will not exceed two years.

f. Removal from office. A member of a board of review may be removed from office by the conference board or city council but only after specific charges have been filed by the conference board or city council.

g. Appointment of members. Members of a county board of review shall be appointed by the county conference board. Members of a city board of review shall be appointed by the city conference board in cities with an assessor or by the city council in cities without an assessor. A city without an assessor can only have a board of review if the population of the city is 75,000 or more. A city with a population of more than 125,000 may appoint a city board of review or request the county conference board to appoint a ten-member county board of review.

71.20(2) *Sessions of boards of review.*

a. It is mandatory that a board of review convene on May 1 and adjourn no later than May 31 of each year. However, if either date falls on a Saturday, Sunday, or legal holiday, the board of review shall convene or adjourn on the following Monday.

b. Extended session. If a board of review determines it will be unable to complete its work by May 31, it may request that the director of revenue extend its session up to July 15. The request must be signed by a majority of the membership of the board of review and must contain the reasons the board of review cannot complete its work by May 31. During the extended session, a board of review may perform the same functions as during its regular session unless specifically limited by the director of revenue.

c. Special session. If a board of review is reconvened by the director of revenue pursuant to Iowa Code section 421.17, the board of review shall perform those functions specified in the order of the director of revenue and shall perform no other functions.

71.20(3) *Actions initiated by boards of review.*

a. Internal equalization of assessments. A board of review in reassessment years as provided in Iowa Code section 428.4 has the power to equalize individual assessments as established by the assessor, but cannot make percentage adjustments in the aggregate valuations of classes of property (1966 O.A.G. 416). In nonreassessment years, a board of review can adjust the valuation of an entire class of property

by adjusting all assessment by a uniform percentage. Nothing contained in this rule shall restrict the director from exercising the responsibilities set forth in Iowa Code section 421.17.

b. Omitted assessments. A board of review may assess for taxation any property which was not assessed by the assessor, including property which the assessor determines erroneously is not subject to taxation by virtue of enjoying an exempt status (*Talley v. Brown,* 146 Iowa 360,125 N.W. 248 (1910)).

c. Notice to taxpayers. If the value of any property is increased by a board of review or a board of review assesses property not previously assessed by the assessor, the person to whom the property is assessed shall be notified by regular mail of the board's action. The notification shall state that the taxpayer may protest the action by filing a written protest with the board of review within five days of the date of the notice. After at least five days have passed since notifying the taxpayer, the board of review shall meet to take final action on the matter, including the consideration of any protest filed. However, if the valuations of all properties within a class of property are raised or lowered by a uniform percentage in a nonreassessment year, notice to taxpayers need be provided only by newspaper publication as described in Iowa Code section 441.35.

71.20(4) *Appeals to boards of review.*

a. A board of review may act only upon written protests which have been filed with the board of review between April 16 and May 5, inclusive. In the event May 5 falls on a Saturday or Sunday, protests filed the following Monday shall be considered to have been timely filed. Protests postmarked by May 5 or the following Monday if May 5 falls on a Saturday or Sunday shall also be considered to have been timely filed. All protests must be in writing and signed by the taxpayer or the taxpayer's authorized agent. A written request for an oral hearing must be made at the time of filing the protest and may be made by checking the appropriate box on the form prescribed by the department of revenue. Protests may be filed for previous years if the taxpayer discovers that a mathematical or clerical error was made in the assessment, provided the taxes have not been fully paid or otherwise legally discharged. The protester may combine on one form assessment protests on parcels separately assessed if the same grounds are relied upon as the basis for protesting each separate assessment. If an oral hearing is requested on more than one of the protests, the person making the combined protests may request that the oral hearings be held consecutively. A board of review may allow protests to be filed in electronic format. Protests transmitted electronically are subject to the same deadlines as written protests.

b. Grounds for protest. Taxpayers may protest to a board of review on one or more of the grounds specified in Iowa Code section 441.37. The grounds for protest and procedures for considering protests are as follows:

(1) The assessment is not equitable when compared with those of similar properties in the same assessing district. If this ground is a basis for the protest, the protest must contain the legal descriptions and assessments of the comparable properties. The comparable properties selected by the taxpayer must be located within the same assessing district as the property for which the protest has been filed (*Maytag Co. v. Partridge,* 210 N.W.2d 584 (Iowa 1973)). In considering a protest based upon this ground, the board of review should examine carefully all information used to determine the assessment of the subject property and the comparable properties and determine that those properties are indeed comparable to the subject property. It is the responsibility of the taxpayer to establish that the other properties submitted are comparable to the subject property and that inequalities exist in the assessments (*Chicago & N. W. Ry. Co. v. Iowa State Tax Commission,* 257 Iowa 1359,137 N.W.2d 246(1965)).

(2) The property is assessed at more than its actual value as defined in Iowa Code section 441.21. If this ground is used, the taxpayer must state both the amount by which the property is overassessed and the amount considered to be the actual value of the property.

(3) The property is not assessable and should be exempt from taxation. If using this ground, taxpayers must state the reasons why it is felt the property is not assessable.

(4) There is an error in the assessment. An error in the assessment would most probably involve erroneous mathematical computations or errors in listing the property. The improper classification of property also constitutes an error in the assessment. If this ground is used, the taxpayer's protest must state the specific error alleged.

A board of review must determine:

1. If an error exists, and
2. How the error might be corrected.

(5) There is fraud in the assessment. If this ground of protest is used, the taxpayer's protest must state the specific fraud alleged, and the board of review must first determine if there is validity to the taxpayer's allegation. If it is determined there is fraud in the assessment, the board of review shall take action to correct the assessment and report the matter to the director of revenue.

(6) There has been a change of value of real estate since the last assessment. The board of review must determine that the value of the property as of January 1 of the current year has changed since January 1 of the previous reassessment year. This is the only ground upon which a protest pertaining to the valuation of a property can be filed in a year in which the assessor has not assessed or reassessed the property pursuant to Iowa Code section 428.4. In a year subsequent to a year in which a property has been assessed or reassessed pursuant to Iowa Code section 428.4, a taxpayer cannot protest to the board of review based upon actions taken in the year in which the property was assessed or reassessed (*James Black Dry Goods Co. v. Board of Review for City of Waterloo,* 260 Iowa 1269,151 N.W.2d 534 (1967); *Commercial Merchants Nat'l Bank and Trust Co. v. Board of Review of Sioux City,* 229 Iowa 1081, 296 N.W. 203 (1941)).

c. Disposition of protests. After reaching a decision on a protest, the board of review shall give the taxpayer written notice of its decision. The notice shall contain the following information:

(1) The valuation and classification of the property as determined by the board of review.

(2) If the protest was based on the ground the property was not assessable, the notice shall state whether the exemption is allowed and the value at which the property would be assessed in the absence of the exemption.

(3) The specific reasons for the board's decision with respect to the protest.

(4) That the board of review's decision may be appealed to the district court within 20 days of the board's adjournment or May 31, whichever date is later. If the adjournment date is known, the date shall be stated on the notice. If the adjournment date is not known, the notice shall state the date will be no earlier than May 31. Notice of the appeal shall be served on the chairperson, presiding officer, or clerk of the board of review after the written notice of appeal has been filed with the clerk of district court.

This rule is intended to implement Iowa Code sections 441.31 to 441.37 and Iowa Code Supplement section 441.38 as amended by 2006 Iowa Acts, House File 2794.

701—71.21(421,17A) Property assessment appeal board.

71.21(1) *Establishment, membership, and location of the property assessment appeal board.*

a. A statewide property assessment appeal board is created for the purpose of establishing a consistent, fair, and equitable property assessment appeal process. The statewide property assessment appeal board is established within the department of revenue. The board's principal office shall be in the office of the department of revenue.

b. The property assessment appeal board shall consist of three members appointed by the governor and subject to confirmation by the senate. The members shall be appointed to staggered six-year terms beginning initially on January 1, 2007, and ending as provided in Iowa Code section 69.19. Members' subsequent terms shall begin and end as provided in Iowa Code section 69.19. The governor shall appoint from the members a chairperson, subject to confirmation by the senate, of the board to a two-year term. Vacancies on the board shall be filled for the unexpired portion of the term in the same manner as regular appointments are made.

Each member of the property assessment appeal board shall be qualified by virtue of at least two years' experience in the area of government, corporate, or private practice relating to property appraisal and property tax administration. One member of the board shall be a certified real estate appraiser or hold a professional appraisal designation, one member shall be an attorney practicing in the area of state and local taxation or property tax appraisals, and one member shall be a professional with experience in the field of accounting or finance and with experience in state and local taxation matters. No more than two members of the board may be from the same political party as that term is defined in Iowa Code section 43.2.

c. The property assessment appeal board shall organize by appointing a secretary who shall take the same oath of office as the members of the board. The board may employ additional personnel as it finds necessary. All personnel employed by the board shall be considered state employees and are subject to the merit system provisions of Iowa Code chapter 8A, subchapter IV.

71.21(2) *Powers and duties of the board.* The property assessment appeal board shall:

a. Review any final decision, finding, ruling, determination, or order of a local board of review relating to assessment protests, valuation, or application of an equalization order.

b. Affirm, reverse, or modify a final decision, finding, ruling, determination, or order of a local board of review.

c. Order the payment or refund of property taxes in a matter over which the board has jurisdiction.

d. Grant other relief or issue writs, orders, or directives that the board deems necessary or appropriate in the process of disposing of a matter over which the board has jurisdiction.

e. Subpoena documents and witnesses and administer oaths.

f. Adopt administrative rules pursuant to Iowa Code chapter 17A for the administration and implementation of its powers, including rules for practice and procedure for protests filed with the board, the manner in which hearings on appeals of assessments shall be conducted, filing fees to be imposed by the board, and for the determination of the correct assessment of property which is the subject of an appeal.

g. Adopt administrative rules pursuant to Iowa Code chapter 17A necessary for the preservation of order and the regulation of proceedings before the board, including forms or notice and the service thereof, which rules shall conform as nearly as possible to those in use in the courts of this state.

h. If an appeal to district court is taken from the action of the property assessment appeal board, notice of appeal shall be served as an original notice on the secretary of the board after the written notice of appeal has been filed with the clerk of district court.

71.21(3) *General counsel.* The property assessment appeal board shall employ a competent attorney to serve as its general counsel, and assistants to the general counsel as it finds necessary for the full and efficient discharge of its duties. The general counsel is the attorney for, and legal advisor of, the board. The general counsel or an assistant to the general counsel shall provide the necessary legal advice to the board in all matters and shall represent the board in all actions instituted in a court challenging the validity of a rule or order of the board. The general counsel shall devote full time to the duties of the office. During employment as general counsel to the board, the counsel shall not be a member of a political committee, contribute to a political campaign, participate in a political campaign, or be a candidate for partisan political office. The general counsel and assistants to the general counsel shall be considered state employees and are subject to the merit system provisions of Iowa Code chapter 8A, subchapter IV.

71.21(4) *Compensation.* The members of the property assessment appeal board shall receive compensation from the state commensurate with the salary of a district judge. The members of the board shall be considered state employees for purposes of salary and benefits and are subject to the merit system provisions of Iowa Code chapter 8A, subchapter IV. Members of the board and any employees of the board, when required to travel in the discharge of official duties, shall be paid their actual and necessary expenses incurred in the performance of their duties.

71.21(5) *Appeal board review committee.* Effective January 1, 2012, a property assessment appeal board review committee is established. Staffing assistance to the committee shall be provided by the department of revenue. The committee shall consist of six members of the general assembly, two appointed by the majority leader of the senate, one appointed by the minority leader of the senate, two appointed by the speaker of the house of representatives, and one appointed by the minority leader of the house of representatives; the director of revenue or the director's designee; a county assessor appointed by the Iowa state association of counties; and a city assessor appointed by the Iowa league of cities.

The property assessment appeal board review committee shall review the activities of the property assessment appeal board since its inception. The review committee may recommend the revision of any rules, regulations, directives, or forms relating to the activities of the property assessment appeal board.

The review committee shall report to the general assembly by January 15, 2013. The report shall include any recommended changes in laws relating to the property assessment appeal board, the reasons for the committee's recommendations, and any other information the committee deems advisable.

71.21(6) *Applicability and scope.* These subrules set forth herein govern the proceedings for all cases in which the property assessment appeal board (board) has jurisdiction to hear appeals from the action of a local board of review. For the purpose of these subrules, the following definitions shall apply:

"Appellant" means the party filing the notice of appeal with the secretary of the property assessment appeal board.

"Board" means the property assessment appeal board as created by chapter 150 of the Acts of the Eighty-first General Assembly and governed by Iowa Code chapter 17A and sections 421.1A and 441.37A.

"Department" means the Iowa department of revenue.

"Local board of review" means the board of review as defined by Iowa Code section 441.31.

"Party" means a property owner, an aggrieved taxpayer, an assessor, an appellant or an appellee in an appeals process before the board.

"Presiding officer" means the chairperson, member or members of the property assessment appeal board who preside over an appeal of proceedings before the property assessment appeal board.

"Secretary" means the secretary for the property assessment appeal board.

71.21(7) *Appeal and jurisdiction.* Notice of appeal confers jurisdiction for the board. The procedure for appeals and parameters for jurisdiction are as follows:

a. Jurisdiction is conferred upon the board by written notice of appeal given to the secretary. The written notice of appeal shall include a petition setting forth the basis of the appeal and the relief sought. The written notice of appeal shall be filed with the secretary within 20 days after the postmarked date of the disposition of the protest by the local board of review. Appeals postmarked within 20 days after the postmarked date of the disposition of the protest by the local board of review shall also be considered to have been timely filed. The appellant may appeal the action of the board of review relating to protests of assessment, valuation, or the application of an equalization order. A party may request to participate by telephone in any hearing before the board.

b. The notice of appeal must be proper in format and content as set forth in subrule 71.21(9), which governs the notice of appeal. Notice of appeal may be delivered in person, mailed by first-class mail, or delivered to an established courier service for immediate delivery to the secretary of the board.

71.21(8) *Scope of review.* The board shall determine anew all questions arising before the local board of review which relate to the liability of the property to assessment or the amount thereof. The board will consider only those grounds set out in the protest to the local board of review. However, additional evidence may be introduced in the board proceedings relevant to the grounds set out in the protest. The board shall afford each party an opportunity to present briefs and oral arguments. There shall be no presumption as to the correctness of the valuation of the assessment appealed from.

71.21(9) *Form of appeal.* The written notice of appeal shall contain a caption in the following form:

THE PROPERTY ASSESSMENT APPEAL BOARD

(Appellant's name and address) v. (Board of Review)	}	NOTICE OF APPEAL and PETITION DOCKET NO. _____ (Docket No. assigned by board)

The notice of appeal shall include:

a. The appellant's name and mailing address;

b. A copy of the petition to the local board of review;

c. Copies of all evidence submitted to the local board of review in support of the petition to the local board of review;

d. A copy of the postmarked envelope and a copy of the letter of disposition by the local board of review;

e. A short and plain statement of the claim showing that the appellant is entitled to relief;

f. The relief sought; and

g. The signature of the appealing party or the party's legal representative.

To have legal representation before the board, a party must file a valid and complete power of attorney form as provided by the board or in compliance with the power of attorney form provided by the board.

71.21(10) *Notice to local board of review.* The secretary shall mail a copy of the appellant's written notice of appeal and petition to the local board of review whose decision is being appealed. Notice to all affected taxing districts shall be deemed to have been given when written notice is provided to the local board of review.

71.21(11) *Certification by local board of review.* Within 14 days after notice of appeal is given, the local board of review shall certify to the board all records, documents, or reports, or disposition order or directive from which an appeal is taken, the complete property record card for the subject property, the protest hearing minutes of the local board of review kept pursuant to Iowa Code chapter 21, and all other pertinent information.

The local board of review shall submit to the board in writing the name, address, and telephone number of the attorney representing the local board of review before the board. The local board of review may make a written request for additional time to certify a copy of its record to the board.

71.21(12) *Docketing.* Appeals shall be assigned consecutive docket numbers. Records consisting of the case name and the corresponding docket number assigned to the case must be maintained by the secretary. The records of each case shall also include each action and each act done, with the proper dates as follows:

a. The title of the appeal including jurisdiction and parcel identification number;

b. Brief statement of the grounds for the appeal and the relief sought;

c. Postmarked date of the local board of review's letter of disposition;

d. The manner and date/time of service of notice of appeal;

e. Date of notice of hearing;

f. Date of hearing; and

g. The decision by the board, or other disposition of the case, and date thereof.

71.21(13) *Appearances.* A party may appear in person, by legal representative or through an attorney. In order to be considered the legal representative before the board, a valid power of attorney form as provided by the board or in compliance with the power of attorney form provided by the board must be properly completed and filed with the board. An attorney shall file an appearance. All orders, correspondence, or other documents shall be served on the designated individual.

71.21(14) *Filing of papers.* After the notice of appeal and petition have been filed, either in person, mailed by first-class mail, or delivered to an established courier service for immediate delivery, all motions, pleadings, briefs, and other papers to be filed shall be filed with the secretary of the board. Motions, pleadings, briefs, and other papers to be filed with the board shall be delivered in person, mailed by first-class mail, or delivered to an established courier service. Parties shall also send copies to all other parties of record, unless represented by counsel of record, and then to such counsel.

a. For most filings in a docket made with the board, only an original is required.

b. For exhibits and other documents to be introduced at hearing, an original plus two copies are required.

c. The board or presiding officer may request additional copies.

71.21(15) *Motions.* All motions shall be in writing, shall be filed with the secretary and shall contain the reasons and grounds supporting the motion. The board shall act upon such motions as justice may require. Motions based on matters which do not appear of record shall be supported by affidavit. Any party may file a written response to a motion no later than 10 days from the date the motion is filed, unless the time period is extended or shortened by the board or presiding officer.

71.21(16) *Authority of board to issue procedural orders.* The board may issue preliminary orders regarding procedural matters. The secretary shall mail copies of all procedural orders to the parties.

71.21(17) *Members participating.* An appeal may be reviewed and considered by less than a majority of the members of the board, and the chairperson of the board may assign members to consider

appeals. Orders and decisions shall be signed by one member of the board and shall name participating members. Decisions shall affirm, modify, or reverse the decision, order, or directive from which an appeal was made. In order for the decision to be valid, a majority of the board must concur on the decision on appeal.

71.21(18) *Notice of hearing.* Unless otherwise designated by the board, the hearing shall be held in the hearing room of the board. All hearings are open to the public. If a hearing is requested, the secretary shall mail a notice of hearing to the parties at least 30 days prior to the hearing. The notice of hearing shall contain the following information:

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

b. A statement of 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. That the parties may appear and present oral arguments;

e. That the parties may submit evidence and briefs;

f. That the hearing will be electronically recorded by the board;

g. That a party may obtain a certified court reporter for the hearing at the party's own expense;

h. That audio visual aids and equipment are to be provided by the party intending to use them;

i. A statement that, upon submission of the appeal, the board will take the matter under advisement. A letter of disposition will be mailed to the parties; and

j. A compliance notice required by the Americans with Disabilities Act (ADA).

71.21(19) *Transcript of hearing.* All hearings shall be electronically recorded. Any party may provide a certified court reporter at the party's own expense. Any party may request a transcription of the hearing. The board reserves the right to impose a charge for copies and transcripts.

71.21(20) *Continuance.* Any hearing may be continued for "good cause." Requests for continuance prior to the hearing shall be in writing and promptly filed with the secretary of the board immediately upon "the cause" becoming known. An emergency oral continuance may be obtained from the board or presiding officer based on "good cause" and at the discretion of the board or presiding officer. In determining whether to grant a continuance, the board or 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.

71.21(21) *Telephone proceedings.* The board, at its discretion and based on "good cause," may conduct a telephone conference in which all parties have an opportunity to participate. The board will determine the location of the parties and witnesses for telephone hearings. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when the location is chosen.

71.21(22) *Disqualification of board member.* A board member or members must, on their own motion or on a motion from a party in the proceeding, withdraw from participating in an appeal if there are circumstances that warrant disqualification.

a. A board member or members shall withdraw from participation in the making of any proposed or final decision in an appeal before the board if that member is involved in one of the following circumstances:

(1) Has a personal bias or prejudice concerning a party or a representative of a party;

(2) Has personally investigated, prosecuted, or advocated in connection with the appeal, the specific controversy underlying that appeal, or another pending factually related matter, or a pending factually related controversy that may culminate in an appeal involving the same parties;

(3) Is subject to the authority, direction, or discretion of any person who has personally investigated, prosecuted, or advocated in connection with that matter, the specific controversy underlying the appeal, or a pending factually related matter or controversy involving the same parties;

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

(5) Has a personal financial interest in the outcome of the appeal or any other significant personal interest that could be substantially affected by the outcome of the appeal;

(6) Has a spouse or relative within the third degree of relationship who:

1. Is a party to the appeal, or an officer, director or trustee of a party;
2. Is a lawyer in the appeal;
3. Is known to have an interest that could be substantially affected by the outcome of the appeal; or
4. Is likely to be a material witness in the appeal; or

(7) Has any other legally sufficient cause to withdraw from participation in the decision making in that appeal.

b. Motion for disqualification. If a party asserts disqualification on any appropriate ground, including those listed in paragraph *"a,"* the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.11. 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 a majority of the board determines that disqualification is appropriate, the board member shall withdraw. If a majority of the board determines that withdrawal is not required, the board shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal and a stay as provided under 701—Chapter 7.

c. 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 functions of the board, including fact gathering for purposes other than investigation of the matter which culminates in an appeal. Factual information relevant to the merits of an appeal received by a person who later serves as presiding officer or a member of the board shall be disclosed if required by Iowa Code section 17A.11 and this rule.

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

71.21(23) *Consolidation and severance.* A majority of the board may determine, in its discretion, if consolidation or severance of issues or proceedings should be performed in order to efficiently resolve matters on appeal before the board.

a. Consolidation. The presiding officer may consolidate any or all matters at issue in two or more appeal proceedings where:

(1) The matters at issue involve common parties or common questions of fact or law;

(2) Consolidation would expedite and simplify consideration of the issues involved; and

(3) Consolidation would not adversely affect the rights of any of the parties to those proceedings.

b. Severance. The presiding officer may, for good cause shown, order any appeal proceedings or portions of the proceedings severed.

71.21(24) *Withdrawal.* An appellant may withdraw the appeal prior to the hearing. Such a withdrawal of an appeal must be in writing and signed by the appellant or the appellant's legal representative. Unless otherwise provided, withdrawal shall be with prejudice and the appellant shall

not be able to refile the appeal. Within 20 days of the board granting a withdrawal of appeal, the appellant may make a motion to reopen the file and rescind the withdrawal based upon fraud, duress, undue influence, or mutual mistake.

71.21(25) *Prehearing conference.* An informal conference of parties may be ordered at the discretion of the board or presiding officer or at the request of any party for any appropriate purpose. Any agreement reached at the conference shall be made a part of the record in the manner directed by the board or presiding officer.

71.21(26) *Hearing procedures.* A party to the appeal may request a hearing, or the appeal may proceed without a hearing. The local board of review may be present and participate at such hearing.

a. Authority of presiding officer. The presiding officer presides at the hearing and may rule on motions, require briefs, issue a decision, and issue such orders and rulings as will ensure the orderly conduct of the proceedings.

b. Representation. Parties to the appeal have the right to participate or to be represented in all hearings. Any party may be represented by an attorney or another person authorized by law. To have legal representation before the board, a party must complete a power of attorney form as provided by the board or in compliance with the power of attorney form provided by the board.

c. Participation in hearing. The parties to the appeal have the right to introduce evidence relevant to the grounds set out in the protest to the local board of review. 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.

d. Decorum. The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly.

e. Conduct of the hearing. The presiding officer shall conduct the hearing in the following manner:

(1) The presiding officer shall give an opening statement briefly describing the nature of the proceedings;

(2) The parties shall be given an opportunity to present opening statements;

(3) The parties shall present their cases in the sequence determined by the presiding officer;

(4) Each witness shall be sworn or affirmed by the presiding officer and shall be subject to examination and cross-examination. The presiding officer may limit questioning in a manner consistent with law; and

(5) When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

71.21(27) *Discovery*

a. Discovery procedure. Discovery procedures applicable in civil actions are available to parties in cases before the board. Unless lengthened or shortened by these rules, the board or presiding officer, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

b. Discovery motions. Prior to filing any motion related to discovery, parties shall make a good-faith effort to resolve discovery disputes without the involvement of the board or presiding officer. Any motion related to discovery shall allege that the moving party has made a good-faith attempt to resolve the discovery issues involved with the opposing party. Opposing parties shall be given the opportunity to respond within 10 days of the filing of the motion unless the time is shortened by order of the board or presiding officer. The board or presiding officer may rule on the basis of the written motion and any response or may have a hearing or other proceedings on the motion.

c. Admissibility of evidence. Evidence obtained in discovery may be used in the case proceeding if that evidence would otherwise be admissible in that proceeding.

71.21(28) *Subpoenas*

a. Issuance of Subpoena for Witness.

(1) An agency subpoena shall be issued to a party on request. The request shall be in writing and include the name, address, and telephone number of the requesting party. In absence of good cause for permitting later action, a request for subpoena must be received at least 10 days before the scheduled hearing.

(2) 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.

b. Issuance of Subpoena for Production of Documents.

(1) An agency subpoena shall be issued to a party on request. The request shall be in writing and include the name, address, and telephone number of the requesting party. In absence of good cause for permitting later action, a request for subpoena must be received at least 20 days before the scheduled hearing.

(2) Except to the extent otherwise provided by law, parties are responsible for service of their own subpoenas.

c. Motion to quash or modify. Upon motion, the board or presiding officer may quash or modify a subpoena for any lawful reason.

71.21(29) *Evidence.*

a. Admissibility. The presiding officer shall rule on admissibility of evidence and may take official notice of facts in accordance with all applicable requirements of law.

b. Stipulations. Stipulation of facts by the parties is encouraged. The presiding officer may make a decision based on stipulated facts.

c. Scope of admissible evidence. Evidence in the proceeding shall be confined to the issues contained in the notice from the board 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. Admissible evidence is that which, in the opinion of the board, is determined to be material, relevant, or necessary for the making of a just decision. Irrelevant, immaterial or unduly repetitious evidence may be excluded. A finding shall be based upon the kind of evidence on which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs, and may be based upon such evidence even if it would be inadmissible in a jury trial. Hearsay evidence is admissible. The rules of privilege apply in all proceedings before the board.

d. Exhibits and briefs. The party seeking admission of an exhibit must provide an opposing party with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents to be used as evidence shall be provided to the opposing party at least 10 days prior to the hearing, unless the time period is extended or shortened by the board or presiding officer. All exhibits and briefs admitted into evidence shall be appropriately marked and be made part of the record. The appellant shall mark exhibits with consecutive numbers. The appellee shall mark exhibits with consecutive letters.

e. Objections. Any party may object to specific evidence or may request limits on the scope of examination or cross-examination. Such an objection shall be accompanied by a brief statement of the grounds upon which the objection 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.

f. Offers of proof. 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.

71.21(30) *Settlements.* Parties to a case may propose to settle all or some of the issues in the case at any time prior to the issuance of a final decision. The board or presiding officer will not approve settlements unless the settlement is reasonable in light of the whole record, consistent with law, and in the public interest. Board adoption of a settlement constitutes the final decision of the board on issues addressed in the settlement.

71.21(31) *Appeals records.* The record of the appeal is maintained at the office of the board. Unless the record is held confidential, parties and members of the public may examine the record and obtain copies of documents.

71.21(32) *Motion to reopen records.* The board or presiding officer, on the board's or presiding officer's own motion or on the motion of a party, may reopen the record for the reception of further evidence. A motion to reopen the record may be made anytime prior to the issuance of a final decision.

71.21(33) *Rehearaing and reconsideration.*

a. Application for rehearing or reconsideration. Any party to a case may file an application for rehearing or reconsideration of the final decision. The application for rehearing or reconsideration shall be filed within 20 days after the final decision in the case is issued.

b. Contents of application. Applications for rehearing or reconsideration shall specify the findings of fact and conclusions of law claimed to be erroneous, with a brief statement of the alleged grounds of error. Any application for rehearing or reconsideration asserting that evidence has arisen since the final order was issued as a ground for rehearing or reconsideration shall present the evidence by affidavit that includes an explanation of the competence of the person to sponsor the evidence and a brief description of the evidence sought to be included.

c. Notice to other parties. A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the board shall serve copies on all parties.

d. Requirements for objections to applications for rehearing or reconsideration. An answer or objection to an application for rehearing or reconsideration must be filed within 14 days of the date the application was filed with the board, unless otherwise ordered by the board.

e. Disposition. Any application for a rehearing shall be deemed denied unless the board grants the application within 20 days after its filing.

71.21(34) *Dismissal.* If a party fails to appear or participate in an appeal hearing after proper service of notice, the presiding officer may dismiss the appeal unless a continuance is granted for good cause. If an appeal is dismissed for failure to appear, the board shall have no jurisdiction to consider any subsequent appeal on the appellant's protest.

71.21(35) *Waivers.*

a. In response to a request, or on its own motion, the board may grant a waiver from a rule adopted by the board, in whole or in part, as applied to a specific set of circumstances, if the board finds, based on clear and convincing evidence, that:

(1) The application of the rule would pose an undue hardship on the person for whom the waiver is requested;

(2) The waiver would not prejudice the substantial rights of any person;

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

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

b. Persons requesting a waiver may submit their request in writing. The waiver request must state the relevant facts and reasons the requester believes will justify the waiver, if the reasons have not already been provided to the board in another pleading.

c. Grants or denials of waiver requests shall contain a statement of the facts and reasons upon which the decision is based. The board may condition the grant of the waiver on such reasonable conditions as appropriate to achieve the objectives of the particular rule in question. The board may at any time cancel a waiver upon appropriate notice and opportunity for hearing.

71.21(36) *Appeals of board decisions.* A party may seek judicial review of a decision rendered by the board by filing a written notice of appeal with the clerk of the district court within 20 days after the letter of disposition of the appeal by the board is mailed to the appellant.

71.21(37) *Time requirements.* Time shall be computed as provided in Iowa Code section 4.1(34).

71.21(38) *Judgment of the board.* Nothing stated in this rule should be construed as prohibiting the exercise of honest judgment, as provided by law, by the board in matters pertaining to valuation and assessment of individual properties.

This rule is intended to implement Iowa Code sections 421.1, 421.1A, 421.2, 441.37A, 441.38 and 441.49 and chapter 17A.

[**ARC 9877B**, IAB 11/30/11, effective 1/4/12]

701—71.22(428,441) Assessors.

71.22(1) *Conflict of interest.* An assessor shall not act as a private appraiser, or as a real estate broker or option agent in the jurisdiction in which serving as assessor (1976 O.A.G. 744).

71.22(2) *Listing of property.*

a. Forms. Assessors may design and use their own forms in lieu of those prescribed by the department of revenue provided that the forms contain all information contained on the prescribed form, are not substantially different from the prescribed form, and are approved by the director of revenue.

b. Assessment rolls. Assessment rolls must be prepared in duplicate for each property in a reassessment year as defined in Iowa Code section 428.4. However, the copy of the roll does not have to be issued to a taxpayer unless there is a change in the assessment or the taxpayer requests the issuance of the duplicate copy.

c. Whenever a date specified in Iowa Code chapter 441 falls on a Saturday, Sunday, or legal holiday, the action required to be completed on or before that date shall be considered to have been timely completed if performed on or before the following day which is not a Saturday, Sunday, or holiday.

d. Buildings erected or improvements made by a person other than the owner of the land on which they are located are to be assessed to the owner of the buildings or improvements. Unpaid taxes are a lien on the buildings or improvements and not a lien on the land on which they are located.

71.22(3) *Notice of protest.* If a protest or appeal is filed with the board of review, property assessment appeal board, or district court against the assessment of property valued at $5 million or more, the assessor shall provide notice to the school district in which the property is located within ten days of the filing of the protest or the appeal, as applicable.

This rule is intended to implement Iowa Code chapter 428 and Iowa Code chapter 441 as amended by 2006 Iowa Acts, House File 2797.

701—71.23 and **71.24** Reserved.

701—71.25(441,443) Omitted assessments.

71.25(1) *Property subject to omitted assessment.*

a. Land and buildings. An omitted assessment can be made only if land or buildings were not listed and assessed by the assessor. The failure to list and assess an entire building is an omission for which an omitted assessment can be made even if the land upon which the building is located has been listed and assessed. See *Okland v. Bilyeu,* 359 N.W.2d 412 (Iowa 1984). However, the failure to consider the value added as a result of an improvement made does not constitute an omission for which an omitted assessment can be made if the building or land to which the improvement was made has been listed and assessed.

b. Previously exempt property. Property which has been erroneously determined to be exempt from taxation may be restored to taxation by the making of an omitted assessment. See *Talley v. Brown,* 146 Iowa 360, 125 N.W. 243 (1910). An omitted assessment is also made to restore to taxation previously exempt property which ceases to be eligible for an exemption.

71.25(2) *Officials authorized to make an omitted assessment.*

a. Local board of review. A local board of review may make an omitted assessment of property during its regular session only if the property was not listed and assessed as of January 1 of the current assessment year. For example, during its regular session which begins May 1, 1986, a local board of review may make an omitted assessment only of property that was not assessed by the assessor as of January 1, 1986. During that session, the board of review could not make an omitted assessment for an assessment year prior to 1986.

b. County auditor and local assessor. The county auditor and local assessor may make an omitted assessment. However, no omitted assessment can be made by the county auditor or local assessor if taxes based on the assessment year in question have been paid or otherwise legally discharged. For example, if a tract of land was listed and assessed and taxes levied against that assessment have been paid or legally discharged, no omitted assessment can be made of a building located upon that tract of land even

though the building was not listed and assessed at the time the land was listed and assessed. See *Okland v. Bilyeu,* 359 N.W.2d 412, 417 (Iowa 1984).

c. County treasurer. The county treasurer may make an omitted assessment within two years from the date the tax list which should have contained the assessment should have been delivered to the county treasurer. For example, for the 1999 assessment year, the tax list is to be delivered to the county treasurer on or before June 30, 2000. Thus, the county treasurer may make an omitted assessment for the 1999 assessment year at any time on or before June 30, 2002. The county treasurer may make an omitted assessment of a building even if taxes levied against the land upon which the building is located have been paid or legally discharged. See *Okland v. Bilyeu,* 359 N.W.2d 412, 417 (Iowa 1984). The county treasurer may not make an omitted assessment if the omitted property is no longer owned by the person who owned the property on January 1 of the year the original assessment should have been made.

d. Director of revenue. The director of revenue may make an omitted assessment of any property assessable by the director at any time within two years from the date the assessment should have been made.

This rule is intended to implement Iowa Code chapter 440 and sections 443.6 through 443.15 as amended by 1999 Iowa Acts, chapter 174.

701—71.26(441) Assessor compliance. The assessor shall determine the value of real property in accordance with rules adopted by the department of revenue and in accordance with forms and guidelines contained in the Iowa Real Property Appraisal Manual prepared by the department. The assessor may use an alternative manual to value property if it is a unique type of property not covered in the manual prepared by the department.

If the department finds that an assessor is not in compliance with the rules of the department relating to valuation of property or has disregarded the forms and guidelines contained in the real property appraisal manual, the department shall notify the assessor and each member of the conference board for that assessing jurisdiction. The notice shall be mailed by restricted certified mail and shall specify the areas of noncompliance and the steps necessary to achieve compliance. The notice shall also inform the assessor and conference board that if compliance is not achieved, a penalty may be imposed.

The conference board shall respond to the department within 30 days of receipt of the notice of noncompliance. The conference board may respond to the notice by asserting that the assessor is in compliance with the rules, guidelines, and forms of the department or by informing the department that the conference board intends to submit a plan of action to achieve compliance. If the conference board responds to the notification by asserting that the assessor is in compliance, a hearing before the director of revenue shall be held on the matter within 60 days of receipt of the notice of noncompliance. If it is agreed that the assessor is not in compliance, the conference board shall submit a plan of action within 60 days of receipt of the notice of noncompliance.

The plan shall contain a time frame under which compliance shall be achieved, which shall be no later than January 1 of the following assessment year. The plan of action shall contain the signature of the assessor and of the chairperson of the conference board. The department shall review the plan to determine whether the plan is sufficient to achieve compliance. Within 30 days of receipt of the plan, the department shall notify the assessor and the chairperson of the conference board that it has accepted the plan or that it is necessary to submit an amended plan of action.

By January 1 of the assessment year following the calendar year in which the plan was submitted to the department, the conference board shall submit a report to the department verifying that the plan of action was followed and compliance has been achieved. The department may conduct a field inspection to ensure that the assessor is in compliance. By January 31, the department shall notify the assessor and the conference board, by restricted certified mail, either that compliance has been achieved or that the assessor remains in noncompliance. If the department determines that the assessor remains in noncompliance, the department shall take steps to withhold up to 5 percent of the reimbursement payment authorized in Iowa Code section 425.1 until the director of revenue determines that the assessor is in compliance.

If the conference board disputes the determination of the department, the chairperson of the conference board may appeal the determination to the state board of tax review.

This rule is intended to implement Iowa Code Supplement section 441.21.

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SECRETARY OF STATE[721]

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DIVISION I
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721—21.1(47) Emergency election procedures. The state commissioner of elections may exercise emergency powers over any election being held in a district in which either a natural or other disaster or extremely inclement weather has occurred. The state commissioner may also exercise emergency powers during an armed conflict involving United States armed forces, or mobilization of those forces, or if an election contest court finds that there were errors in the conduct of an election making it impossible to determine the result.

21.1(1) *Definitions.*

"Commissioner" means the county commissioner of elections.

"Election contest court" means any of the courts specified in Iowa Code sections 57.1, 58.4, 61.1, 62.1 and 376.10.

"Extremely inclement weather" means a natural occurrence, such as a rainstorm, windstorm, ice storm, blizzard, tornado or other weather conditions, which makes travel extremely dangerous or which threatens the public peace, health and safety of the people or which damages and destroys public and private property.

"Natural disaster" means a natural occurrence, such as a fire, flood, blizzard, earthquake, tornado, windstorm, ice storm, or other events, which threatens the public peace, health and safety of the people or which damages and destroys public and private property.

"Other disaster" means an occurrence caused by machines or people, such as fire, hazardous substance or nuclear power plant accident or incident, which threatens the public peace, health and safety of the people or which damages and destroys public and private property.

"State commissioner" means the state commissioner of elections.

21.1(2) *Notice of natural or other disaster or extremely inclement weather.* The county commissioner of elections, or the commissioner's designee, may notify the state commissioner of elections that due to a natural or other disaster or extremely inclement weather an election cannot safely be conducted in the time or place for which the election is scheduled to be held. If the commissioner or the commissioner's designee is unable to transmit notice of the hazardous conditions, the notice may be given by any elected county official. Verification of the commissioner's agreement with the severity of the conditions and the danger to the election process shall be transmitted to the state commissioner as soon as possible. Notice may be given by telephone or by facsimile machine, but a signed notice shall also be delivered to the state commissioner.

21.1(3) *Declaration of emergency due to natural or other disaster or extremely inclement weather.* After receiving notice of hazardous conditions, the state commissioner of elections, or the state commissioner's designee, may declare that an emergency exists in the affected precinct or precincts. A copy of the declaration of the emergency shall be provided to the commissioner.

21.1(4) *Emergency modifications to conduct of elections.* When the state commissioner of elections has declared that an emergency exists due to a natural or other disaster or to extremely inclement weather, the county commissioner of elections, or the commissioner's designee, shall consult with the state commissioner to develop a plan to conduct the election under the emergency conditions. All modifications to the usual method for conducting elections shall be approved in advance by the state commissioner unless prior approval is impossible to obtain.

Modifications may be made to the method for conducting the election including relocation of the polling place, postponement of the hour of opening the polls, postponement of the date of the election if no candidates for federal offices are on the ballot, reduction in the number of precinct election officials in nonpartisan elections, or other reasonable and prudent modifications that will permit the election to be conducted.

21.1(5) *Relocation of polling place.* The substitute polling place shall be as close as possible to the usual polling place and shall be within the same precinct if possible. Preference shall be given to buildings which are accessible to the elderly and disabled. Buildings supported by taxation shall be made available without charge by the authorities responsible for their administration. If it is necessary, more than one precinct may be located in the same room.

A notice of the location of the substitute polling place shall be posted on the door of the former polling place not later than one hour before the scheduled time for opening the polls or as soon as possible. If it is unsafe or impossible to post the sign on the door of the former polling place, the notice shall be posted in some other visible place at or near the site of the former polling place. If time permits, notice of the relocation of the polling place shall be published in the same newspaper in which notice of election was published, otherwise notice of relocation may be published in any newspaper of general circulation in the political subdivision which will appear on or before election day. The commissioner shall inform all broadcast media and print news organizations serving the jurisdiction of the modifications.

21.1(6) *Postponement of election.* An election, other than an election at which a federal office appears on the ballot, may be postponed until the following Tuesday. If the election involves more than one precinct, the postponement must include all precincts within the political subdivision. If the election is postponed, ballots shall not be reprinted to reflect the modification in the election date. The date of the close of voter preregistration by mail for the election shall not be extended. Precinct election registers prepared for the original election date may be used or reprinted at the commissioner's discretion.

On the day that the postponed election is actually held, all election day procedures must be repeated.

21.1(7) *Absentee voting in postponed elections.* Absentee ballots shall be delivered to voters pursuant to Iowa Code section 53.22 until the date the election is actually held. Absentee ballots shall be accepted at the commissioner's office until the hour the polls close on the date the election is held. Absentee ballots which are postmarked no later than the day before the election is actually held shall be accepted if received no later than the time prescribed by the Iowa Code for the usual conduct of the election. The time shall be calculated from the date on which the election is held, not the date for which the election was originally scheduled. However, if absentee ballots have been tabulated before the election is postponed, the absentee ballots shall be sealed in an envelope by the absentee and special voters precinct board and stored securely until the date the election is actually held. The sealed envelopes shall be opened by the absentee and special voters precinct board on the date the election is actually held, counters on the tabulating equipment (if any) shall be reset to zero, and all absentee ballots tabulated on the original election date shall be retabulated.

21.1(8) *Absentee and special voters precinct board in postponed elections.* The absentee and special voters precinct board shall meet to consider provisional ballots at the times specified in Iowa Code sections 50.22 and 52.23, calculated from the date the election is held. No absentee ballots shall be counted until the date the election is held.

21.1(9) *Canvass of votes in postponed elections.* The canvass of votes shall also be rescheduled for one week after the originally scheduled canvass date.

21.1(10) *Postponements made on election day.* If the emergency is declared while the polls are open and the decision is made to postpone the election, each precinct polling place in the political subdivision shall be notified to close its doors and to halt all voting immediately. People present in the polling place who are waiting to vote shall not be given ballots. People who have received and marked their ballots shall deposit them in the ballot box; unmarked ballots may be returned to the precinct election officials.

The precinct election officials shall seal all ballots which were cast before the declaration of the emergency in secure containers. The containers shall be clearly marked as ballots from the postponed election. If it is safe to do so, the ballot containers, election register, and other election supplies shall be transported to the commissioner's office. The ballots shall be stored in a secure place. If it is unsafe to travel to the commissioner's office, the chairperson of the precinct election board shall see that the ballots and the election register are securely stored until it is safe to return them to the commissioner. If no contest is pending six months after the canvass for the election is completed, the unopened, sealed ballot containers shall be destroyed.

If automatic tabulating equipment is used, the automatic tabulating equipment shall be closed and sealed without printing the results. Before the date the election is held, the automatic tabulating equipment shall be reset to zero. Documents showing the progress of the count, if any, shall be sealed in an envelope and stored. No one shall reveal the progress of the count. After six months, the sealed envelope containing the vote totals shall be destroyed if no contest is pending.

21.1(11) *Records kept.* The state commissioner of elections shall maintain records of each emergency declaration. The records of emergency declarations for federal elections shall be kept for 22 months, and records for all other elections shall be kept for six months following the election. The records shall include the following information:

a. The county in which the emergency occurred.

b. The date and time the emergency declaration was requested.

c. The name and title of the person making the request.

d. Name and date of the election affected.

e. The jurisdiction for which the election is to be conducted (school, city, county, or other).

f. The number of precincts in the jurisdiction.

g. The number of precincts affected by the emergency.

h. The nature of the emergency, i.e., natural or other disaster, or extremely inclement weather.

i. The date or dates of the occurrence of the natural or other disaster or extremely inclement weather.

j. Conditions affecting the conduct of the election.

k. Whether the polling places may safely be opened on time.

l. Action taken: such as moving the polling place, change voting system, postpone election until the following Tuesday.

m. Method to be used to inform the public of changes made in the election procedure.

n. The signature of the state commissioner or the state commissioner's designee who was responsible for declaring the emergency.

21.1(12) *Federal elections.*

a. If an emergency occurs that will adversely affect the conduct of an election at which candidates for federal office will appear on the ballot, the election shall not be postponed or delayed. Emergency measures shall be limited to relocation of polling places, modification of the method of voting, reduction of the number of precinct election officials at a precinct and other modifications of prescribed election procedures which will enable the election to be conducted on the date and during the hours required by law.

The primary election held in June of even-numbered years and the general election held in November of even-numbered years shall not be postponed. Special elections called by the governor pursuant to Iowa Code section 69.14 shall not be postponed unless no federal office appears on the ballot.

b. If a federal or state court order extends the time established for closing the polls pursuant to Iowa Code section 49.73, any person who votes after the statutory hour for closing the polls shall vote only by casting a provisional ballot pursuant to Iowa Code section 49.81. Provisional ballots cast after the statutory hour for closing the polls shall be sealed in a separate envelope from provisional ballots cast during the statutory polling hours. The absentee and special voters precinct board shall tabulate and report the results of the two sets of provisional ballots separately.

21.1(13) *Military emergencies.* A voter who is entitled to vote by absentee ballot under the federal Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) and Iowa Code chapter 53, division II, "Absent Voting by Armed Forces," may return an absentee ballot via electronic transmission only if the voter is located in an area designated by the U.S. Department of Defense to be an imminent danger pay area. Procedures for the return of absentee ballots by electronic transmission are described in subrule 21.320(4).

21.1(14) *Election contest emergency.* If an election contest court finds that there were errors in the conduct of an election which make it impossible to determine the result of the election, the contest court shall notify the state commissioner of elections of its finding. The state commissioner shall order a repeat

election to be held. The repeat election date shall be set by the state commissioner. The repeat election shall be conducted under the state commissioner's supervision.

The repeat election shall be held at the earliest possible time, but it shall not be held earlier than 14 days after the date the election was set aside. Voter registration, publication, equipment testing and other applicable deadlines shall be calculated from the date of the repeat election.

The repeat election shall be conducted under the same procedures required for the election that was set aside, except that all known errors in preparation and procedure shall be corrected. The nominations from the initial election shall be used in the repeat election unless the contest court specifically rejects the initial nomination process in its findings. Precinct election officials for the repeat election may be replaced at the discretion of the auditor.

The following materials prepared for the original election shall be used or reconstructed for the repeat election:

Ballots (showing the date of repeat election). This may be stamped on ballots printed for the original election.

Notice of election (showing the date of repeat election).

This rule is intended to implement Iowa Code section 47.1.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.2(47) Electronic submission of absentee ballot applications and affidavits of candidacy. Absentee ballot applications and affidavits of candidacy may be submitted electronically using either fax or E-mail.

21.2(1) *Electronic copies of absentee ballot applications and affidavits of candidacy accepted for filing.* Assuming that all other legal requirements are met, absentee ballot applications and affidavits of candidacy required by Iowa Code chapters 43, 44, 45, 161A, 260C, 277, 376 and 420 may be submitted electronically by either fax or E-mail if presented to the appropriate filing officer as an exact copy of the original and if the submission is in compliance with subrule 21.2(2).

21.2(2) *Original absentee ballot applications.* The original absentee ballot application submitted electronically shall also be mailed or delivered to the commissioner. If mailed, the envelope bearing the original absentee ballot application shall be postmarked not later than the Friday before the election. This subrule shall not apply to documents submitted electronically by UOCAVA voters pursuant to rule 721—21.320(53).

a. The voter's absentee ballot shall be rejected by the absentee and special voters precinct board if the original absentee ballot application which was filed electronically is not received by the time the polls close on election day.

b. The voter's absentee ballot shall be rejected by the absentee and special voters precinct board if the postmark on the envelope containing the original absentee ballot application is either illegible or later than the Friday before the election.

21.2(3) *Original affidavits of candidacy.* The original copy of an affidavit of candidacy submitted electronically shall also be filed with the appropriate commissioner. The envelope bearing the original affidavit (if any) shall be postmarked not later than the last day to file the document.

a. The filing shall be void if the original affidavit of candidacy filed electronically is not received within seven days after the filing deadline for the original affidavit of candidacy.

b. The filing shall be void if the postmark on the envelope containing the original affidavit of candidacy is later than the filing deadline.

c. If an affidavit of candidacy filing is voided because the original affidavit of candidacy submitted by facsimile machine was postmarked too late or arrives too late, the person who filed the document shall be notified immediately in writing.

This rule is intended to implement Iowa Code sections 43.11, 43.19, 43.54, 43.67, 43.78, 44.3, 45.3, 45.4, 46.20, 47.1, and 47.2; sections 53.2, 53.8, 53.17, 53.22, 53.25, and 53.40 as amended by 2009 Iowa Acts, House File 475; sections 53.45, 61.3, 161A.5, and 277.4; sections 260C.15 and 376.4 as amended by 2009 Iowa Acts, House File 475; and sections 376.11 and 420.130.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 9879B**, IAB 11/30/11, effective 1/4/12]

721—21.3(49,48A) Voter identification documents.

21.3(1) *Identification documents for persons other than election day registrants.* Unless the person is registering to vote at the polls on election day, precinct election officials shall accept the identification documents listed in Iowa Code section 48A.8 from any person who is asked or required to present identification pursuant to Iowa Code section 49.77 as amended by 2009 Iowa Acts, House File 475.

21.3(2) *Identification for election day registrants.*

a. A person who applies to register to vote on election day shall provide proof of identity and residence pursuant to Iowa Code section 48A.7A in the precinct where the person is applying to register and vote.

b. Any registered voter who attests for another person registering to vote at the polls on election day shall be a registered voter of the same precinct. The registered voter may be a precinct election official or a pollwatcher, but may not attest for more than one person applying to register at the same election.

21.3(3) *Current and valid identification.*

a. "Current and valid" or "identification," for the purposes of this rule, means identification that meets the following criteria:

(1) The expiration date on the identification has not passed. An identification is still valid on the expiration date. An Iowa nonoperator's identification that shows "none" as the expiration date shall be considered current and valid.

(2) The identification has not been revoked or suspended.

b. A current and valid identification may include a former address.

21.3(4) *Identification not provided.* A person who has been requested to provide identification and does not provide it shall vote only by provisional ballot pursuant to Iowa Code section 49.81. However, a person who is registering to vote on election day pursuant to Iowa Code section 48A.7A may establish identity and residency in the precinct by written oath of a person who is registered to vote in the precinct.

This rule is intended to implement Iowa Code section 48A.7A and section 49.77 as amended by 2009 Iowa Acts, House File 475, and P.L. 107-252, Section 303.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.4(49) Changes of address at the polls. An Iowa voter who has moved from one precinct to another in the county where the person is registered to vote may report a change of address at the polls on election day.

21.4(1) To qualify to vote in the election being held that day, the voter shall:

a. Go to the polling place for the precinct where the voter lives on election day.

b. Complete a registration form showing the person's current address in the precinct.

c. Present proof of identity as required by subrule 21.3(1).

21.4(2) The officials shall require a person who is reporting a change of address at the polls to cast a provisional ballot if the person's registration in the county cannot be confirmed. Registration may be confirmed by:

a. Telephoning the office of the county commissioner of elections, or

b. Reviewing a printed list of all registered voters who are qualified to vote in the county for the election being held that day, or

c. Researching the county's voter registration records using a computer.

21.4(3) In precincts where the voter's declaration of eligibility is included in the election register pursuant to rule 721—21.5(49) and Iowa Code section 49.77, the commissioner shall provide to each precinct one of the two following methods for recording changes of address:

a. The voter shall be given both an eligibility declaration and a voter registration form. The eligibility declaration may be printed on the same piece of paper as the voter registration form.

b. The commissioner shall provide blank lines on the election register for the precinct election officials to record the voter's name, address, and, if provided, telephone number, and, in primary

elections, political party affiliation. The voter shall sign the election register next to the printed information. The voter shall also complete a voter registration form showing the voter's current address.

This rule is intended to implement Iowa Code section 49.77 as amended by 2009 Iowa Acts, House File 475.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.5(49) Eligibility declarations in the election register. To compensate for the absence of a separate declaration of eligibility form, the commissioner shall provide to each precinct a voter roster with space for each person who appears at the precinct to vote to print the following information: first and last name, address, and, at the voter's option, telephone number, and, in primary elections, political party affiliation.

The roster forms shall include the name and date of the election and the name of the precinct, and may be provided on paper that makes carbonless copies. If a multicopy form is used, the commissioner shall retain the original copy of the voter roster with other records of the election.

This rule is intended to implement Iowa Code section 49.77.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.6(43,50) Turnout reports. Rescinded IAB 6/2/10, effective 7/1/10.

721—21.7(48A) Election day registration. In addition to complying with the identification provisions in rule 721—21.3(49,48A), precinct election officials shall comply with the following requirements:

21.7(1) Precinct election officials shall inspect the identification documents presented by election day registrants to verify the following:

a. The photograph shows the person who is registering to vote.

b. The name on the identification document is the same as the name of the applicant.

c. The address on the identification document is in the precinct where the person is registering to vote.

21.7(2) Precinct election officials shall verify that each person who attempts to attest to the identity and residence of a person who is registering to vote on election day is a registered voter in the precinct and has not attested for any other voter in the election. The officials shall note in the election register that the person has attested for an election day registrant.

21.7(3) Precinct election officials shall permit any person who is in line to vote at the time the polls close to register and vote on election day if the person otherwise meets all of the election day registration requirements.

21.7(4) In precincts where an electronic program is not used to check the name of an election day registrant against the statewide list of felons who have had their right to vote revoked, precinct election officials shall provide each election day registrant with a "Notice to Election Day Registrants" prepared by the state commissioner before allowing the voter to register and vote on election day. The "Notice to Election Day Registrants" prepared by the state commissioner will be posted on the state commissioner's Web site.

This rule is intended to implement 2007 Iowa Acts, House File 653.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8777B**, IAB 6/2/10, effective 5/7/10]

721—21.8(48A) Notice to election day registrant. The commissioner shall send to each person who registers to vote on election day, pursuant to Iowa Code section 48A.7A, an acknowledgment of the registration by nonforwardable mail. If the postal service returns the acknowledgment as undeliverable, the commissioner shall send a notice to the voter by forwardable mail. The notice shall be substantially in the form titled "Notice to Election Day Registrant" posted on the state commissioner's Web site.

This rule is intended to implement Iowa Code sections 48A.7A and 48A.26A.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.9(49) "Vote here" signs.

1. Size. The signs shall be no smaller than 16 inches by 24 inches.

2. Exceptions. If a driveway leads away from the entrance to the voting area, or if the driveway is located in such a way that posting a "vote here" sign at the driveway entrance would not help potential voters find the voting area, no "vote here" sign shall be posted at the entrance to that driveway.

This rule is intended to implement Iowa Code section 49.21.

721—21.10(43) Application for status as a political party. A political organization which is not currently qualified as a political party may file an application for determination of political party status with the state commissioner of elections. The application may be filed after the completion of the executive council's canvass of votes for the general election, but not later than one year after the date of the election at which the organization's candidate for President of the United States or governor received at least 2 percent of the vote.

21.10(1) *Application form.* The application shall be substantially in the form titled "Application for Political Party Status" posted on the state commissioner's Web site.

21.10(2) *Response.* If the political organization meets the requirements established in Iowa Code section 43.2, the commissioner shall declare that the organization has qualified as a political party, effective 21 days after the application is approved. If the organization does not meet the requirements, the state commissioner shall immediately notify the applicant in writing of the reason for the rejection of the application.

21.10(3) *Disqualification of political party.* If at the close of nominations for the general election a political party has not nominated a candidate for the office of President of the United States, or for governor, as the case may be, the political party shall be disqualified immediately.

If the candidate of a political party for President of the United States or for governor, as the case may be, does not receive 2 percent of the votes cast for that office at a general election, the political party shall be disqualified. The effective date of the disqualification shall be the date of the completion of the state canvass of votes.

When a political party is disqualified, the state commissioner shall immediately notify the chairperson or central committee of the disqualified political party.

21.10(4) *Notice of qualification and disqualification of political parties.* The state commissioner of elections shall immediately notify the state registrar of voters, the voter registration commission, and the county commissioners of elections when a political party is qualified or disqualified. The notice shall include the name of the political party and the date upon which change in political party status becomes effective.

The state commissioner of elections shall also publish notice of the qualification or disqualification of a political party in a newspaper of general circulation in each congressional district. The publication shall be made within 30 days of the approval of an application for qualification or within 30 days of the effective date of a disqualification.

This rule is intended to implement Iowa Code sections 43.2 and 47.1.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.11(44) Nonparty political organizations—nominations by petition. Rescinded IAB 9/10/97, effective 10/15/97.

721—21.12 to **21.19** Reserved.

721—21.20(62) Election contest costs. In determining the amount of the bond for election contests, the commissioner shall consider the following aspects of the cost of the election contest proceedings:

1. Fees as provided in Iowa Code section 62.22.
2. Fees for judges as provided in Iowa Code section 62.23.
3. The cost of making an official record of the proceedings.

721—21.21(62) Limitations. The amount of the bond shall not include costs not directly related to the contest court proceedings. Specifically, the amount of the bond shall not be intended to replace any

potential lost income to the county caused by the delay in implementing the decision of the voters at the election being contested.

Rules 721—21.20(62) and 721—21.21(62) are intended to implement Iowa Code sections 62.6, 62.22, 62.23, and 62.24.

721—21.22 to **21.24** Reserved.

721—21.25(50) Administrative recounts. When the commissioner suspects that voting equipment used in the election malfunctioned or that programming errors may have affected the outcome of the election, the commissioner may request an administrative recount after the day of the election but not later than three days after the canvass of votes. The request shall be made in writing to the board of supervisors explaining the nature of the problem and listing the precincts to be recounted and which offices and questions shall be included in the administrative recount. The board of supervisors shall respond as soon as possible after receipt of the commissioner's request.

The recount shall be conducted by members of the absentee and special voters precinct board following the provisions of Iowa Code section 50.48 as amended by 2009 Iowa Acts, House File 475, Iowa Code section 50.49 and 721—Chapter 26. The commissioner may use different memory cards for the recount and shall retain the information on the memory cards used in the election pursuant to 721—subrule 22.51(13). The commissioner may also use different election definition files if the commissioner believes the original election definition files were flawed. If the commissioner uses different election definition files for the recount, the commissioner shall also retain the election definition files for the election as required by 721—subrule 22.51(14).

This rule is intended to implement Iowa Code section 50.48 as amended by 2009 Iowa Acts, House File 475, and Iowa Code section 50.49.
[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.26 to **21.29** Reserved.

721—21.30(49) Inclusion of annexed territory in city reprecincting and redistricting plans. If a city has annexed territory after January 1 of a year ending in zero and before the completion of the redrawing of precinct and ward boundaries during a year ending in one, the city shall include the annexed land in precincts drawn pursuant to Iowa Code sections 49.3 and 49.5.

21.30(1) When the city council draws precinct and ward boundaries, if any, the city shall use the population of the annexed territory as certified by the city to the state treasurer pursuant to Iowa Code section 312.3(4).

21.30(2) When the board of supervisors, or the temporary county redistricting commission, draws precinct and county supervisor district boundaries, if any, it shall subtract from the population of the adjacent unincorporated area the population of the annexed territory as certified by the city to the state treasurer pursuant to Iowa Code section 312.3(4).

21.30(3) The use of population figures for reprecincting or redistricting shall not affect the official population of the city or the county. Only the U.S. Bureau of the Census may adjust the official population figures, by corrections or by conducting special censuses. See Iowa Code section 9F.6.

This rule is intended to implement Iowa Code sections 49.3 and 49.5.

721—21.31(275) School director district maximum allowable deviation between director districts. Each director district shall have a population that exceeds the population of any other director district by no more than 10 percent. Director district plans with variations in excess of 10 percent between two or more districts shall be accompanied by justification for the deviation and shall be rejected by the secretary of state unless the deviation is necessary to comply with one of the other standards enumerated in Iowa Code section 275.23A.

This rule is intended to implement Iowa Code section 275.23A.
[**ARC 9559B**, IAB 6/15/11, effective 5/23/11; **ARC 9891B**, IAB 11/30/11, effective 1/4/12]

721—21.32(372) City ward maximum allowable deviation between city wards. Each city ward shall have a population that exceeds the population of any other city ward by no more than 10 percent. City ward plans with variations in excess of 10 percent between two or more wards shall be accompanied by justification for the deviation and shall be rejected by the secretary of state unless the deviation is necessary to comply with one of the other standards enumerated in Iowa Code section 372.13, subsection 7.

This rule is intended to implement Iowa Code section 372.13.
[**ARC 9559B**, IAB 6/15/11, effective 5/23/11; **ARC 9891B**, IAB 11/30/11, effective 1/4/12]

721—21.33(49) Redistricting special election blackout period. A special election shall not be held on the three Tuesdays preceding and following January 15 of years ending in the number two.

This rule is intended to implement Iowa Code chapter 49.
[**ARC 9893B**, IAB 11/30/11, effective 11/9/11]

721—21.34 to **21.49** Reserved.

721—21.50(49) Polling place accessibility standards.

21.50(1) *Inspection required.* Before any building may be designated for use as a polling place, the county commissioner of elections or the commissioner's designee shall inspect the building to determine whether it is accessible to persons with disabilities.

21.50(2) *Frequency of inspection.* Polling places that have been inspected using the Polling Place Accessibility Survey Form prescribed in subrule 21.50(4) shall be reinspected if structural changes are made to the building or if the location of the polling place inside the building is changed.

21.50(3) *Review of accessibility.* Not less than 90 days before each primary election, the commissioner shall determine whether each polling place needs to be reinspected.

21.50(4) *Standards for determining polling place accessibility.* The survey form available on the state commissioner's Web site titled "Polling Place Accessibility Survey" shall be used to evaluate polling places for accessibility to persons with disabilities.

The term "off-street parking" used in the polling place accessibility survey means parking places in lots separated from the street and includes angle parking along the street if the accessible route from the parking place to the polling place is entirely out of the path of traffic. Parking arrangements that require either the driver or passengers of the vehicle to go into the traveled part of the street are not accessible.

An access aisle at street level that is at least 60 inches wide and the same length as each accessible parking space shall be provided. An accessible public sidewalk curb ramp shall connect the access aisle to the continuous passage to the polling place. At least one parking place shall be van-accessible with a 96-inch access aisle connected to the continuous passage to the polling place by an accessible public sidewalk curb ramp. Two accessible parking spaces may share a common access aisle.

21.50(5) *Temporary waiver of accessibility requirements.* Notwithstanding the waiver provisions of 721—Chapter 10, if the county commissioner is unable to provide an accessible polling place for any precinct, the commissioner shall apply for a temporary waiver of accessibility requirements pursuant to this subrule. Applications shall be filed with the secretary of state not later than 60 days before the date of any scheduled election. If a waiver is granted, it shall be valid for two years from the date of approval by the secretary of state.

a. Each application shall include the following documents:

(1) Application for Temporary Waiver of Accessibility Requirements.

(2) A copy of the Polling Place Accessibility Survey Form for the polling place to be used.

(3) A copy of the Polling Place Accessibility Survey Form for any other buildings that were surveyed and rejected as possible polling place sites for the precinct.

b. If an accessible place becomes available at least 30 days before an election, the commissioner shall change polling places and shall notify the secretary of state. The notice shall include a copy of the Polling Place Accessibility Survey Form for the new polling place.

21.50(6) *Emergency waivers.* During the 60 days preceding an election, if a polling place becomes unavailable for use due to fire, flood, or changes made to the building, or for other reasons, the

commissioner must apply for an emergency waiver of accessibility requirements in order to move the polling place to an inaccessible building. Emergency waiver applications must be filed with the secretary of state as soon as possible before election day. To apply for an emergency waiver, the commissioner shall send the following documents:

a. Application for Temporary Waiver of Accessibility Requirements.

b. A copy of the Polling Place Accessibility Survey Form for the polling place selected.

c. A copy of the Polling Place Accessibility Survey Form for any other buildings that were surveyed and rejected as possible polling place sites for this precinct (if any).

21.50(7) *Application form.* The form posted on the state commissioner's Web site titled "Temporary Waiver of Accessibility Requirements" shall be used to apply for a temporary waiver of accessibility requirements.

21.50(8) *Evaluation of waivers.* When the secretary of state receives waiver applications, the applications shall be reviewed carefully. A response shall be sent to the commissioner within one week by E-mail or by fax to notify the commissioner when the waiver request was received and whether additional information is needed.

21.50(9) *Granting waivers.* If the secretary of state determines from the documents filed with the waiver request that conditions justify the use of a polling place that does not meet accessibility standards, the secretary of state shall grant the waiver of accessibility requirements. If the secretary of state determines from the documents filed with the waiver request that all potential polling places have been surveyed and no accessible place is available, and the available building cannot be made temporarily accessible, the waiver shall be granted.

21.50(10) *Notice required.* Each notice of election published pursuant to Iowa Code section 49.53 shall clearly describe which polling places are inaccessible. The notice shall include a description of the services available to persons with disabilities who live in precincts with inaccessible polling places. The notice shall be in substantially the following form:

Any voter who is physically unable to enter a polling place has the right to vote in the voter's vehicle. For further information, please contact the county auditor's office at the telephone number or E-mail address listed below:

Telephone: _____ E-mail address: _____.

For TTY access, dial 711 + [auditor's office number].

21.50(11) *Denial of waiver requests.* The secretary of state shall review each waiver request. The secretary of state shall consider the totality of the circumstances as shown by the information on the waiver request, information contained in previous applications for waivers for the same precinct and for other precincts in the county, and other relevant available information. The waiver request may be denied if it appears that the commissioner has not made a good-faith effort to find an accessible polling place. If the waiver request is denied, the secretary of state shall notify the commissioner in writing of the reason for denying the request.

This rule is intended to implement Iowa Code section 49.21.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 9879B**, IAB 11/30/11, effective 1/4/12]

721—21.51 to **21.74** Reserved.

721—21.75(49) Voting centers for certain elections. The commissioner may establish voting centers for the regular city election, city primary election, city runoff election, regular school election, and special elections.

21.75(1) *Definition.*

"Voting center" means a location established by the commissioner for the purpose of providing ballots to all registered voters who are qualified to vote in a particular jurisdiction for a regular city election, city primary election, city runoff election, regular school election, or special election.

21.75(2) *Minimum requirements.*

a. Establishment. One or more voting centers may be established in lieu of precinct polling places for the elections at which the use of voting centers is permitted. Regular polling place sites that are

accessible to people with disabilities may be used as voting centers for any election at which the use of voting centers is permitted. Other suitable locations may also be used.

b. Location of voting centers. If voting centers are established for an election, at least one voting center must be located within the boundaries of the political subdivision for which the election is being conducted. At the commissioner's discretion, additional vote centers may be established as long as the voting center is located within the boundaries of the political subdivision for which the election is being conducted.

c. Accessibility. A voting center is subject to the requirements of Iowa Code section 49.21 relating to accessibility to persons who are elderly and persons with disabilities and relating to the posting of signs.

21.75(3) *Hours.* Voting center hours shall be the same as permitted for an election pursuant to Iowa Code section 49.73.

21.75(4) *Publications.* The location of each voting center shall be published in the notice of election by the commissioner in the same manner as the location of polling places is required to be published. The notice of election shall also include a description of the voting center in substantially the following form:

For the _____ election to be held on [date], voting centers will be available. Any registered voter of [jurisdiction name] may vote at any of the following places in this election:

[List addresses of voting centers.]

21.75(5) *Posting notices at regular polling places on election day.* If voting centers are established in lieu of regular polling places for an election, the commissioner shall post a notice of voting center locations, not later than the hour at which the polls open on the day of the election, on each door to the usual polling place in the precinct. The notice shall remain posted until the polls have closed.

21.75(6) *I-Voters use prohibited.* The commissioner shall not provide direct access from voting centers to the I-Voters system on election day.

21.75(7) *Determining ballot rotations.* For the purposes of determining ballot rotations pursuant to Iowa Code section 49.31 in an election for which the commissioner has established voting centers, the commissioner may use either precincts established pursuant to Iowa Code sections 49.3 to 49.5 or consolidated precincts established pursuant to Iowa Code section 49.11, subsection 3, paragraph *"a."* If the commissioner uses consolidated precincts established pursuant to Iowa Code section 49.11, subsection 3, paragraph *"a,"* the commissioner shall use the same consolidated precincts used in the last regularly scheduled election conducted for the political subdivision in which voting centers were not used.

21.75(8) *Operation of voting centers.*

a. Election registers and voter lists. Each voting center shall have an election register containing the names, addresses and voter statuses of all registered voters who are eligible to vote in that election. The election register may be a paper list or may be available on computers in an electronic format, rather than as an interactive connection to I-Voters.

b. Election day registration at voting centers. A person who needs to register to vote may register and vote at a voting center provided that the person has appropriate identification and is a resident of the jurisdiction served by the voting center.

c. Voters reporting address changes at voting centers. Any person who is already registered in the county and updates the person's voter registration address at a voting center shall show identification listed in Iowa Code section 48A.8. Persons unable to provide requested identification shall be offered a provisional ballot pursuant to Iowa Code section 49.81.

d. Ballots. Each voting center shall have all ballot styles necessary to provide a ballot to any voter who is eligible to vote in the election for the jurisdiction served by the voting center.

e. Precinct election officials. Voting centers shall be administered by a minimum of three precinct election officials selected pursuant to Iowa Code sections 49.12 to 49.16. These officials shall be trained before each election and shall have specific instructions regarding the differences between voting centers and polling places.

f. Ballot boxes used with optical scan voting equipment at voting centers. The commissioner may instruct two precinct election officials not of the same political party to open the ballot box periodically throughout election day to ensure the ballots are stacking evenly in the ballot box to prevent a voting equipment malfunction. The precinct election officials charged with inspecting the ballot box shall ensure the ballot box is locked and secured at all times. As an alternative to this procedure, the commissioner may supply any voting center with additional ballot boxes and the precinct election officials may move the optical scan voting equipment to a new ballot box if necessary. All ballot boxes containing voted ballots shall be locked and secured by the precinct election officials at all times.

21.75(9) *Postelection review of voter participation.*

a. Within 45 days after the election, the commissioner shall review the signed declarations of eligibility or the signed election registers from each voting center, and if any person is found to have voted in more than one voting center in the election, the commissioner shall immediately notify the county attorney.

b. The notice to the county attorney shall include a copy of the person's voter registration record and copies of the declarations of eligibility signed by the voter. The notice shall also include a reference to Iowa Code sections 39A.2(2) and 49.11(3)*"b."*

This rule is intended to implement Iowa Code sections 49.9 and 49.11.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.76 to **21.199** Reserved.

DIVISION II
BALLOT PREPARATION

721—21.200(49) Constitutional amendments and public measures.

21.200(1) The order of placement on the ballot for constitutional amendments and statewide public measures to be voted upon at a single election shall be determined by the state commissioner, and a number shall be assigned to each constitutional amendment or statewide public measure by the state commissioner.

a. The number assigned by the state commissioner to each constitutional amendment or statewide public measure to appear on the ballot for a single election shall be printed on the ballot immediately preceding and above the words "Shall the following amendment to the Constitution (or public measure) be adopted?" or the words "Shall there be a Convention to revise the Constitution, and propose amendment or amendments to same?"

b. The number assigned by the state commissioner shall be printed on the ballot at least 1/8 of an inch high in the designated place.

c. Even if only one constitutional amendment or statewide public measure is to appear on a ballot to be voted upon at a single election, an identifying number shall be assigned by the state commissioner and shall be printed on the ballot in the prescribed manner.

21.200(2) The order of placement on the ballot for each local public measure to be voted upon at a single election shall be determined by the commissioner, and a letter shall be assigned to each local public measure by the commissioner.

a. The letter assigned by the commissioner shall be printed on the ballot at least ⅛ of an inch high in the designated place.

b. Even if only one public measure is to appear on a ballot to be voted upon at a single election, an identifying letter shall be assigned by the commissioner and shall be printed on the ballot in the prescribed manner.

21.200(3) The words describing proposed constitutional amendments and statewide public measures when they appear on the ballot shall be determined by the state commissioner. The state commissioner shall select the words describing the proposed constitutional amendments and statewide public measures in the following manner:

a. Not less than 150 days prior to the election at which a proposed constitutional amendment or statewide public measure is to be voted on by the voters, the state commissioner shall prepare a proposed

description to be used on the ballots in administrative rule form and shall file the proposed rules with the administrative rules coordinator for publication in the Iowa Administrative Bulletin.

b. The rules shall provide that written comments regarding the proposed description will be accepted by the state commissioner for a period of time not less than 20 days after the date of publication in the Iowa Administrative Bulletin.

c. The state commissioner shall review any written comments which have been timely received and make any changes deemed to be warranted in the description to be printed on the ballots.

This rule is intended to implement Iowa Code sections 47.1 and 49.44.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.201(44) Competing nominations by nonparty political organizations.

21.201(1) *Nominations by convention and by petitions.* If one or more nomination petitions are received from nonparty political organization candidates for an office for which the same organization has also nominated one candidate by convention, the candidate nominated by convention shall be considered the nominee of the organization. The names of the other candidates shall appear on the ballot as candidates "nominated by petition," and those candidates shall be notified in writing not later than seven days after the close of the filing period.

21.201(2) *Multiple nomination petitions.* If nomination petitions are received from more than one candidate from the same nonparty political organization for the same office and the organization has not nominated a candidate for the office by convention, the name of each of these candidates shall be written on a separate piece of paper, all of which shall be as nearly uniform in size and material as possible and placed in a receptacle so that the names cannot be seen. On the next working day following the close of the nomination period, all affected candidates shall be notified of the time and place of the drawing. The candidates shall be invited to attend or to send a representative. In the presence of witnesses, the state commissioner of elections or the county commissioner, as appropriate, or a designee of the state or county commissioner, shall publicly draw one of the names; and that person shall be declared to be the nominee of the nonparty political organization. The names of the other candidates shall appear on the ballot as candidates "nominated by petition." A copy of the written record of the result of the drawing shall be kept with the nomination petition of each affected candidate, and each candidate shall be sent a copy for the candidate's records not later than seven days after the close of the filing period.

21.201(3) *Multiple nomination certificates.* If more than one nomination certificate is received for the same office from groups with the same nonparty political organization name, the name of each of these candidates shall be written on a separate piece of paper, all of which shall be as nearly uniform in size and material as possible and placed in a receptacle so that the names cannot be seen. On the next working day following the close of the nomination period, all affected candidates shall be notified of the time and place of the drawing. The candidates shall be invited to attend or to send a representative. In the presence of witnesses, the state commissioner of elections or the county commissioner, as appropriate, or a designee of the state or county commissioner, shall publicly draw one of the names; and that person shall be declared to be the nominee of the nonparty political organization. The names of the other candidates, including any candidate who filed nomination petitions, shall appear on the ballot as candidates "nominated by petition." A copy of the written record of the result of the drawing shall be kept with the nomination certificate of each affected candidate, and each candidate shall be sent a copy for the candidate's records not later than seven days after the close of the filing period.

This rule is intended to implement Iowa Code section 44.17.

721—21.202(43,52) Form of primary election ballot. All primary election ballots shall meet the following formatting requirements:

21.202(1) *Required information.* In addition to other requirements listed in the Iowa Code, primary election ballots shall also include the following information:

a. The name of the election.

b. The name of the party, which shall be printed at the top of the ballot in at least 24-point type.

c. The name of the county.

d. Instructions for how to mark the ballot.

21.202(2) *Headings and lines.* Rescinded IAB 9/8/10, effective 8/16/10.

21.202(3) *Office titles and order of offices.* Each office printed on the ballot shall be preceded by an office title. The order of offices on the primary election ballot shall be as follows:

a. In gubernatorial election years, the order of office titles on the primary election ballot shall be listed as follows:

(1) U.S. Senator (if any).
(2) U.S. Representative, District ___.
(3) Governor.
(4) Secretary of State.
(5) Auditor of State.
(6) Treasurer of State.
(7) Secretary of Agriculture.
(8) Attorney General.
(9) State Senator, district ___ (if any).
(10) State Representative, District ___.
(11) Board of Supervisors (if plan II or plan III, then Board of Supervisors, District ___).
(12) Treasurer.
(13) Recorder.
(14) County Attorney.

b. In presidential election years, the order of office titles on the primary election ballot shall be listed as follows:

(1) U.S. Senator (if any).
(2) U.S. Representative, District ___.
(3) State Senator, District ___ (if any).
(4) State Representative, District ___.
(5) Board of Supervisors (if plan II or plan III, then Board of Supervisors, District ___).
(6) Auditor.
(7) Sheriff.

c. If an office is printed on the primary election ballot followed by the words "To Fill Vacancy," that office shall be listed after the other offices under the appropriate heading. If the office followed by the words "To Fill Vacancy" is the board of supervisors, that office shall appear after the other board of supervisors office(s).

21.202(4) *Vote for number.* Under each office title, the number of choices a voter may make in the race shall be printed in the following form: "Vote for no more than ___." The number of choices the voter may make for each race is the number of individuals to be elected to the office at the general election.

21.202(5) *Write-in vote targets.* After the candidates' names for each office (if any), a target shall be placed next to a line for voters to write in a nominee for the office. The number of write-in targets and lines printed under each office shall match the vote for number referenced in subrule 21.202(4). Under each write-in line, the following words shall be printed: "Write-in vote, if any."

21.202(6) *Font size.* Candidates' names shall be printed in upper and lower case letters, and the font size shall be no less than 10-point type.

21.202(7) *Two-sided ballots.* If a primary election ballot must be printed on two sides, the words "Turn the ballot over" shall be printed on both sides of the ballot, at the bottom.

This rule is intended to implement 2009 Iowa Code Supplement section 43.31 [2009 Iowa Acts, House File 475, section 6].

[**ARC 8698B**, IAB 4/21/10, effective 6/15/10; **ARC 9049B**, IAB 9/8/10, effective 8/16/10]

721—21.203(49,52) Form of general election ballot. All general election ballots shall meet the following formatting requirements:

21.203(1) *Required information.* In addition to other requirements listed in the Iowa Code, general election ballots shall also include the following information:

a. The name of the election.

b. The name of the county.

c. Instructions for how to mark the ballot, including instructions for voting on judicial retentions and constitutional amendments or public measures and instructions for straight-party voting.

d. Ballot location of the judges' names and any constitutional amendment(s).

21.203(2) *Headings and lines.* Rescinded IAB 9/8/10, effective 8/16/10.

21.203(3) *Office titles, order of offices and public measures.* Each office printed on the ballot shall be preceded by an office title. The order of offices and public measures listed on the general election ballot shall be as follows:

a. In gubernatorial election years, the order of office titles and public measures on the general election ballot shall be listed as follows:

(1) U.S. Senator (if any).
(2) U.S. Representative, District ___.
(3) Governor and Lt. Governor.
(4) Secretary of State.
(5) Auditor of State.
(6) Treasurer of State.
(7) Secretary of Agriculture.
(8) Attorney General.
(9) State Senator, District ___ (if any).
(10) State Representative, District ___.
(11) Board of Supervisors (if plan II or plan III, then Board of Supervisors, District ___).
(12) Treasurer.
(13) Recorder.
(14) County Attorney.
(15) Township Trustee (if any).
(16) Township Clerk (if any).
(17) County Public Hospital Trustee (if any).
(18) Soil and Water Conservation District Commissioner.
(19) County Agricultural Extension Council Member.
(20) Other nonpartisan offices (if any).
(21) Supreme Court Justice (if any).
(22) Court of Appeals Judge (if any).
(23) District Court Judge (if any).
(24) District Court Associate Judge (if any).
(25) Associate Juvenile Judge (if any).
(26) Associate Probate Judge (if any).
(27) Public Measures (if any). Under the public measures heading, measures shall be listed in the following order:

1. Constitutional Amendment (if any).
2. State Public Measure (if any).
3. County Public Measure (if any).
4. City Public Measure (if any).

b. In presidential election years, the order of office titles on the general election ballot shall be listed as follows:

(1) President and Vice President.
(2) U.S. Senator (if any).
(3) U.S. Representative, District ___.
(4) State Senator, District ___ (if any).
(5) State Representative, District ___.
(6) Board of Supervisors (if plan II or plan III, then Board of Supervisors, district ___).
(7) Auditor.

(8) Sheriff.
(9) Township Trustee (if any).
(10) Township Clerk (if any).
(11) County Public Hospital Trustee (if any).
(12) Soil and Water Conservation District Commissioner.
(13) County Agricultural Extension Council Member.
(14) Other nonpartisan offices (if any).
(15) Supreme Court Justice (if any).
(16) Court of Appeals Judge (if any).
(17) District Court Judge (if any).
(18) District Court Associate Judge (if any).
(19) Associate Juvenile Judge (if any).
(20) Associate Probate Judge (if any).
(21) Public Measures (if any). Under the public measures heading, measures shall be listed in the following order:
1. Constitutional Amendment (if any).
2. State Public Measure (if any).
3. County Public Measure (if any).
4. City Public Measure (if any).

c. If an office is printed on the general election ballot followed by the words "To Fill Vacancy," that office shall be listed after the other offices under the appropriate heading. If the office followed by the words "To Fill Vacancy" is the board of supervisors, that office shall appear after the other board of supervisors office(s).

21.203(4) *Vote for number.* Under each office title, the number of choices a voter may make in the race shall be printed in the following form: "Vote for no more than ___". The number of choices the voter may make for each race is the number of individuals to be elected to the office at the general election. Under the "President and Vice President" office title, "Vote for no more than one team" shall be printed on the ballot. Under the "Governor and Lt. Governor" office title, "Vote for no more than one team" shall be printed on the ballot.

21.203(5) *Write-in vote targets.* After the candidates' names for each office (if any), a target shall be placed next to a line for voters to write in a nominee for the office. The number of write-in targets and lines printed under each office shall match the vote for number referenced in subrule 21.203(4). Under each write-in line, the following words shall be printed: "Write-in vote, if any". For the offices of President and Vice President, there shall be one write-in target printed to the left of two write-in lines. Under the write-in lines, the commissioner shall print the following: "Write-in vote for President, if any" and "Write-in vote for Vice President, if any". For the offices of governor and lieutenant governor, there shall be one write-in target printed to the left of two write-in lines. Under the write-in lines, the commissioner shall print the following: "Write-in vote for Governor, if any" and "Write-in vote for Lt. Governor, if any".

21.203(6) *Font size.* Candidates' names shall be printed in upper and lower case letters, and the font size shall be no less than 10-point type.

21.203(7) *Two-sided ballots.* If a general election ballot must be printed on two sides, the words "Turn the ballot over" shall be printed on both sides of the ballot, at the bottom.

This rule is intended to implement 2009 Iowa Code Supplement section 49.57A [2009 Iowa Acts, House File 475, section 32].
[**ARC 8698B**, IAB 4/21/10, effective 6/15/10; **ARC 9049B**, IAB 9/8/10, effective 8/16/10]

721—21.204(260C) Tabulating election results by school district for merged area special elections. All results for merged area special elections, including special precinct results, shall be tabulated by school district. To tabulate the special precinct results in this manner, the county commissioner may either program the voting equipment to tabulate the ballots in this manner or manually sort and tabulate the ballots by school district.

This rule is intended to implement Iowa Code chapter 260C.
[**ARC 9879B**, IAB 11/30/11, effective 1/4/12]

721—21.205 to **21.299** Reserved.

DIVISION III
ABSENTEE VOTING

721—21.300(53) Satellite absentee voting stations.

21.300(1) *Establishment of stations.* Satellite absentee voting stations may be established by the county commissioner of elections or by a petition of eligible electors of the jurisdiction conducting the election.

a. Satellite absentee voting stations established by the county commissioner. The county commissioner of elections may designate locations in the county for satellite absentee voting stations. Satellite absentee voting stations established by the commissioner shall be accessible to elderly and disabled voters. Satellite absentee voting stations must also be established so as to provide for voting in secret and ballot security.

b. Satellite absentee voting stations established after receipt of a valid petition. A petition requesting a satellite absentee voting station shall be substantially in the form titled "Petition Requesting Satellite Absentee Voting Station" available on the state commissioner's Web site. If the commissioner receives a petition requesting a satellite absentee voting station on or before the petition deadline set forth in Iowa Code section 53.11, the commissioner shall determine the validity of the petition within 24 hours. A petition requesting a satellite absentee voting station is valid if it contains signatures of not less than 100 eligible electors of the jurisdiction conducting the election. Electors signing the petition must include their signature, house number, street, and date the petition was signed. Signatures on lines not containing all of the required information shall not be counted. The heading on each page of the petition shall include the satellite location requested and the election name or date for which the location is requested. Signatures on petition pages without the required heading shall not be counted.

c. Mandatory rejection of certain satellite absentee voting stations. Otherwise valid petitions for satellite absentee voting stations shall be rejected within four days of the commissioner's receipt of the petition if:

(1) The site requested is not accessible to elderly and disabled voters,

(2) The site requested has other physical limitations that make it impossible to meet the requirements for ballot security and secret voting, or

(3) The owner of the site refuses permission to locate the satellite absentee voting station at the site requested on the petition.

d. Discretionary rejection of certain satellite absentee voting stations. Otherwise valid petitions for satellite absentee voting stations may be rejected within four days of the commissioner's receipt of the petition if:

(1) A petition is received requesting satellite voting for a city runoff election and a special election is scheduled to be held between the regular city election and a city runoff election.

(2) The owner of the site demands payment for its use.

e. Provision of ballots. Only ballots from the county in which the site is located may be provided at the satellite absentee voting station. Ballots must be provided for the precinct in which the satellite absentee voting station is located; however, it is not necessary to provide ballots from all of the precincts in the political subdivision for which the election is being conducted.

21.300(2) *Notice provided.* Notice shall be published at least seven days before the opening of any satellite absentee voting station. If more than one satellite absentee voting station will be provided, a single publication may be used to notify the public of their availability. If it is not possible to publish the notice at least seven days before the station opens due to the receipt of a petition, the notice shall be published as soon as possible.

A notice shall also be posted at each satellite absentee voting station at least seven days before the opening of the satellite absentee voting station. The notice shall remain posted as long as the satellite

absentee voting station is scheduled for service. If it is not possible to post the notice at least seven days before the station opens due to the receipt of a petition, the notice shall be posted as soon as possible.

Both the published and posted notices shall include the following information:

a. The name and date of the election for which ballots will be available.

b. The location(s) of the satellite absentee voting station(s).

c. The dates and times that the station(s) will be open.

d. The precincts for which ballots will be available.

e. An announcement that voter registration forms will be available for new registrations in the county and that changes in the registration records of people who are currently registered within the county may be made at any time.

If the satellite absentee voting station is located in a building with more than one public entrance, brief notices of the location of the satellite absentee voting station shall be posted on building directories, bulletin boards, or doors. These notices shall be posted no later than the time the station opens and shall be removed immediately after the satellite absentee voting station has ceased operation for an election.

21.300(3) *Staff.* Satellite absentee voting station workers may be selected from among the staff members of the commissioner's office, from the election board panel drawn up pursuant to Iowa Code sections 49.15 and 49.16, or a combination of these two sources. Compensation of workers selected from the election board panel shall be at the rate provided in Iowa Code section 49.20.

At least three people shall be assigned to work at each satellite absentee voting station; more workers may be added at the commissioner's discretion. All workers must be registered voters of the county, and for primary and general elections the workers must be registered with a political party; however, workers not affiliated with any party may be assigned to work at a satellite absentee voting station as long as not more than one-third of the workers assigned to a particular satellite absentee voting station are not affiliated with a political party. For all elections, no more than a simple majority of the workers shall be members of the same political party.

People who are prohibited from working at the polls pursuant to Iowa Code section 49.16 may not work at satellite absentee voting stations.

21.300(4) *Oath required.* Before the first day of service at a satellite absentee voting station, each worker shall take an oath substantially in the form titled "Election Official/Clerk Oath" available on the state commissioner's Web site. The oath must be taken before each election.

21.300(5) *Suggested supplies for each satellite absentee voting station.* A list of supplies suggested for each satellite absentee voting station is available on the state commissioner's Web site.

21.300(6) *Ballot transport and storage.* At the commissioner's discretion the ballots may be transported between the commissioner's office and the satellite absentee voting station by the workers who will be on duty that day, or by two people of different political parties who have been designated as couriers by the commissioner. It is not necessary for the same people to transport the ballots in both directions.

If the ballots are transported by the satellite absentee voting station workers, two workers who are members of different political parties and the ballots must travel together in the same vehicle.

Ballots may be stored at the satellite absentee voting station during hours when the station is closed only if they are kept in a locked cabinet or container. The cabinet must be located in a room which is kept locked when not in use. Voted absentee ballots must be delivered to the commissioner's office at least once each week.

21.300(7) *Ballot receipts.* Satellite absentee voting station workers shall sign receipts for the ballots taken to the satellite absentee voting site. The receipt shall be substantially in the form titled "Satellite Absentee Voting Station Ballot Record and Receipt" available on the state commissioner's Web site. A copy of the ballot record and receipt shall be retained in the commissioner's office. The original shall be sent with the ballots to the satellite absentee voting station.

21.300(8) *Arrangement of the satellite absentee voting station.* Protection of the security of the ballots (both voted and unvoted) and the secrecy of each person's vote shall be considered in the arranging of the satellite absentee voting station.

a. Security. The satellite absentee voting station shall be arranged so that ballots are protected against removal from the station by unauthorized persons.

b. Voting area. Voting booths without curtains shall be placed so that passersby and other voters may not walk directly behind a person using the booth. At least one voting booth must be accessible to the disabled. The booth must be designed to accommodate a person seated in a chair or wheelchair. A chair must be provided for voters who wish to sit down while voting or waiting in line.

c. Campaign signs and electioneering. No signs supporting or opposing any candidate or question on the ballot shall be posted on the premises of or within 300 feet of any outside door of any building affording access to a satellite absentee voting station during the hours when absentee ballots are available at the satellite absentee voting station. No electioneering shall be allowed within the sight or hearing of voters while they are at the satellite absentee voting station.

21.300(9) *Operation of the satellite absentee voting station.* At all times the satellite absentee voting station shall have at least two workers present to preserve the security of the ballots, both voted and unvoted.

21.300(10) *Voter registration at the satellite absentee voting station.* Each satellite absentee voting station shall provide forms necessary to register voters, including the oaths necessary to process voters registering pursuant to Iowa Code section 48A.7A, and to record changes in voter registration records. Workers shall also be provided with a method of verifying whether people applying for absentee ballots are registered voters.

The commissioner may provide a list of registered voters in the precincts served by the station. The list may be on paper or contained in a computerized data file. As an alternative, the commissioner may provide a computer connection with the commissioner's office.

21.300(11) *Procedure for issuing absentee ballot.* The instructions for absentee voting are available on the state commissioner's Web site and shall be provided to satellite absentee voting station workers unless the commissioner prepares instructions containing substantially the same information as the instructions available on the state commissioner's Web site.

21.300(12) *Closing a station.* The instructions for closing a satellite absentee voting station are available on the state commissioner's Web site and shall be provided to satellite absentee voting station workers unless the commissioner prepares instructions containing substantially the same information as the instructions available on the state commissioner's Web site.

21.300(13) *Use of I-Voters at satellite absentee voting stations.* Any county commissioner who wants to use the I-Voters statewide voter registration database at a satellite absentee voting station shall:

a. Complete an application to use I-Voters at a satellite absentee voting station. A separate application shall be completed for each satellite absentee voting station. The application is available on the state commissioner's Web site. The application shall be submitted at least seven days before the opening of the satellite absentee voting station. If it is not possible to submit an application at least seven days before the station opens due to the receipt of a petition, the application shall be submitted as soon as possible. The application will be considered by the state commissioner as soon as practicable after it is received. The state commissioner reserves the right to reject an application for any reason or to limit the number of users at any satellite absentee voting station.

b. Use a cellular telephone service or a wired Internet connection to connect to the Internet from the satellite absentee voting station. If the county uses a wired Internet connection, the commissioner shall use either a regular or a wireless router between the wired Internet connection and the county's computers. Connection to a facility's wireless network is not permitted.

c. Configure any wireless routers to be used between the facility's wired Internet connection and the county's laptop computers as follows:

(1) A minimum 10-character password must be assigned to the router administration screens.

(2) WPA (AES) security for wireless connections with a minimum 10-character password must be used.

(3) Remote management of the router must be prohibited.

(4) Universal Plug & Play must be turned off.

(5) Port forwarding on the router must not be disabled.

(6) Unauthorized connections shall be prohibited, including smartphones, personal digital assistants (PDAs) and laptops.

d. Configure any wired routers to be used between the facility's wired Internet connection and the county's laptop computers as follows:

(1) Remote management of the router must be prohibited.

(2) Universal Plug & Play must be turned off.

(3) Port forwarding on the router must not be disabled.

(4) Unauthorized connections shall be prohibited, including smartphones, PDAs and laptops.

(5) Administrator passwords for the routers must be changed from the default passwords, and standard county password policies shall be followed.

e. Laptops used at a satellite absentee voting station shall be configured as follows:

(1) The hard drives must be encrypted.

(2) The operating system must be fully supported by the operating system vendor.

(3) The operating system must be fully patched.

(4) Antivirus software and anti-spyware must be installed and up to date.

(5) A full antivirus and anti-spyware scan must be done during the week before a laptop is used at a satellite absentee voting station and at least once a week thereafter while the laptop is being used at satellite absentee voting stations.

(6) The administrator password must be changed from the default password.

(7) Guest user accounts must be disabled or renamed.

(8) File/print sharing must be turned off, and remote access must be disabled.

(9) Bluetooth must be turned off.

(10) The Windows firewall must be turned on.

f. Laptops connected to I-Voters at a satellite absentee voting station shall never be left unattended.

g. Laptops connected to I-Voters at a satellite absentee voting station shall not have any USB memory sticks or CDs/DVDs inserted in the computer after the virus scan is conducted pursuant to subrule 21.300(13), paragraph *"e."*

h. Laptops connected to I-Voters at a satellite absentee voting station shall not be used to visit any other Web sites.

i. No software applications, other than I-Voters, shall be used while the I-Voters application is in use at a satellite absentee voting station.

This rule is intended to implement Iowa Code section 53.11.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 9139B**, IAB 10/6/10, effective 9/16/10]

721—21.301(53) Absentee ballot requests from voters whose registration records are "inactive."

21.301(1) *In person.* Absentee voters whose registration records are "inactive" and who appear in person to vote, either at the office of the commissioner or at a satellite absentee voting station, shall be assigned a status of "active" after requesting an absentee ballot.

21.301(2) *By mail.* When a request for an absentee ballot is received by mail from a voter whose registration record has been made "inactive" pursuant to Iowa Code section 48A.29, the commissioner shall update the voter's residential address to the address listed on the absentee ballot request if requested by the voter and assign the voter a status of "active."

21.301(3) *Absentee ballots received from a voter subsequently assigned "inactive" status.* The commissioner shall set aside the absentee ballot of a voter whose status is changed to "inactive" pursuant to Iowa Code section 48A.26, subsection 6, after the voter has submitted the voter's ballot. The commissioner shall notify the voter, pursuant to Iowa Code section 53.31, informing the voter that the absentee ballot may be counted if the voter personally delivers or mails a copy of the voter's identification as set forth in Iowa Code section 48A.8 to the commissioner's office before the absentee and special voters precinct board convenes to count absentee ballots, or reconvenes to consider challenged absentee ballots pursuant to Iowa Code section 50.22. If the commissioner does not receive a copy of the voter's identification before the absentee and special voters precinct board reconvenes

to consider challenged absentee ballots pursuant to Iowa Code section 50.22, the absentee and special voters precinct board shall reject the absentee ballot.

This rule is intended to implement Iowa Code section 48A.29 and sections 48A.26, 48A.37 and 53.25 as amended by 2009 Iowa Acts, House File 475.
[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.302(48A) In-person absentee registration. After the close of voter registration for an election, a person who appears in person to apply for and vote an absentee ballot may register to vote if the person provides proof of identity and residence in the precinct in which the voter intends to vote using identification that meets the requirements set forth in Iowa Code section 48A.7A. The voter must also complete an oath of person registering on election day. If the voter does not have appropriate identification, the voter may establish identity and residence using the attestation procedure in Iowa Code section 48A.7A, subsection 1, paragraph *"c."* Otherwise, the person may cast only a provisional ballot pursuant to Iowa Code section 49.81. Provisional ballot envelopes shall be used.

This rule is intended to implement Iowa Code section 48A.7A.
[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.303(53) Mailing absentee ballots. The commissioner shall mail the following materials to each person who has requested an absentee ballot:

1. Ballot. The ballot that corresponds to the voter's residence, as indicated by the address on the absentee ballot application.
2. Public measure text. The full text of any public measures that are summarized on the ballot, but not printed in full.
3. Secrecy envelope. Secrecy envelope, if the ballot cannot be folded to cover all of the voting ovals, as required by Iowa Code section 53.8(1).
4. Affidavit envelope. The affidavit envelope, which shall be marked with the I-Voters-assigned sequence number used to identify the absentee request in the commissioner's records.
5. Return carrier envelope. The return carrier envelope, which shall be addressed to the commissioner's office and bear appropriate return postage or a postal permit guaranteeing that the commissioner will pay the return postage and which shall be marked with the I-Voters-assigned sequence number used to identify the absentee request in the commissioner's records.
6. Delivery envelope. The delivery envelope, which shall be addressed to the voter and bear the I-Voters-assigned sequence number used to identify the absentee request in the commissioner's records. All other materials shall be enclosed in the delivery envelope.
7. Instructions. Absentee voting instructions, which shall be in substantially the form prescribed by the state commissioner of elections.
8. Receipt. The receipt form required by 2007 Iowa Acts, Senate File 601, section 227, which may be printed on the instructions required by numbered paragraph "7" above.

This rule is intended to implement Iowa Code sections 53.8 and 53.17 as amended by 2009 Iowa Acts, House File 475.
[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.304(53) Absentee ballot requests from voters whose registration records are "pending." A voter who requests an absentee ballot and is assigned a status of "pending" must provide identification pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475.

21.304(1) *In-person applicants.* In-person applicants for absentee ballots assigned a status of "pending" must show identification pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475, before casting a ballot. If an in-person applicant provides identification as required by Iowa Code section 48A.8 when casting an absentee ballot in person, the commissioner shall assign the voter's registration record a status of "active" and provide the voter with an absentee ballot. Voters who are unable to provide identification as required by Iowa Code section 48A.8 shall be offered a provisional ballot pursuant to Iowa Code section 49.81.

21.304(2) *By-mail applicants.* By-mail applicants for absentee ballots assigned a status of "pending" must either come to the commissioner's office and show identification pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475, or mail a photocopy of identification pursuant to Iowa Code section 48A.8 before the voter's absentee ballot can be counted by the absentee and special voters precinct board. The commissioner shall mail the voter a notice informing the voter of the requirement to provide one of the identification documents listed in Iowa Code section 48A.8 before the voter's absentee ballot can be considered for counting by the absentee and special voters precinct board. If a by-mail applicant provides identification as required by Iowa Code section 48A.8, the commissioner shall assign the voter's registration record a status of "active."

21.304(3) *By-mail absentee voters assigned a status of "pending" who do not provide identification prior to election day.* The ballot of a by-mail absentee voter assigned a status of "pending" who has not shown identification in person at the commissioner's office or provided a photocopy of identification by mail pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475, shall be challenged by a member of the absentee and special voters precinct board on election day pursuant to Iowa Code section 53.31. The absentee and special voters precinct board shall immediately mail notice of the challenge to the voter. The notice shall include the deadline for the voter to provide identification pursuant to Iowa Code section 48A.8. If the voter provides identification pursuant to Iowa Code section 48A.8 prior to the time the absentee and special voters precinct board reconvenes to consider challenged absentee ballots pursuant to Iowa Code section 50.22, the voter's ballot shall be considered for counting by the absentee and special voters precinct board. If the voter does not provide identification pursuant to Iowa Code section 48A.8 prior to the time the absentee and special voters precinct board reconvenes to consider challenged absentee ballots pursuant to Iowa Code section 50.22, the voter's absentee ballot shall be rejected by the absentee and special voters precinct board. The voter shall be notified of the reason for rejection pursuant to Iowa Code section 53.25 as amended by 2009 Iowa Acts, House File 475.

This rule is intended to implement Iowa Code section 53.31 and sections 48A.8 and 53.25 as amended by 2009 Iowa Acts, House File 475.
[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.305(53) Confirming commissioner's receipt of an absentee ballot on election day. If a voter's name is on the absentee list prepared pursuant to Iowa Code sections 49.72 and 53.19 as amended by 2010 Iowa Acts, Senate File 2196, and the voter appears at the polling place to vote on election day, the precinct election officials may contact the commissioner's office to confirm whether the commissioner has received the voter's absentee ballot. If the precinct election officials are able to confirm either that the commissioner has not received the voter's absentee ballot or that the voter's absentee ballot has been received but cannot be counted due to a defective or incomplete affidavit, the precinct election officials shall permit the voter to cast a regular ballot at the polling place.

After confirming that a voter's absentee ballot has not been received or that a voter's absentee ballot has been received but cannot be counted due to a defective or incomplete affidavit, the commissioner shall mark the voter's absentee ballot as "Void" in the statewide voter registration system. The commissioner shall enter "Voted at polls" in the comment box that appears when the ballot is marked as "Void."

If a voter's absentee ballot is returned to the commissioner's office after being marked as "Void" pursuant to this rule, the absentee ballot shall be rejected by the absentee and special voters precinct board pursuant to Iowa Code section 53.25 because the voter cast a ballot in person at the polling place.

This rule is intended to implement Iowa Code sections 49.72, 49.81 and 53.19 as amended by 2010 Iowa Acts, Senate File 2196.
[**ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.306 to **21.319** Reserved.

721—21.320(53) Absentee voting by UOCAVA voters. This rule applies only to absentee voting by persons who are entitled to vote by absentee ballot under the federal Uniformed and Overseas Citizens

Absentee Voting Act (UOCAVA) and Iowa Code chapter 53, division II, "Absent Voting by Armed Forces."

21.320(1) *Definitions.* The following definitions apply to this rule:

"Armed forces," as used in this rule, is defined in Iowa Code section 53.37(3).

"FPCA" means the federal postcard absentee ballot application and voter registration form authorized for use in Iowa by Iowa Code section 53.38.

"UOCAVA voter" means any person who is entitled to vote by absentee ballot under the Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) and Iowa Code chapter 53, division II, "Absent Voting by Armed Forces."

21.320(2) *Requests for absentee ballots.* All requests for absentee ballots shall be made in writing. Additional requirements for requesting absentee ballots and for processing the requests are set forth below.

a. Forms. UOCAVA voters may use the following official forms to request absentee ballots:

(1) A federal postcard absentee ballot application and voter registration form (FPCA).

(2) A state of Iowa official absentee ballot request form.

(3) For general elections only, a proxy absentee ballot application prescribed by the state commissioner of elections and submitted pursuant to Iowa Code Supplement section 53.40(1)*"b."*

b. Form not required. UOCAVA voters may request absentee ballots in writing without using an official form. The written request shall be honored if it includes all of the following information about the voter:

(1) Name.

(2) Age or date of birth.

(3) Iowa residence, including street address (if any) and city.

(4) Address to which the ballot shall be sent.

(5) Township of residence, if applicable.

(6) County of residence.

(7) Party affiliation, if the request is for a ballot for a primary election.

(8) Signature of voter.

(9) Statement explaining why the voter is eligible to receive ballots under the provisions of Iowa Code chapter 53, division II. For example, "I am a U.S. citizen living in France."

c. Methods for transmitting absentee ballot requests. UOCAVA voters may transmit absentee ballot requests by any of the following methods:

(1) Mail.

(2) Personal delivery by the voter or a person designated by the voter.

(3) Facsimile machine.

(4) Scanned application form or letter transmitted by E-mail. Requests by E-mail that do not include either an image of the physical signature or a digital signature shall not be accepted.

d. Original request not needed. If the request is sent by E-mail or by fax, it is not necessary for the UOCAVA voter to send to the commissioner the original copy of the FPCA or other official form or written request for an absentee ballot.

e. Multiple requests from the same person. Before the ballot is ready to mail, if the commissioner receives more than one request for an absentee ballot for a particular election (or series of elections) by or on behalf of a UOCAVA voter, the last request received shall be the one honored. However, if one of the requests is for a general election ballot and is made using the proxy absentee ballot application process permitted by Iowa Code Supplement section 53.40(1)*"b,"* the request received from the voter shall be the one honored, not the proxy request.

f. Subsequent request after ballot has been sent. Not more than one ballot shall be transmitted by the commissioner to any UOCAVA voter for a particular election unless, after the ballot has been mailed or transmitted electronically pursuant to rule 721—21.320(53), the voter reports a change in the address, E-mail address or fax number to which the ballot should be sent. The commissioner shall void the original absentee ballot request and include a comment in the voter's registration record, noting the I-Voters-sequence number of the original ballot and noting that a replacement ballot was sent to an

updated address. If the original ballot is returned voted, it shall be counted only if the replacement ballot does not arrive before the deadline for receiving absentee ballots set forth in Iowa Code section 53.17.

g. Requests for absentee ballots through the end of the calendar year. 2009 Iowa Code Supplement section 53.40 as amended by 2010 Iowa Acts, Senate File 2194, permits UOCAVA voters to request the commissioner to send absentee ballots for all elections as permitted by state law. In response to an absentee ballot request in which the UOCAVA voter requests ballots for all elections, the commissioner shall send the applicant a ballot for each election held after the request is received through the end of the calendar year in which the request is received. If the applicant does not request ballots for all elections or does not specify which elections the request is for, the commissioner shall send the applicant a ballot only for federal elections through the end of the calendar year in which the request is received.

(1) When an absentee ballot for a UOCAVA voter is returned as undeliverable by the United States Postal Service or an E-mail server or a fax cannot be transmitted to the number provided by the voter, the commissioner shall do the following:

1. Verify that the commissioner's office sent the absentee ballot to the address, E-mail address or fax number requested by the UOCAVA voter. If the absentee ballot was sent incorrectly, the commissioner shall correct the error and immediately transmit a new absentee ballot.

2. If the absentee ballot was sent to the correct mailing address, E-mail address or fax number, the commissioner shall E-mail the voter if the commissioner has an E-mail address on file to inform the voter that the voter's ballot was returned undeliverable, and the commissioner must be provided with a new FPCA containing a new mailing address if the voter wishes to continue to receive absentee ballots.

3. If the absentee ballot was sent to the correct mailing address, E-mail address or fax number, the commissioner shall also attempt to contact the voter by sending a forwardable notice to both the voter's residential address and the voter's absentee mailing address informing the voter that the voter's ballot was returned undeliverable, and the commissioner must be provided with a new FPCA containing a new mailing address, E-mail address or fax number if the voter wishes to continue to receive absentee ballots.

4. If the absentee ballot was mailed, E-mailed or sent to the correct address or fax number, the commissioner shall terminate the voter's current FPCA request and shall not send the voter any further ballots unless a new absentee ballot request is received from the voter.

(2) If the voter provides a new FPCA with a new mailing address, E-mail address or fax number before election day, the commissioner shall enter a new absentee request on the voter's registration record and transmit the ballot via the method requested by the voter. The voter may request that the commissioner transmit the ballot electronically pursuant to subrule 21.320(3).

21.320(3) *Electronic transmission of absentee ballots to UOCAVA voters.*

a. Electronic transmission of absentee ballots by facsimile machine or by E-mail is limited to UOCAVA voters who specifically ask for this service. A UOCAVA voter who asks for electronic transmission of an absentee ballot may request this service for all elections for which the person is qualified to vote or for specific elections either individually or for a specific period of time. The commissioner may employ FVAP's secure transmission program to facilitate electronic transmission of absentee ballots to UOCAVA voters.

b. Forms. The state commissioner shall provide the following forms and instructions for the electronic transmission of absentee ballots to UOCAVA voters:

(1) Instructions to the county commissioners of elections for providing this service.

(2) Instructions to the voter for marking and returning the ballot.

(3) The affidavit envelope form, which can be printed by the voter on an envelope and used for the voter's declaration of eligibility and voter registration application, if necessary.

(4) The return envelope form, which can be printed by the voter on an envelope and used to return the ballot, postage paid through the FPO/APO postal service.

21.320(4) *Ballot return by electronic transmission.*

a. Electronic transmission of a voted absentee ballot from the voter to the commissioner is permitted only for UOCAVA voters who are in an area designated as an imminent danger pay area, as provided in subrule 21.1(13). In addition, the absentee ballot may be returned via electronic transmission only if the voter waives the right to a secret ballot. In addition to signing the affidavit

required by Iowa Code section 53.13, the voter shall sign a statement in substantially the following form: "I understand that by returning this ballot by electronic transmission my voted ballot will not be secret. I hereby waive my right to a secret ballot."

b. When an absentee ballot is received via electronic transmission, the person receiving the transmission shall examine it to determine that all pages have been received and are legible. The person receiving an electronic transmission shall not reveal how the voter voted.

c. The absentee ballot shall be sealed in an envelope marked with the voter's name. The affidavit of the voter and the application for the ballot shall be attached to the envelope. These materials shall be stored with other returned absentee ballots.

This rule is intended to implement Iowa Code sections 53.40 and 53.46.
[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8777B**, IAB 6/2/10, effective 5/7/10]

721—21.321 to **21.349** Reserved.

721—21.350(53) Absentee ballot processing for elections held following July 1, 2007. Rescinded IAB 9/26/07, effective 9/7/07.

721—21.351(53) Receiving absentee ballots. The commissioner shall carefully account for and protect all absentee ballots returned to the office.

21.351(1) *Note receipt.* The commissioner shall write or file-stamp on the return carrier envelope the date that the ballot arrived in the commissioner's office. The commissioner shall also record receipt of the ballot in I-Voters.

21.351(2) *Temporary storage.* If necessary, the commissioner shall immediately put the ballot into a secure container, such as a locked ballot box, until the ballots can be moved to the secure storage area.

21.351(3) *Secure area.* The commissioner shall deliver the ballots to a secure area where returned absentee ballots will be reviewed for completeness and defects.
[**ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.352(53) Review of returned affidavit envelopes.

21.352(1) *Personnel.* The commissioner may assign staff members to complete the review of returned affidavit envelopes. Only persons who have been trained for this responsibility shall be authorized to review affidavit envelopes.

21.352(2) *Affidavit envelopes reviewed.* The affidavit envelopes of all absentee ballots returned to the commissioner's office shall be reviewed, including those of ballots returned by the bipartisan team delivering absentee ballots to health care facilities, such as hospitals and nursing homes. If a reviewer finds that any absentee affidavits returned from any health care facility are incomplete or defective, the commissioner shall send the bipartisan delivery team back to assist voters as needed with completing affidavits or to deliver any replacement ballots.

21.352(3) *Instructions.* Each reviewer shall receive instructions in substantially the form prepared by the state commissioner of elections. The instructions shall provide basic security and procedural guidance and include a method for accounting for all returned absentee ballots. The prohibitions shall include:

a. Leaving unsecured ballots unattended.

b. Altering any information on any affidavit.

c. Adding any information to any affidavit, except as specifically required to comply with the requirements of the law.

d. Sealing any affidavit envelope found open.

e. Discarding any return carrier envelopes, ballots, or affidavit envelopes returned by voters.
[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.353(53) Opening the return carrier envelopes. The commissioner may direct a staff member to open the return carrier envelopes either manually or with an automatic letter opener, if one is available. Only a trained reviewer may remove the contents of the envelope.

721—21.354(53) Review process. A reviewer shall remove the contents from only one return carrier envelope at a time.

21.354(1) *Return carrier envelopes preserved.* The return carrier envelopes shall be stored in a manner that will facilitate their retrieval, if necessary. They shall be stored for 22 months for federal elections and 6 months for local elections.

21.354(2) *Examination of affidavit envelope.* The reviewer shall make sure that:

a. The affidavit envelope is sealed, apparently with the ballot inside.

b. The affidavit envelope has not been opened and resealed.

c. The affidavit includes all of the following:

(1) A signature.

(2) For primary elections only, political party affiliation.

21.354(3) *No defects or incomplete information.* If the reviewer finds that the required information on the affidavit is complete and that there are no defects that would cause the absentee and special voters precinct board to reject the ballot, the reviewer shall put the affidavit envelope into a group of envelopes to be retained in the secure storage area with others that require no further attention until they are delivered to the absentee and special voters precinct board.

21.354(4) *Defective and incomplete affidavits.* The commissioner shall contact the voter if the reviewer finds any of the following flaws in the affidavit or affidavit envelope:

a. The commissioner shall contact the voter immediately if the affidavit envelope is defective. An affidavit envelope is defective if:

(1) The absentee ballot is not enclosed in the affidavit envelope.

(2) The affidavit envelope is not sealed.

(3) The affidavit envelope has been opened and resealed.

(4) The voter submits a change of address in a new precinct after returning a voted absentee ballot.

b. The commissioner shall contact the voter within 24 hours if the affidavit is incomplete. An incomplete affidavit lacks:

(1) The signature of the voter.

(2) For primary elections only, political party affiliation.

c. If an affidavit envelope has flaws that are included in both paragraphs *"a"* and *"b,"* the commissioner shall follow the process in paragraph *"a."*

21.354(5) *Defective and incomplete affidavits stored separately.* The commissioner shall store the defective and incomplete affidavit envelopes separately from other returned absentee ballot affidavit envelopes.

a. Incomplete affidavit envelopes requiring voter correction must be available for retrieval when the voter comes to make corrections.

b. Defective affidavit envelopes must be attached to the replacement ballot (if any) for review by the absentee and special voters precinct board.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.355(53) Notice to voter. When the commissioner finds an incomplete absentee ballot affidavit or finds a defective affidavit envelope, the commissioner shall notify the voter in writing and, if possible, by telephone and by E-mail. The commissioner shall keep a separate checklist for each voter showing the reasons for which the voter was contacted and the methods used to contact the voter.

21.355(1) *Notice to voter—incomplete ballot affidavit.* Within 24 hours after receipt of an absentee ballot with an incomplete affidavit, the commissioner shall send a notice to the voter at the address where the voter is registered to vote, as well as to the address where the ballot was sent, if it is a different address. The notice shall include:

a. Explanation of missing required information (lack of signature or, for primary elections only, political party affiliation).

b. The voter's options for correcting the affidavit as follows:

(1) Completing the affidavit at the commissioner's office by 5 p.m. the day before the election;

(2) Requesting a replacement ballot pursuant to Iowa Code section 53.18; or

(3) Voting at the polls on election day.

c. Address of commissioner's office, business hours and contact information.

21.355(2) *Notice to voter—defective ballot affidavit.* Immediately after determining that an absentee ballot affidavit envelope is defective, the commissioner shall send a notice to the voter at the address where the voter is registered to vote, as well as to the address where the ballot was sent, if it is a different address. The notice shall include the following information:

a. Reason for defect.

b. The voter's options for correcting the defect as follows:

(1) Requesting a replacement ballot; or

(2) Voting at the polls on election day.

c. Process for requesting a replacement ballot.

d. Address of commissioner's office, business hours and contact information.

21.355(3) *Telephone contact.* If the voter has provided a telephone number, either on the absentee ballot application or on the voter's registration record, the commissioner shall also attempt to contact the voter by telephone. The commissioner shall keep a written record of the telephone conversation. The written record shall include the following information:

a. Name of the person making the call.

b. Date and time of the call.

c. Whether the person making the call spoke to the voter.

21.355(4) *E-mail contact.* If the voter has provided an E-mail address, either on the absentee ballot application or on the voter's registration record, the commissioner shall also attempt to contact the voter by E-mail. The E-mail message shall be the same message that was mailed to the voter. A copy of the E-mail message shall be attached to the checklist.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8779B**, IAB 6/2/10, effective 7/1/10]

Rules 721—21.351(53) through 721—21.355(53) are intended to implement 2009 Iowa Code Supplement section 53.18 as amended by 2010 Iowa Acts, Senate file 2196, and section 53.25.

721—21.356 to **21.358** Reserved.

721—21.359(53) Processing absentee ballots before election day. The commissioner may only direct the absentee and special voters precinct board to open affidavit envelopes on the Monday before election day under the following circumstances:

For any election, only if the commissioner has provided secrecy envelopes (or folders) pursuant to subrule 21.359(1) and the commissioner determines removing secrecy envelopes from affidavit envelopes is necessary due to the quantity of voted absentee ballots received as set forth in Iowa Code section 53.23, subsection 3, paragraph *"a."*

For general elections, if the commissioner convenes the absentee and special voters precinct board pursuant to Iowa Code section 53.23, subsection 3, paragraph *"c,"* to begin tabulation of absentee ballots.

21.359(1) The secrecy envelope shall completely cover the ballot. The envelope shall have the following message printed on it using at least 24-point type:

Secrecy Envelope

After you vote, put your ballot in here.

21.359(2) When the absentee and special voters precinct board convenes to begin processing absentee ballots, the board shall first review voters' affidavits to determine which ballots will be accepted for counting and prepare the notices to those voters whose ballots have been rejected for the reasons set forth in 2009 Iowa Code Supplement section 53.25. Affidavit envelopes containing ballots that are rejected shall be stored in the manner prescribed by Iowa Code section 53.26. The applications submitted for rejected ballots shall be stored in a secure location for the time period required by Iowa Code section 50.19.

21.359(3) The affidavit envelopes containing ballots that have been accepted for counting by the absentee and special voters precinct board shall be stacked with the affidavits facing down. The envelopes shall be opened and the secrecy envelope containing the ballot shall be removed.

21.359(4) If a voter has not enclosed the ballot in a secrecy envelope and the ballot has not been folded in a manner that conceals all votes marked on the ballot, the officials shall put the ballot in a secrecy envelope without examining the ballot.

21.359(5) The following security procedures shall be followed:

a. The process shall be witnessed by observers appointed by the county chairperson of each of the political parties referred to in Iowa Code section 49.13, subsection 2. If, after receiving notice from the commissioner pursuant to Iowa Code section 53.23, subsection 3, paragraph *"a,"* either or both political parties fail to appoint an observer, the commissioner may continue with the proceedings.

b. No ballots shall be counted or examined before election day except as provided in Iowa Code section 53.23, subsection 3, paragraph *"c,"* as amended by 2009 Iowa Acts, House File 670, section 1.

c. When secrecy envelopes are removed from affidavit envelopes on the day before an election and not tabulated as permitted by Iowa Code section 53.23, subsection 3, paragraph *"c,"* as amended by 2009 Iowa Acts, House File 670, section 1, the number of secrecy envelopes shall be recorded before the ballots are stored and the number shall be verified before any ballots are removed from the secrecy envelopes on election day. The ballots may be bundled and sealed in groups of a specified number to make counting easier.

This rule is intended to implement Iowa Code section 53.23 as amended by 2009 Iowa Acts, House File 670.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.360(53) Failure to affix postmark date. Rescinded IAB 4/20/11, effective 3/31/11.

721—21.361(53) Rejection of absentee ballot. The absentee and special voters precinct board shall reject absentee ballots without opening the affidavit envelope if any of the conditions cited in Iowa Code section 53.25 as amended by 2009 Iowa Acts, House File 475, exist.

21.361(1) An absentee ballot shall be rejected if the affidavit lacks the voter's signature.

21.361(2) An absentee ballot shall be rejected if the applicant is not a duly registered voter in the precinct in which the ballot is cast. "Precinct" means a precinct established pursuant to Iowa Code sections 49.3 through 49.5 or a consolidated precinct established by the commissioner pursuant to Iowa Code section 49.11, subsection 3, paragraph *"a."*

21.361(3) An absentee ballot shall be rejected if the affidavit envelope is open.

21.361(4) An absentee ballot shall be rejected if the affidavit envelope has been opened and resealed.

21.361(5) An absentee ballot shall be rejected if the affidavit envelope contains more than one ballot of any kind.

21.361(6) An absentee ballot shall be rejected if the voter has voted in person at the polls.

21.361(7) An absentee ballot shall be rejected if in primary elections the voter does not declare a party affiliation on the voter's affidavit.

This rule is intended to implement Iowa Code sections 49.9 and 53.14 and section 53.25 as amended by 2009 Iowa Acts, House File 475.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.362 to **21.369** Reserved.

721—21.370(53) Training for absentee ballot couriers. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.371(53) Certificate. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.372(53) Frequency of training. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.373(53) Registration of absentee ballot couriers. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.374(53) County commissioner's duties. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.375(53) Absentee ballot courier training. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.376(53) Receiving absentee ballots. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.377 to **21.399** Reserved.

DIVISION IV
INSTRUCTIONS FOR SPECIFIC ELECTIONS

721—21.400(376) Signature requirements for certain cities. This rule applies to cities which have all of the following characteristics:

1. Nomination procedures under Iowa Code section 376.3 are used. (This includes cities with primary or runoff election provisions. It does not include cities with nominations under Iowa Code chapter 44 or 45.)
2. Some or all council members are voted upon by the electors of wards, rather than by the electors of the entire city.
3. Ward boundaries have been changed since the last regular city election at which the ward seat was on the ballot.
4. The number of wards has not changed.

Calculation of the number of signatures for ward seats shall use the vote totals from the wards as the wards were configured at the time of the last regular city election at which the ward seat was on the ballot.

This rule is intended to implement Iowa Code section 376.4.

721—21.401(376) Signature requirements in cities with primary or runoff election provisions. In cities using the provisions of Iowa Code section 376.4 for nomination of candidates and in which more than one council member was elected at-large at the last preceding regular city election, the number of signatures shall be calculated by the following formula:

V = the total number of votes cast for all candidates for council member at-large at the last regular city election;

E = the number of people to be elected at the last regular city election;

$$\frac{V}{E} \times .02 = \text{the number of signatures needed by each candidate in the next regular city election.}$$

This rule is intended to implement Iowa Code section 376.4.

721—21.402(372) Filing deadline for charter commission appointment petition. If a special election has been called by a city to present to the voters the question of adopting a different form of city government, receipt by the city council of a petition requesting appointment of a charter commission shall stay the special election if the petition is received no later than 5 p.m. on the Friday preceding the date of the special election.

This rule is intended to implement Iowa Code section 372.3.

721—21.403(81GA,HF2282) Special elections to fill vacancies in elective city offices for cities that may be required to conduct primary elections.

21.403(1) *Notice to the commissioner.* At least 60 days before the proposed date of the special election, the city council shall give written notice to the commissioner who will be responsible for conducting the special election.

a. If the commissioner finds no conflict with other previously scheduled elections, or with other limitations on the dates of special elections, the commissioner shall immediately notify the council that the date has been approved.

b. No special city elections to fill vacancies for cities that may be required to conduct primary elections shall be held with the general election, with the primary election, or with the annual school election. To do so would be contrary to the provisions of Iowa Code section 39.2.

21.403(2) *Election calendar.* The election calendar shall be adjusted as follows:

a. The deadline for candidates to file nomination papers with the city clerk shall be not later than 12 noon on the fifty-third day before the election.

b. The city clerk shall deliver all nomination papers accepted by the clerk to the county commissioner of elections not later than 5 p.m. on the fifty-third day before the election.

c. A candidate who has filed nomination papers for the special election may withdraw not later than 5 p.m. on the fiftieth day before the election.

d. A person who would have the right to vote for the office in question may file a written objection to the legal sufficiency of a candidate's nomination papers or to the qualifications of the candidate for this special election not later than 12 noon on the fiftieth day before the election.

e. The hearing on the objection must be held within 24 hours of receipt of the objection.

This rule is intended to implement Iowa Code section 372.13(2) as amended by 2006 Iowa Acts, House File 2282, section 2.

721—21.404(81GA,HF2282) Special elections to fill vacancies in elective city offices for cities without primary election requirements. This rule applies to cities that have adopted by ordinance one of the following options: nominations under Iowa Code chapter 44 or chapter 45, or a runoff election requirement if no candidate in the special election receives a majority of the votes cast.

21.404(1) *Notice to the commissioner.* At least 32 days before the proposed date of the special election, the city council shall give written notice to the commissioner who will be responsible for conducting the special election. If the commissioner finds no conflict with other previously scheduled elections, or with other limitations on the dates of special elections, the commissioner shall immediately notify the council that the date has been approved.

21.404(2) *Special elections to fill vacancies held in conjunction with the general election.* If the proposed date of the special election coincides with the date of the general election, the council shall give notice of the proposed date of the special city election not later than 76 days before the date of the general election. Candidates shall file nomination papers with the city clerk not later than 5 p.m. on the seventieth day before the general election. The city clerk shall deliver the nomination papers accepted by the clerk not later than 5 p.m. on the sixty-ninth day before the general election. Objection and withdrawal deadlines shall be 64 days before the general election, the same as the deadlines for candidates who file their nomination papers with the commissioner. Hearings on objections shall be held as soon as possible in order to facilitate printing of the general election ballot.

21.404(3) *Election calendar.* If the special election date is not the same as the date of the general election, the election calendar shall be adjusted as follows:

a. The deadline for candidates to file nomination papers with the city clerk shall be not later than 12 noon on the twenty-fifth day before the election.

b. The city clerk shall deliver all nomination papers accepted by the clerk to the county commissioner of elections not later than 5 p.m. on the twenty-fifth day before the election.

c. A candidate who has filed nomination papers for the special election may withdraw not later than 5 p.m. on the twenty-second day before the election.

d. A person who would have the right to vote for the office in question may file a written objection to the legal sufficiency of a candidate's nomination papers or to the qualifications of the candidate for this special election not later than 12 noon on the twenty-second day before the election.

e. The hearing on the objection must be held within 24 hours of receipt of the objection.

This rule is intended to implement Iowa Code section 372.13(2) as amended by 2006 Iowa Acts, House File 2282, section 2.

721—21.405 to **21.499** Reserved.

721—21.500(277) Signature requirements for school director candidates. The number of signatures required to be filed by candidates for the office of director in the regular school election shall be calculated from the number of registered voters in the district on May 1 of the year in which the election will be held. If May 1 falls on a day when the commissioner's office is closed for business, the commissioner shall use the number of registered voters in the district on the next day that the commissioner's office is open for business to determine the number of required signatures. Candidates who are seeking election in districts with election plans as specified in Iowa Code section 275.12(2)*"b"* and *"c,"* where the candidate must reside in a specific director district, but is voted upon by all of the electors of the school district, shall be required to file a number of signatures calculated from the number of registered voters in the whole school district. Candidates who will be voted upon only by the electors of a director district shall be required to file a number of signatures calculated from the number of registered voters in the director district in which the candidate resides and seeks to represent.

If a special election is to be held to fill a vacancy on the school board, the number of registered voters on the date the commissioner receives notice of the special election shall be used to calculate the number of signatures required for the special election.

This rule is intended to implement Iowa Code sections 277.4 and 279.7.

[**ARC 9466B**, IAB 4/20/11, effective 3/31/11]

721—21.501 to **21.599** Reserved.

721—21.600(43) Primary election signatures—plan three supervisor candidates. Rescinded IAB 11/30/11, effective 1/4/12.

721—21.601(43) Plan III supervisor district candidate signatures after a change in the number of supervisors. After the number of supervisors has been increased or decreased pursuant to Iowa Code section 331.203 or 331.204, the signatures for candidates at the next primary and general elections shall be calculated as follows:

21.601(1) *Primary election.* Divide the total number of votes cast in the county at the previous general election for the office of president or for governor, as applicable, by the number of supervisor districts and multiply the quotient by .02. If the result of the calculation is less than 100, the result shall be the minimum number of signatures required. If the result of the calculation is greater than or equal to 100, the minimum requirement shall be 100 signatures.

21.601(2) *Nominations by petition.* If the effective date of the change in the number of districts was later than the date specified in Iowa Code section 45.1(6), divide the total number of registered voters in the county on the date specified in Iowa Code section 45.1(6) by the number of supervisor districts and multiply the quotient by .01. If the result of the calculation is less than 150, the result shall be the minimum number of signatures required. If the result of the calculation is greater than or equal to 150, the minimum requirement shall be 150 signatures.

721—21.602(43) Primary election—nominations by write-in votes for certain offices.

21.602(1) The process described in subrule 21.602(2) shall be used to determine whether the primary election is conclusive and a candidate was nominated for partisan offices that are:

a. Not mentioned in Iowa Code section 43.53 (township offices) or 43.66 (state representative and state senator), and

b. For which no candidate's name was printed on the primary election ballot, and

c. For which no candidate's name was printed on the primary election ballot in any previous primary election.

21.602(2) To be nominated by write-in votes, the person must receive at least 35 percent of the number of votes cast in the previous general election for that party's candidate for president of the United States or for governor, as the case may be, as follows:

a. Statewide office: 35 percent of votes cast statewide.

b. Congressional district: 35 percent of votes cast within the current boundaries of the Congressional district.

c. County office, including plan II supervisors: 35 percent of the votes cast within the county.

d. Plan III county supervisor: 35 percent of the votes cast within the supervisor district. If the boundaries of the supervisor district have changed since the previous general election, the number of votes cast within the county for the party candidate for president or for governor, as the case may be, shall be divided by the number of supervisor districts in the county; then the quotient shall be multiplied by 0.35.

21.602(3) If a write-in candidate is declared nominated at the canvass of votes, Iowa Code section 43.67, which requires the appropriate election commissioner to notify the candidate, shall apply.

This rule is intended to implement Iowa Code section 43.66.

721—21.603 to **21.799** Reserved.

721—21.800(423B) Local sales and services tax elections.

21.800(1) Petitions requesting imposition, rate change, use change, or repeal of local sales and services taxes shall be filed with the county board of supervisors.

a. Each person signing the petition shall include the person's address (including street number, if any) and the date that the person signed the petition.

b. Within 30 days after receipt of the petition, the supervisors shall provide written notice to the county commissioner of elections directing that an election be held to present to the voters of the entire county the question of imposition, rate change, use change, or repeal of a local sales and services tax. In the notice the supervisors shall include the date of the election.

c. The election shall be held on the first possible special election date for counties set forth in Iowa Code section 39.2, subsection 4, paragraph *"c,"* but no sooner than 84 days after the date upon which notice is given to the commissioner.

21.800(2) As an alternative to the method of initiating a local option tax election described in subrule 21.800(1), governing bodies of cities and the county may initiate a local option tax election by filing motions with the county auditor pursuant to Iowa Code section 423B.1, subsection 4, paragraph *"b,"* requesting submission of a local option tax imposition, rate change, use change, or repeal to the qualified electors. Within 30 days of receiving a sufficient number of motions, the county commissioner shall notify affected jurisdictions of the local option tax election date. The election shall be held on the first possible special election date for counties set forth in Iowa Code section 39.2, subsection 4, paragraph *"c,"* but no sooner than 84 days after the date upon which the commissioner received the motion triggering the election.

21.800(3) Notice of local sales and services tax election.

a. Not less than 60 days before the date that a local sales and services tax election will be held, the county commissioner of elections shall publish notice of the ballot proposition. The notice does not need to include sample ballots, but shall include all of the information that will appear on the ballot for each city and for the voters in the unincorporated areas of the county.

b. The city councils and the supervisors shall provide to the county commissioner the following information to be included in the notice and on the ballots for imposition elections:

(1) The rate of the tax.

(2) The date the tax will be imposed (which shall be the next implementation date provided in Iowa Code section 423B.6 following the date of the election and at least 90 days after the date of the election, except that an election to impose a local option tax on a date immediately following the scheduled repeal date of an existing similar tax may be held at any time that otherwise complies with the requirements of Iowa Code chapter 423B). The imposition date shall be uniform in all areas of the county voting on the tax at the same election.

(3) The approximate amount of local option tax revenues that will be used for property tax relief in the jurisdiction.

(4) A statement of the specific purposes other than property tax relief for which revenues will be expended in the jurisdiction.

c. The information to be included in the notice shall be provided to the commissioner by the city councils of each city in the county not later than 67 days before the date of the election. If a jurisdiction fails to provide the information in subparagraphs 21.800(3)*"b"*(1), 21.800(3)*"b"*(3), and 21.800(3)*"b"*(4) above, the following information shall be substituted in the notice and on the ballot:

(1) One percent (1%) for the rate of the tax.

(2) Zero percent (0%) for property tax relief.

(3) The specific purpose for which the revenues will otherwise be expended is: Any lawful purpose of the city (or county).

d. The notice of election provided for in Iowa Code section 49.53 as amended by 2009 Iowa Acts, House File 475, shall also be published at the time and in the manner specified in that section.

This rule is intended to implement Iowa Code section 423B.1.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.801(423B) Form of ballot for local option tax elections. If questions pertaining to more than one of the authorized local option taxes are submitted at a single election, all of the public measures shall be printed on the same ballot. The form of ballots to be used throughout the state of Iowa for the purpose of submitting questions pertaining to local option taxes shall be as follows:

21.801(1) *Local sales and services tax propositions.* Sales and services tax propositions shall be submitted to the voters of an entire county. If the election is being held for the voters to decide whether to impose the tax in a county where a local option sales and services tax has previously been approved for part of the county, the question of imposition shall be voted upon in all parts of the county where the tax has not been approved. If the election is being held for the voters to decide whether to repeal the tax in a county where a local option sales and services tax has previously been approved for part of the county, the question of repeal shall be voted upon in all parts of the county where the tax was previously imposed. If the election is being held for the voters to decide whether to change the rate or use of the tax in a county where a local option sales and services tax has previously been approved for part of the county, the question of rate or use change shall be voted upon in all parts of the county where the tax was previously imposed.

The ballot submitted to the voters of each incorporated area and the unincorporated area of the county shall show the intended uses for that jurisdiction. The ballot submitted to the voters in contiguous cities within a county shall show the intended uses and repeal dates, if not uniform, for each of the contiguous cities. The ballots shall be in substantially the following form:

a. Imposition question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the [city of _____] [unincorporated area of the county of _____], at the rate of _____ percent (_____ %) to be effective on _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

A local sales and services tax shall be imposed in the [city of _____] [unincorporated area of the county of _____] at the rate of _____ percent (_____ %) to be effective on _____ (month and day), _____ (year).

Revenues from the sales and services tax shall be allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

b. Imposition question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective on _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

A local sales and services tax shall be imposed in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective on _____ (month and day), _____ (year).

Revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

c. Imposition question with an automatic repeal date for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the [city of _____] [unincorporated area of the county of _____], at the rate of _____ percent (_____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

A local sales and services tax shall be imposed in the [city of _____] [unincorporated area of the county of _____] at the rate of _____ percent (_____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

Revenues from the sales and services tax shall be allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

d. Imposition question with an automatic repeal date for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of ____ percent (____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special

paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

A local sales and services tax shall be imposed in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

Revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

e. Repeal question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize repeal of the ____ percent (_____%) local sales and services tax in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The _____ percent (_____%) local sales and services tax shall be repealed in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).
Revenues from the sales and services tax have been allocated as follows:
(Choose one or more of the following:)
[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

f. Repeal question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize repeal of the ____ percent (_____%) local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The _____ percent (_____%) local sales and services tax shall be repealed in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

Revenues from the sales and services tax have been allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

g. Rate change question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize an increase (or decrease) in the rate of the local sales and services tax to _____ percent (_____%) in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The rate of the local sales and services tax shall be increased (or decreased) to ____ percent (_____%) in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year). The current rate is ____ percent (_____%).

Revenues from the sales and services tax are allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

h. Rate change question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize an increase (or decrease) in the rate of the local sales and services tax to _____ percent (_____%) in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The rate of the local sales and services tax shall be increased (or decreased) to _____ percent (_____%) in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

Revenues from the sales and services tax are allocated as follows:

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues are otherwise expended is (are):
(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues are otherwise expended is (are):
(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues are otherwise expended is (are):
(List specific purpose or purposes)

i. Use change question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize a change in the use of the _____ percent (_____%) local sales and services tax in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The use of the _____ percent (_____%) local sales and services tax shall be changed in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

PROPOSED USES OF THE TAX:

If the change is approved, revenues from the sales and services tax shall be allocated as follows:
(Choose one or more of the following:)
[_____ for property tax relief (insert percentage or dollar amount)]
[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]
[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

CURRENT USES OF THE TAX:

Revenues from the sales and services tax are currently allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

j. Use change question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize a change in the use of the _____ percent (_____%) local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The use of the _____ percent (_____%) local sales and services tax shall be changed in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

PROPOSED USES OF THE TAX:

If the change is approved, revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

CURRENT USES OF THE TAX:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

k. Imposition question with differing automatic repeal dates for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective from _____ (month/day/year) until automatic repeal date specified.

A local sales and services tax shall be imposed in the following cities at the rate of _____ percent (_____%) to be effective from _____ (month/day/year) until the date specified below and the revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:

The tax shall be repealed on _____ (month/day/year).

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

FOR THE CITY OF _____:

The tax shall be repealed on _____ (month/day/year).

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

FOR THE CITY OF _____:

The tax shall be repealed on _____ (month/day/year).

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

21.801(2) *For a local vehicle tax:*

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize the county of (insert name of county) to impose a local vehicle tax at the rate of _____ dollars ($_____) per vehicle and to exempt the following classes from the tax:

_____.

The revenues are to be expended as set forth in the text of the public measure.

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using optical scan ballots which are read by automatic tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The county of _____, Iowa shall be authorized to impose a local vehicle tax at the rate of _____ dollars ($_____) per vehicle and to exempt the following classes of vehicles from the tax:

_____

_____ (insert percentage or dollar amount) of the revenues is/are to be used for property tax relief.

The balance of the revenues is to be expended for:

(List purposes for which remaining revenues will be used)

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.802(423B) Local vehicle tax elections.

21.802(1) Petitions requesting imposition of local vehicle taxes shall be filed with the county board of supervisors.

a. Each person signing the petition shall add the person's address (including street number, if any) and the date that the person signed the petition.

b. Within 30 days after receipt of the petition, the supervisors shall provide written notice to the county commissioner of elections directing that an election be held to present to the voters of the entire county the question of imposition of a local vehicle tax. In the notice the supervisors shall include the date of the election.

c. The election shall be held on the first possible special election date for counties set forth in Iowa Code section 39.2, subsection 4, paragraph *"c,"* but no sooner than 84 days after the date upon which notice is given to the commissioner.

21.802(2) Notice of local vehicle tax election. Not less than 60 days before the date that a local vehicle tax election will be held, the county commissioner of elections shall publish notice of the ballot proposition. The notice does not need to include a sample ballot, but shall include all of the information that will appear on the ballot. The notice of election provided for in Iowa Code section 49.53 as amended by 2009 Iowa Acts, House File 475, shall also be published at the time and in the manner specified in that section.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.803(82GA,HF2663) Revenue purpose statement ballots. When a school district wishes to adopt, amend or extend the revenue purpose statement specifying the uses of the funds received from the secure an advanced vision for education fund, which is also referred to as the "penny sales and services tax for schools," the following ballot formats shall be used.

21.803(1) *Ballot to propose a revenue purpose statement.* The ballot for an election to propose a revenue purpose statement specifying the use of funds received from the secure an advanced vision for education fund shall be in substantially the following form:

(Insert letter to be assigned by the commissioner.)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: To adopt a revenue purpose statement specifying the use of money from the penny sales and services tax for schools received by _____ School District.

In the _____ School District, the following revenue purpose statement, which specifies the use of the penny sales and services tax for schools (sales and services tax funds from the secure an advanced vision for education fund for school infrastructure) shall be adopted:

(Insert here the revenue purpose statement that was adopted by the school board and that states the intended uses of the funds by the school district. The use or uses must be among the approved uses of the tax that are authorized by 2008 Iowa Acts, House File 2663, section 29.)

21.803(2) *Ballot to amend a revenue purpose statement.* The ballot for an election to decide a change in the revenue purpose statement specifying the use of funds received from the secure an advanced vision for education fund shall be in substantially the following form:

(Insert letter to be assigned by the commissioner.)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: To authorize a change in the use of money from the penny sales and services tax for schools received by _____ School District.

In the _____ School District, the revenue purpose statement, which specifies the use of the penny sales and services tax for schools (sales and services tax funds from the secure an advanced vision for education fund for school infrastructure) shall be changed.

Proposed uses. If the change is approved, the revenue purpose statement shall read as follows:

(Insert here the revenue purpose statement that was adopted by the school board and that states the intended uses of the funds by the school district. The use or uses must be among the approved uses of the tax that are authorized by 2008 Iowa Acts, House File 2663, section 29.)

Current uses. If the change is not approved, the funds shall continue to be used as follows:

(Insert here the current revenue purpose statement or list the current voter-approved uses of the funds by the school district, if the school infrastructure local option tax was adopted before the revenue purpose statement was required.)

21.803(3) *Ballot to extend a revenue purpose statement.* The ballot for an election to extend a revenue purpose statement specifying the use of funds received from the secure an advanced vision for education fund shall be in substantially the following form:

(Insert letter to be assigned by the commissioner.)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: To authorize _____ School District to continue to spend money from the penny sales and services tax for schools for the previously approved uses until (specify date or insert amended date).

_____ School District is authorized to extend the current revenue purpose statement which specifies use of the penny sales and services tax for schools (sales and services tax funds from the secure an advanced vision for education fund for school infrastructure) received from (date) until (specify date or insert amended date). If an extension is not approved, the current revenue purpose statement will expire on (date). If an extension is approved, the revenue purpose statement will read as follows:

(Insert here the revenue purpose statement, including the new expiration date. If there is not a predicted expiration date, the ballot language must state that the revenue purpose statement will remain in effect until it is changed.)

This rule is intended to implement 2008 Iowa Acts, House File 2663, section 29.

721—21.804 to **21.809** Reserved.

721—21.810(34A) Referendum on enhanced 911 emergency telephone communication system funding.

21.810(1) *Form of ballot.* The ballot for the E911 referendum shall be in substantially the following form:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a monthly surcharge of (an amount to be determined by the local joint E911 service board of up to one dollar) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within (description of the proposed service area).

A map may be used to show the proposed E911 service area. If a map is used the public measure shall read as follows:

"Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a monthly surcharge of (an amount to be determined by the local joint E911 service board of up to one dollar) on

each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within the proposed E911 service area shown on the map below."

21.810(2) *Cost of election.* The E911 service board shall pay the costs of the referendum election.

21.810(3) *Enhanced 911 emergency service funding referendum held in conjunction with a scheduled election.*

a. Notice to commissioner. The joint E911 service board shall notify the commissioner in writing, no later than the last day upon which nomination papers may be filed, of their intention to conduct the referendum with the scheduled election. The notice shall contain the complete text of the referendum question including the description of the proposed E911 service area. If a map is to be used on the ballot to describe the proposed E911 service area, the map shall be included. If the E911 service area includes more than one county, the service board shall notify the commissioner of each of the counties.

b. Conduct of election. All qualified electors in a precinct which is to be served, in whole or in part, by the proposed E911 service area, shall be permitted to vote on the question. The results of the referendum shall be canvassed by the board of supervisors at the time of the canvass of the scheduled election. The commissioner shall immediately certify the results to the joint E911 board.

c. Service board duties. If subscribers from more than one county are included within the proposed service area, the E911 service board shall meet as a board of canvassers to compile the results from the counties. The canvass shall be held on the tenth day following the election at a time established by the E911 service board. The service board shall prepare an abstract showing in words and numbers the number of votes cast for and against the question and, if a simple majority of those voting on the question has voted in the affirmative, the board shall declare that the surcharge has been adopted. Votes cast and not counted as a vote for or against the question shall not be used in computing the total vote cast for and against the question.

21.810(4) *Form of ballot for alternative surcharge.* The ballot for elections conducted pursuant to Iowa Code section 34A.6A shall be in the following form:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a temporary monthly surcharge increase to (an amount between one dollar and two dollars and fifty cents to be determined by the local joint E911 service board) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within (description of the proposed service area). The surcharge shall be collected for not more than 24 months, after which the surcharge shall revert to one dollar per month for each line.

A map may be used to show the proposed E911 service area. If a map is used the public measure shall read as follows:

"Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a temporary monthly surcharge increase to (an amount between one dollar and two dollars and fifty cents to be determined by the local joint E911 service board) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within the proposed E911 service area shown on the map below. The surcharge shall be collected for not more than 24 months, after which the surcharge shall revert to one dollar per month for each line."

This rule is intended to implement Iowa Code sections 34A.6 and 34A.6A.

721—21.811 to **21.819** Reserved.

721—21.820(99F) Gambling elections.

21.820(1) Petitions requesting elections to approve or disapprove the conduct of gambling games on an excursion gambling boat or at a gambling structure shall be filed with the county board of

supervisors and shall be substantially in the form posted on the state commissioner's Web site titled "Petition Requesting Special Election."

a. Within 10 days after receipt of a valid petition, the supervisors shall provide written notice to the county commissioner of elections directing the commissioner to submit to the qualified electors of the county a proposition to approve or disapprove the conduct of gambling games on an excursion gambling boat or at a gambling structure in the county. The election shall be held on the next possible special election date pursuant to Iowa Code section 39.2, subsection 4, paragraph *"a,"* but no fewer than 46 days from the date notice is given to the county commissioner.

b. If a regularly scheduled or special election is to be held in the county on the date selected by the supervisors, notice shall be given to the commissioner no later than the last day upon which nomination papers may be filed for that election. If the excursion gambling boat or the gambling structure election is to be held with a local option tax election, the supervisors shall provide the commissioner at least 60 days' written notice. Otherwise, the supervisors shall give at least 46 days' written notice.

21.820(2) Form of ballot for election called by petition. Ballots shall be in substantially the following form:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Gambling games on an excursion gambling boat or at a gambling structure in _____ County are approved.

21.820(3) Form of ballot for elections to continue gambling games on an excursion gambling boat or at a gambling structure:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: Gambling games on an excursion gambling boat or at a gambling structure in _____ County are approved.

Gambling games, with no wager or loss limits, on an excursion gambling boat or at a gambling structure in _____ County are approved. If approved by a majority of the voters, operation of gambling games with no wager or loss limits may continue until the question is voted upon again at the general election held in 2010. If disapproved by a majority of the voters, the operation of gambling games on an excursion gambling boat or at a gambling structure will end within 60 days of this election. (Iowa Code section 99F.7(10)*"c"*)

21.820(4) Ballot form to permit gambling games at existing pari-mutuel racetracks:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

The operation of gambling games at (name of pari-mutuel racetrack) in _____ County is approved.

21.820(5) Abstract of votes. A copy of the abstract of votes of the election shall be sent to the state racing and gaming commission.

21.820(6) Ballot form for general election for continuing operation of gambling games at pari-mutuel racetracks:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: The continued operation of gambling games at (name of pari-mutuel racetrack) in _____ County is approved.

The continued operation of gambling games at (name of pari-mutuel racetrack) in _____ County is approved. If approved by a majority of the voters, operation of gambling games may continue at (name of pari-mutuel racetrack) in _____ County until the question is voted on again at the general election in eight years. If disapproved by a majority of the voters, gambling games at (name of pari-mutuel racetrack) in _____ County will end.

21.820(7) Ballot form for general election for continuing gambling games on an excursion gambling boat or at a gambling structure:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: The continued operation of gambling games on an excursion gambling boat or at a gambling structure in _____ County is approved.

The continued operation of gambling games on an excursion gambling boat or at a gambling structure in _____ County is approved. If approved by a majority of the voters, operation of gambling games may continue on an excursion gambling boat or at a gambling structure in _____ County until the question is voted on again at the general election in eight years. If disapproved by a majority of voters, gambling games on an excursion gambling boat or at a gambling structure in _____ County will end nine years from the date of the original issue of the license to the current licensee.

This rule is intended to implement Iowa Code section 99F.7 and Iowa Code Supplement section 99F.4D.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.821 to **21.829** Reserved.

721—21.830(357E) Benefited recreational lake district elections. Elections for benefited recreational lake districts shall be conducted according to the following procedures.

21.830(1) *Conduct of election.* It is not mandatory for the county commissioner of elections to conduct elections for a benefited recreational lake district. However, if both a public measure and a candidate election will be held on the same day in a benefited recreational lake district, the same person shall be responsible for conducting both elections. All elections must be held on a Tuesday.

21.830(2) *Ballots.* Ballots for benefited recreational lake district trustee elections shall be printed on opaque white paper, 8 by 11 inches in size. The ballots for the initial election for the office of trustee shall be in substantially the following form:

OFFICIAL BALLOT
BENEFITED RECREATIONAL LAKE DISTRICT
Election date
(facsimile signature of person responsible for printing ballots)

FOR TRUSTEE:
To vote: Neatly print the names of at least three people you would like to see elected to the office of Trustee of the Benefited Recreational Lake District. You may vote for as many people as you wish, but you must vote for at least three.
(At the bottom of the ballot a space shall be included for the endorsement of the precinct election official, like this:)

Precinct official's endorsement: _____

21.830(3) *Canvass of votes.* On the Monday following the election, the board of supervisors shall canvass the votes cast at the election. At the initial election the supervisors shall choose three trustees from among the five persons who received the most votes. The results of benefited recreational lake district elections shall be certified to the district board of trustees.

This rule is intended to implement Iowa Code section 357E.8.

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◊ Two or more ARCs

CHAPTER 112
PRIMARY ROAD ACCESS CONTROL
[Prior to 6/3/87, Transportation Department[820]—(06,C) Ch 1]

761—112.1(306A) General information.

112.1(1) *Statement of policy.* The efficiency and safety of a highway depend to a large extent upon the amount and character of interruptions to the movement of traffic. The primary cause of these interruptions is vehicular movements to and from businesses, residences, and other developments along the highway. All primary highways are controlled access facilities. Regulation and overall control of highway access are necessary to provide efficient and safe highway operation and to utilize the full potential of the highway investment. Accordingly, the department hereby establishes rules for control of access to primary highways.

112.1(2) *Information and forms.* Information and forms regarding this chapter may be obtained from any of the department's six district offices; the Office of Traffic and Safety, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; or the Internet Web site: http://www.iowadot.gov/traffic/index.htm.

112.1(3) *Considerations.* If the department determines that the literal application of these rules to a specific situation will create or result in an unsafe situation or an unreasonable design, the department shall use sound engineering practices to determine the appropriate design for the specific situation. The appropriate district office shall include justification for the design in the permit or the highway project file, as applicable. The appropriate design shall address:

a. Safety to the traveling public.

b. Perpetuation of the traffic-carrying capacity of the highway.

c. Protection of the rights of the traveling public and of property owners, including the rights of abutting property owners.

d. Topography and geometric limitations and constraints affecting typical engineering standards.

112.1(4) *Permit approval process.*

a. A district representative may, in response to an application for an access connection to the primary highway system, grant approval for an access permit. The process for inquiring about and applying for an access connection to the primary highway system is through one of the department's six district offices. All applications for access permits must be applied for in the particular district where the entrance is proposed. A district representative will do one of the following: approve the application for an access permit, approve the application for an access permit with conditions, or deny the application for an access permit. The district representative may use the considerations set forth in subrule 112.1(3) in making the decision. The district representative shall notify the applicant of the determination in writing.

b. Upon receipt of a denial letter or if the permit was approved with conditions, the applicant may choose to pursue a waiver from the director of transportation, pursuant to subrule 112.1(5).

112.1(5) *Waivers.* The director of transportation may, in response to a written petition, waive provisions of this chapter in accordance with 761—Chapter 11. The written petition must contain the information as required in 761—subrule 11.5(2) and shall be submitted to the Office of Policy and Legislative Services, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

112.1(6) *Waivers involving interstate highways.* The director of transportation shall not waive these rules in access situations involving the interstate highway system, including its ramps, without the approval of the Federal Highway Administration.

[**ARC 9873B**, IAB 11/30/11, effective 1/4/12]

761—112.2(306A) Definitions. The following terms, when used in this chapter, shall have the following meanings unless the context otherwise requires:

"Access." A means of ingress or egress between a primary highway and abutting property or an intersecting local public road or street.

"Acquisition." To receive title by gift, purchase or condemnation.

"Bridge." Any structure, including supports, that is erected over a depression or obstruction, has a track or passageway for carrying traffic or other moving loads, and has a length measured along the center of the driveway of more than 20 feet between undercopings of abutments or extreme ends of openings for multiple boxes.

"Built-up area." An area adjacent to a primary road that meets the following general criteria:

1. The lots or area abutting the primary road does not have sufficient setback for the construction of a frontage road, and the development in depth precludes the establishment of a frontage-type road to the rear of the lots or area.

2. When a "built-up area" exists on one side of a primary road, the other side of the road is also considered to be "built-up" for the purpose of determining access requirements.

"Clear zone." The roadside border area, starting at the edge of the traveled way, available for use by errant vehicles.

"Concrete box culvert." A concrete structure not classified as a bridge, that provides an opening under a roadway or driveway, is either precast or cast in place, and has vertical sidewalls, a top slab and a floor.

"Controlled access highway." All primary highways are controlled access facilities.

"District representative." A department employee who processes requests for access in an assigned geographical area.

"Entrance." A physical connection between a primary highway and abutting property or an intersecting local public road or street.

"Entrance type." Entrances are divided into the following three classes according to their normal usage:

1. Type "A" entrance. An entrance developed to carry sporadic or continuous heavy concentrations of traffic. Generally, a Type "A" entrance carries in excess of 150 vehicles per hour. An entrance of this type would normally consist of multiple approach lanes and may incorporate a median. Possible examples include racetracks, large industrial plants, shopping centers, subdivisions, or amusement parks.

2. Type "B" entrance. An entrance developed to serve moderate traffic volumes. Generally, a Type "B" entrance carries at least 20 vehicles per hour but less than 150 vehicles per hour. An entrance of this type would normally consist of one inbound and one outbound traffic lane. Possible examples include service stations, small businesses, drive-in banks, or light industrial plants.

3. Type "C" entrance. An entrance developed to serve light traffic volumes. Generally, a Type "C" entrance carries less than 20 vehicles per hour. An entrance of this type would not normally accommodate simultaneous inbound and outbound vehicles. Possible examples include residential, farm or field entrances.

"Entrance width." See subrule 112.4(7).

"Fringe area." A suburban-type area adjacent to a primary road that meets the following general criterion: The layout of the lots or area abutting the primary road, including intermittent or unrelated development, permits construction of a frontage road in front of, or a frontage-type road to the rear of, the development.

"Frontage." The length along a public road right-of-way of a single property tract. A corner property at an intersection of two public roads has separate frontage along each roadway.

"Frontage road." A public road or street auxiliary to and usually located alongside and parallel to a primary highway for maintaining local road continuity and for control of access.

"Fully controlled access highway." A highway for which the rights of ingress and egress from abutting properties have been legally eliminated by the roadway jurisdiction. Permanent access to the facility is allowed only at interchange locations. No permanent at-grade access is allowed.

"Highway," "street" or "road." A public way for the purpose of vehicular travel, including the entire area between the right-of-way lines.

"Interchange." A system that provides for the movement of traffic between intersecting roadways via one or more grade separations.

"Median." The portion of a divided highway or divided entrance separating traffic moving in opposite directions. Medians may be depressed, raised or painted. Openings in the primary highway median to accommodate entrances are governed by the following:

1. New median openings should not be permitted except to accommodate intersecting local public roads or streets or large traffic-generating facilities such as large shopping centers or industrial plants. Median openings may be permitted in these instances if satisfactorily justified and in the public interest.
2. If a median opening exists prior to the construction of a driveway or local public road or street, the opening may be modified to accommodate the turning movements of the traffic expected.
3. Costs incurred for adding or modifying median openings shall not be borne by the department.
4. The department reserves the right to close an existing median opening when the department deems it is necessary.

"Normal peak hour traffic." The highest number of vehicles found to be entering and leaving an entrance during 60 consecutive minutes in a 24-hour period, excluding holidays.

"Pavement." The portion of a roadway used for the movement of vehicles, excluding shoulders.

"Predetermined access location." A location of access reserved for the adjacent property at the time access rights are acquired.

"Primary road" or *"primary highway."* A road or street designated as a "primary road" in accordance with Iowa Code subsection 306.3(6). This definition includes primary road extensions in cities and primary roads under construction.

"Priority I highway." A primary highway constructed as a fully controlled access highway. Permanent access to the facility is allowed only at interchange locations. No permanent at-grade access is allowed.

"Priority II highway." A primary highway constructed as a two-lane or multilane (more than two lanes) facility with a high degree of access control. Access to the facility is allowed only at interchanges and selected at-grade locations.

The minimum allowable spacing between access locations is one-half mile. Limiting primary highway access to existing public road intersections at intervals of one mile is preferable.

"Priority III highway." A primary highway constructed as a two-lane or multilane facility. Access to the facility is allowed at interchanges and at-grade locations.

The minimum allowable spacing between access locations is 1,000 feet. Spacing of one-quarter mile is preferable.

"Priority IV highway." A primary highway constructed as a two-lane facility; however, the definition may include a multilane facility. Priority IV is divided into Priority IV(a) and Priority IV(b).

1. For highways designated as Priority IV(a), the minimum allowable spacing between access locations is 600 feet.
2. For highways designated as Priority IV(b), the minimum allowable spacing between access locations is 300 feet.

"Priority V highway." A primary highway where access rights to it were acquired between 1956 and 1966, entrances were reserved at that time with no spacing limitations, and the department has subsequently determined that a higher degree of access control is desirable. The definition also includes a highway where access rights have not been acquired, but the department anticipates acquiring access rights in the future.

In rural areas, entrances to the highway are generally restricted to one entrance for contiguous highway frontage not exceeding 1,000 feet, two entrances for contiguous highway frontage exceeding 1,000 feet but not exceeding 2,000 feet, and so on.

"Priority VI highway." A primary highway where the acquisition of access rights or additional access rights is not anticipated. This definition may also include a highway where access rights were acquired between 1956 and 1966, entrances were reserved at that time with no spacing limitations, and the department has subsequently determined that restricting access to the facility is no longer necessary.

Access locations are approved based on safety and need.

"Ramp bifurcation." The point where the baseline of the ramp intersects the centerline of the adjacent roadway.

"Recreational trail." A trail established for biking, pedestrian, snowmobiling, cross-country skiing, or equestrian use.

"Right-of-way line." The boundary line between the land acquired for or dedicated to public road use and the adjacent property.

"Roadway." The portion of a highway used for the movement of vehicles, including shoulders and auxiliary lanes. A divided highway has two or more roadways.

"Rural area." An area clearly not meeting the criteria set forth for a built-up or fringe area. Rural area also includes agricultural land within the corporate limits of a city.

"Rural-designed area." An area in which the predominant cross section accommodates surface drainage from the roadway and adjacent terrain via an open ditch.

"Shoulder." The portion of a public road contiguous to the traveled way for the accommodation of disabled vehicles and for emergency use.

"Sight distance." The distance of clear vision along a primary highway in each direction from any given point of access where a vehicle must stop before entering the highway.

1. Sight distance at an access location is measured from the driver's height of eye (3.5 feet) to the height of an approaching vehicle (4.25 feet).

2. An access location should be established where desirable sight distance is available and shall not be authorized in a location providing less than minimum sight distance, as shown below.

POSTED DAYTIME SPEED LIMIT (mph)	DESIRABLE SIGHT DISTANCE (feet)	MINIMUM SIGHT DISTANCE (feet)
70	910	730
65	820	645
60	730	570
55	645	495
50	570	425
45	495	360
40	425	305
35	360	250
30	305	200

3. On a four-lane divided primary highway where access is proposed at a location that will not be served by a median crossover, sight distance is required only in the direction of the flow of traffic.

"Special access connection." An access location authorized to the primary road system in an area where access rights were previously acquired.

"Traveled way." The portion of a roadway used for the movement of vehicles, excluding shoulders and auxiliary lanes.

"Turning lane." An auxiliary lane, including taper areas, primarily used for the deceleration or storage of vehicles leaving the through traffic lanes.

"Urban-designed area." A built-up or fringe area in which the predominant cross section accommodates roadway surface drainage by means of a curbed roadway.

761—112.3(306A) General requirements for control of access.

112.3(1) *Establishment of controlled access highway.* Access locations necessary for free and convenient access that exist at the time a primary highway is established are hereby approved if the department deems they are reasonably located.

112.3(2) *Frontage roads.* If a frontage road is open to public travel, access from the abutting property shall be to the frontage road.

a. Access to frontage roads maintained by the department shall be authorized in accordance with rules 761—112.4(306A), 761—112.8(306A) and 761—112.9(306A).

b. Access to frontage roads maintained by other governmental agencies shall conform to those agencies' access requirements.

112.3(3) *Enforcement of access control.*

a. Fences. The department may construct and maintain fences or other appropriate physical separations within the primary highway right-of-way to effectively enforce and control access to the highway.

b. Unauthorized construction or modification of entrances. If an entrance is constructed or altered without the approval of the department or if the work is not completed in conformity with an approved permit or agreement, the department may notify the owner by certified mail of the violation and the need to restore the area to the standards which existed immediately prior to construction or alteration or advise of the changes necessary to conform. If after 20 days the changes have not been made, the department may make the necessary changes and immediately send a statement of the cost to the property owner. If within 30 days after sending the statement the cost is not paid, the department may institute proceedings in the district court system to collect the cost.

c. Written permission—right to inspect. A person must have written permission from the department via the specified permit or agreement before the person may construct or alter an entrance.

(1) The department reserves the right to inspect and approve any work performed within the right-of-way.

(2) If the work is not performed as required by the permit or agreement, the department may revoke its permission and deny access until the conditions are corrected.

(3) If the work performed does not conform to the department's specifications, the department may make the necessary changes, charge the costs to the party responsible and pursue other available remedies.

112.3(4) *Maintenance of entrances.*

a. Property owners having access to a primary highway are responsible for the maintenance of their entrances as follows:

(1) For an entrance that does not have a paved surface, the property owner is responsible for maintaining the entrance from the outer shoulder line of the primary highway to the right-of-way line.

(2) For an entrance that has a paved surface, the property owner is responsible for maintaining the entrance from the paved edge of the primary highway to the right-of-way line.

b. Drainage structures located within the primary highway right-of-way shall be maintained by the department except for concrete box culverts and bridges constructed by a permit holder under authority of an entrance permit. These structures shall be maintained by the permit holder.

761—112.4(306A) General requirements for entrances where access rights have not been acquired. This rule establishes the general requirements for access to primary highways where access rights have not been acquired.

112.4(1) *Entrance permit.* A person shall not modify an existing entrance or construct a new entrance to a primary highway from abutting property or from a local public road or street until the department has issued an entrance permit for the work.

a. An application for an entrance permit shall be submitted to the appropriate district representative on a form prescribed by the department.

b. The department shall be provided with a plan, drawing or sketch of the property or site to be served by the requested access. This may vary from a simple sketch in the case of a Type "C" entrance to a detailed plan in the case of a Type "A" entrance. See rule 761—112.5(306A) for further Type "A" entrance requirements.

c. The application shall be signed by the owner or owners of record. The signature(s) shall be notarized.

d. If the request is for a property within the corporate limits of a city, an authorized representative of the city must sign the application recommending approval. See subrule 112.4(5).

e. The application shall be approved or denied by the appropriate district representative.

f. If the district representative denies the application, the applicant may appeal the decision by submitting to the appropriate district engineer the application along with background information and an explanation of the need for access.

g. If the district engineer denies the application, the applicant may appeal the decision by submitting to the director of transportation the application along with background information and an explanation of the need for access. The director's decision is final agency action.

112.4(2) *Construction or modification of entrances.*

a. All work performed on a primary highway under the terms of an entrance permit shall comply with the conditions of the permit. These conditions include any accompanying plans, drawings, sketches, or other attachments to the permit. The permit holder or the permit holder's contractor shall have a copy of the permit available at the work site.

b. During the time an entrance is being constructed or modified, care must be taken to ensure the safety of the workers on the site and of the traveling public. The work shall be accomplished in a manner that will minimize interference with normal highway operations. Care must be taken during construction or modification of the entrance and development of the abutting property to avoid tracking mud or other material onto the primary highway.

112.4(3) *Construction costs.* Construction costs, including any costs incurred for modifying the existing primary highway as may be required by the entrance permit, should not be borne by the department.

112.4(4) *Maintenance of entrances.* See subrule 112.3(4).

112.4(5) *Primary road extensions.*

a. On primary road extensions, the location and geometrics of entrances must meet local requirements within the limitations of this chapter, and entrance permit applications must be approved by authorized city officials before final action is taken by the department.

b. Applicants are responsible for ensuring compliance with local building codes, setback requirements, minimum lot sizes, density of buildings, provisions for adequate parking, and other local ordinances and regulations.

c. Entrance permits issued by the department apply to the construction of entrances within the primary highway right-of-way and do not release applicants from compliance with local ordinances and regulations. These requirements are not altered by the issuance of entrance permits. Applicants are responsible for obtaining the required local approvals and permits.

d. Without an approved permit, there shall be no encroachment onto the primary highway right-of-way.

112.4(6) *Considerations for entrance width and radius or flared returns.*

a. Entrance width and the size of radius or flared returns should be determined based on the predominant type of vehicle that will use the entrance. The combination of entrance width and return radii or flares should permit vehicles to enter and exit the highway with minimum disruption to through traffic, yet be restrictive enough to discourage erratic maneuvers.

b. Entrance width should minimize speed differential, which is the difference between the speed of through traffic and the speed of vehicles that are turning into the entrance. In general, the narrower the entrance, the more vehicles must slow down to negotiate the entrance. An increase in speed differential increases the tendency for potential crashes. Use of larger turning radii or flares will reduce speed differential.

c. An entrance can also be too wide. An entrance that is too wide may confuse motorists by creating uncertainty as to where they should position their vehicles within the entrance. Pedestrian traffic must also be considered. Wider entrances may place pedestrians in greater conflict with vehicular traffic.

112.4(7) *Entrance widths.* The width of an entrance is the distance between the beginning points of the return radii or flares, measured perpendicular to the centerline of the entrance.

a. Type "A" entrances. Each case requires special study. See rule 761—112.5(306A).

b. Type "B" entrances.

(1) The minimum allowable width is 24 feet.

(2) The maximum allowable width is 45 feet.

(3) For one-way operation, the minimum allowable width is 12 feet and the maximum allowable width is 30 feet.

c. Type "C" entrances.

(1) The minimum allowable entrance width is 20 feet. In an area where the posted speed limit is 35 miles per hour or less, a minimum width of 15 feet may be allowed.

(2) The maximum allowable width is 30 feet.

(3) If an entrance will serve more than one property, the minimum allowable width is 20 feet and the maximum allowable width is 35 feet.

d. City street and secondary road intersections. The department shall determine the width of city street and secondary road intersections on a case-by-case basis, taking into consideration both local and department standards.

112.4(8) *Radius or flared returns.* Return radii for granular entrances shall be measured along the edge of the primary highway shoulder. Return radii for paved entrances shall be measured along the edge of the primary highway pavement.

If the predominant types of vehicles that will use an entrance are passenger cars and straight trucks, paragraphs *"a"* to *"i"* of this subrule apply. If the predominant types are truck tractor-semitrailer combinations and large equipment, paragraph *"j"* applies.

a. Type "A" entrances. Each case requires special study. See rule 761—112.5(306A).

b. Type "B" entrances, rural-designed area, not paved.

(1) For an entrance angle of 90 degrees to the centerline of the primary highway, the return radii should not exceed 35 feet.

(2) For an entrance angle of 60 degrees to the centerline of the primary highway, the return radius of the obtuse angle should not exceed 50 feet. The return radius of the acute angle should not exceed 25 feet.

(3) For an entrance angle that is between 90 and 60 degrees, the maximum radii of the obtuse and acute angles should be interpolated between the values given in subparagraphs (1) and (2) above and rounded to the nearest 5 feet.

(4) Entrance angles that are less than 60 degrees require department review to establish appropriate radii.

c. Type "B" entrances, rural-designed area, paved.

(1) For an entrance angle of 90 degrees to the centerline of the primary highway, the return radii should not exceed 50 feet.

(2) For an entrance angle of 60 degrees to the centerline of the primary highway, the return radius of the obtuse angle should not exceed 60 feet. The return radius of the acute angle should not exceed 25 feet.

(3) For an entrance angle that is between 90 and 60 degrees, the maximum radii of the obtuse and acute angles should be interpolated between the values given in subparagraphs (1) and (2) above and rounded to the nearest 5 feet.

(4) Entrance angles that are less than 60 degrees require department review to establish appropriate radii.

d. Type "B" entrances, urban-designed area, paved or not paved.

(1) All Type "B" entrances within an urban-designed area should be paved for a minimum distance of 10 feet back from the primary highway curb, as measured 90 degrees to the edge of the primary highway roadway.

(2) The return radii should be no less than 10 feet nor greater than 20 feet.

e. Rescinded IAB 10/30/02, effective 12/4/02.

f. Type "C" entrances, rural-designed area, not paved.

(1) For an entrance angle of 60 to 90 degrees to the centerline of the primary highway, the return radii should not exceed 15 feet for either the obtuse or acute angle.

(2) Entrance angles that are less than 60 degrees require department review to establish appropriate radii.

g. Type "C" entrances, rural-designed area, paved.

(1) For an entrance angle of 60 to 90 degrees to the centerline of the primary highway, the return radii should not exceed 20 feet.

(2) Entrance angles that are less than 60 degrees require department review to establish appropriate radii.

(3) If an existing entrance is being reconstructed, the returns may be replaced in kind.

h. Type "C" entrances, urban-designed area, paved or not paved.

(1) All Type "C" entrances within an urban-designed area should be paved for a minimum distance of 10 feet back from the primary highway curb, as measured 90 degrees to the edge of the primary highway roadway.

(2) The return radii should equal the distance between the back of the curb and the front edge of the sidewalk, not to exceed 10 feet.

(3) When no sidewalk is present or anticipated, the maximum radii should be 10 feet.

i. Flared entrances, urban-designed area. In an urban-designed area, entrances may be constructed with flared returns rather than radius returns. When used, the flare shall be constructed at a 2:1 ratio with the "2" value measured on a line parallel to the entrance centerline and the "1" value measured on a line perpendicular to the entrance centerline. The length of the flare as measured parallel to the entrance centerline should be equal to the radii requirements shown in paragraphs 112.4(8)*"d"* and *"h"* above.

j. Truck tractor-semitrailer combinations. Truck tractor-semitrailer combinations and large equipment vary greatly in length and generally require a customized design for the entrance. Flares will generally not accommodate the movement of these types of vehicles and therefore should not be used. To reduce encroachments onto the traveled way and opposing entrances, turning templates should be used. All turning movements should be evaluated to ensure the entrance width and radii are designed to handle the types and volume of traffic anticipated.

112.4(9) *Entrance angle.*

a. In general, the entrance angle shall be established as near to 90 degrees to the centerline of the primary highway as site conditions will allow.

b. Normally, the centerline of that part of an entrance lying within the right-of-way shall be at a right angle to the centerline of the primary highway for a minimum distance of 30 feet from the near edge of the primary highway pavement.

c. An entrance established for two-way operation for a service station or other development where two access points are authorized shall be 70 to 90 degrees to the centerline of the primary highway.

d. On a divided primary highway where two access locations are authorized for one-way operation, the "ingress" may be 45 to 60 degrees to the centerline of the primary highway and the "egress" may be 60 to 90 degrees to centerline of the primary highway.

112.4(10) *Slope and cross section of entrances in rural-designed area.*

a. The finished, surface elevation of an entrance over a culvert, or the location where a culvert would normally be placed, should be lower than the primary highway pavement, preferably an extension of the 4 percent shoulder grade, to prevent surface water from draining onto the highway pavement. The shoulder grade should be extended onto the entrance at a distance sufficient to provide a safe platform for a vehicle to stop before entering the highway.

b. If an entrance requires drainage pipe, the entrance side slopes from highway shoulder to the entrance pipe shall be no steeper than 8:1 and from the entrance pipe to the right-of-way line shall be no steeper than 6:1. A smooth transition from the 8:1 to the 6:1 slope is required.

c. If an entrance does not require drainage pipe, the entrance side slopes from highway shoulder to the minimum clear zone distance shall be no steeper than 10:1, right-of-way width permitting. From the point of minimum clear zone to the right-of-way line, a smooth transition to a 6:1 slope is acceptable.

d. Upgrading only the surfacing material of an existing entrance will not require a change in existing side slopes.

112.4(11) *Entrance grade.* The grade of an entrance is an important element when considering overall motorist safety because the grade impacts speed differential. Vehicles must slow appreciably to turn into an entrance; therefore, the steeper the entrance grade, the greater the reduction in speed required to prevent "bottoming out." Ideally, the maximum practical grade for entrances varies from 8

to 14 percent for low-volume entrances to approximately 5 percent for high-volume entrances. Above these values, bumpers and other low-hanging parts of a vehicle will scrape the entrance.

An entrance's vertical profile should allow for a smooth transition to and from the highway. Flattening entrance grade lines is another tool in providing safe access to and from the highway system.

761—112.5(306A) Additional requirements for Type "A" entrances. This rule establishes additional requirements for Type "A" entrances serving commercial, industrial or residential developments.

112.5(1) *General.*

a. The most important factors in developing an access plan for a commercial, industrial or residential development are a determination of the potential traffic generated by the site and a determination of the directional distribution of site-generated traffic on the major approach routes and proposed entrances serving the site. Entrances serving the site represent an important element in the efficiency and safety of the highway handling the site-generated traffic. To properly handle traffic from these entrances, the anticipated traffic volumes must be determined by the applicant and submitted to the department.

b. The location of entrances, particularly commercial entrances, is a critical factor in minimizing disruption to traffic and pedestrians. A site should be developed with an internal circulation pattern for traffic movements so that access to the site may be gained by a free flow of traffic from the primary road system. Parking stalls and pedestrian movements should be located away from the main entrance to the facility.

c. Adequate storage for vehicles must be provided on commercial and industrial sites so that vehicles do not wait on the highway to enter. Adequate storage space is a function of the demand volume, the service time per facility, and the number of service facilities available. Service time is dependent upon the time required to maneuver into position and the time needed to obtain the service. The geometrics of the internal circulation pattern control a portion of the service time. The radii of internal curves should be as large as possible. Buildings on a site should be arranged to allow for the maximum storage available on the site for exiting traffic and situated so that they will not disrupt the free flow of entering traffic.

d. A service station site should be designed to provide a minimum distance of 15 feet from the right-of-way line to the near edge of the pump island. No portion of the highway right-of-way shall be used for servicing vehicles.

e. When property is being developed, consideration must be given to locating the access directly opposite an existing commercial entrance or street intersection.

f. Comments from local authorities regarding the proposed development should be included in the application to allow the department to incorporate the input of local authorities into the final design of the entrance location. This input should refer to the zoning plan, land use plan, or metrotransportation plan.

112.5(2) *Type "A" access requests.*

a. Application for entrance permit. An entrance permit application for a Type "A" entrance shall, when relevant to the proposed development, include the following data in detail:

(1) Type and location of the proposed development.

(2) Site plan.

(3) Location of all proposed entrances, turning lanes on adjacent highways or streets, and internal traffic lanes and parking facilities within the development area. This information shall be sufficiently complete to allow determination of dimensions, the direction of traffic flow, and restrictions to traffic caused by plantings, curbing, medians, walls, signing, etc.

(4) Detailed design of proposed highway pavement widenings, additional lane provisions, relocations, and other highway improvements considered necessary to the efficient operation of the proposed development.

(5) Signal warrant analysis and application to construct a traffic control device, when required. See paragraphs *"b"* and *"c"* of this subrule.

(6) Preliminary drainage data.

(7) Gross leasable floor area in square feet.

(8) Number of parking spaces.

(9) Anticipated total daily trips inbound and outbound during an average 24-hour period for total site development. Special holiday shopping traffic shall not be used for this estimate.

(10) Estimated traffic volumes arriving and departing during the normal peak hour.

(11) Estimated distribution of traffic via individual entrances for the normal peak hour.

(12) Estimated distribution of traffic by percentage of total daily trips via major highways from origin to the development.

b. Signal warrant analysis. The applicant must submit to the department a signal warrant analysis for all multimovement access points within the study area for the proposed development. The purpose of the analysis is to determine if traffic signals are warranted. The analysis should also evaluate the feasibility of coordinating any proposed traffic signals with existing traffic signals in the study area to achieve the desired traffic progression. The department may require a proposed entrance to be redesigned or relocated if the proposed entrance meets signal warrant thresholds but does not meet other standards in these rules.

c. Application to construct a traffic control device. The applicant shall submit for department approval an application to construct a traffic control device if an existing traffic signal will be modified or a new traffic signal will be installed.

112.5(3) *Agreement supplementary to permit.*

a. A major development often involves a variety of special access requirements. In addition to the entrance permit, an agreement between the department, the local governmental unit and the applicant may be required to fit the particular situation, listing in detail the responsibilities of each party.

b. Upon receipt of the agreement, the applicant shall be responsible for obtaining the necessary signature approvals including those of appropriate local authorities and returning the agreement to the appropriate district representative.

c. The department shall notify the applicant when it has approved or denied the agreement. No work shall be done within the primary highway right-of-way until the department approves the agreement. Any work completed without the prior approval of the department is a violation of Iowa Code section 319.14.

112.5(4) *Primary highway improvements.* The cost of primary highway improvements needed to handle the volume of traffic generated by the development should not be the responsibility of the department.

761—112.6(306A) Drainage requirements. This rule establishes drainage requirements for all locations where access is requested to the primary highway system.

112.6(1) Entrances must be constructed so that they do not adversely affect primary highway drainage or drainage of the adjacent property. The drainage and the stability of the highway subgrade must not be impaired by driveway construction or roadside development. Construction of an entrance shall not cause water to flow across the primary highway pavement or to pond on the shoulders or in the ditch, or result in erosion within the primary highway right-of-way limits.

112.6(2) Drainage collected by ditches, gutters or pipes on private property shall not be discharged into the primary highway drainage system unless expressly approved by the department. An applicant may be required to submit a drainage study to the department that justifies the drainage system proposed and the pipe or sewer sizes to be used. The applicant shall not interfere with the natural course of drainage.

112.6(3) When the construction of an entrance necessitates crossing a highway ditch that has been constructed to carry drainage, a drainage structure shall be installed in the ditch by the applicant at the applicant's expense. The low point of the ditch shall dictate the location for culvert placement unless otherwise specified by the department. Under no circumstances shall existing ditches or gutters be filled without adequate alternate provisions for drainage.

a. The department's engineering staff will assist in determining the size and length of culverts and aprons. A culvert shall be of adequate size to handle drainage, but in most situations the culvert shall not be less than 18 inches in diameter. Where shallow ditches exist, the department may approve

small arched culverts or culvert sizes less than 18 inches in diameter. Culvert pipe shall comply with departmental standard specifications as they exist at the time of installation.

b. Length of culvert pipe shall be sufficient to accommodate the entrance slopes. The finished surface elevation of an entrance over a culvert pipe, or the location where a culvert would normally be placed, should be sloped away from the primary highway pavement, preferably an extension of the 4 percent shoulder slope, to prevent surface water from draining onto the highway pavement.

c. Drainage structures located within the primary highway right-of-way shall be maintained by the department except for concrete box culverts and bridges constructed by a permit holder under authority of an entrance permit. These structures shall be maintained by the permit holder.

112.6(4) Where drainage is carried along an existing curb, the entrance shall be constructed with a rise in elevation of at least 6 inches from the street gutter at the entrance to a point 6 feet behind the gutter to prevent runoff from spilling onto private property. The flow line of the gutter through the entrance shall be restored.

761—112.7(306A) Access to Priority I, II, III and IV highways. Access rights are acquired on Priority I, II, III and IV highways. See rules 761—112.11(306A) and 761—112.12(306A). After access rights are acquired, additional access may be allowed as follows:

112.7(1) *Priority I highway.* The department may allow a temporary at-grade access in emergency situations or for construction or maintenance purposes. Temporary access to the interstate highway system requires the concurrence of the Federal Highway Administration. See subrule 112.13(4).

112.7(2) *Priority II, III and IV highways.* An additional entrance to a property from which access rights have been acquired may be permitted only as a special access connection. See rule 761—112.13(306A). This includes a temporary at-grade access for emergency situations or for construction or maintenance purposes. See subrule 112.13(4).

761—112.8(306A) Access to Priority V highways, rural areas. This rule establishes requirements for access to Priority V highways in rural areas.

112.8(1) *General.* Where access rights have not been acquired, access is generally limited to one entrance for contiguous highway frontage not exceeding 1,000 feet, two entrances for contiguous highway frontage exceeding 1,000 feet but not exceeding 2,000 feet, and so on. Ownership on each side of the highway shall be considered as separate ownership. Except for the above-stated restrictions and those contained in subrules 112.8(2) and 112.8(3), no spacing restrictions shall be imposed. Additional entrances may be permitted when a single entrance will not provide adequate access due to topographic conditions or when additional entrances will comply with future construction plans for the roadway and the access priority classification to be applied.

112.8(2) *Access requirements near public road intersections.*

a. A property abutting a primary road and a local public road or another primary road may be granted access to the primary road at a distance generally no less than 300 feet from the intersection of the centerlines of the two roads.

b. At a "T" type intersection, access to the primary road may be located directly opposite the intersection.

c. Access shall not be permitted onto a local public road within the primary road right-of-way limits. The centerline of an access onto a local public road should be no closer than 150 feet to the near edge of the primary highway traveled way.

112.8(3) *Property lines.* The centerline of an entrance to the primary roadway should be no closer than 50 feet to the property line as extended to intersect the roadway centerline at a right angle. No portion of an entrance located within the right-of-way should extend beyond the property line as extended. If an entrance does extend onto an adjoining property within the right-of-way, the applicant should contact that property owner to request the property owner's concurrence or to suggest a joint entrance. An entrance that will serve two properties abutting the primary road may be centered on the property line by mutual agreement between the property owners.

761—112.9(306A) Access to Priority V highways, fringe or built-up areas, and Priority VI highways, all areas. This rule establishes requirements for access to Priority V highways in fringe or built-up areas, and access to Priority VI highways in rural, fringe, or built-up areas.

112.9(1) *General.* Property frontage may be granted access where needed to the primary road, provided safety and construction standards are satisfactory. In a rural area, a minimum distance of 30 feet between toes of slopes along the centerline of the ditch shall be maintained. In a fringe or built-up area, there shall be a minimum of 15 feet of curb maintained between near edges of curb drops when more than one access is allowed to a single highway frontage. If the property is within corporate limits, city requirements apply if they are more restrictive.

112.9(2) *Access requirements near public road intersections.*

a. Rural area. Same as subrule 112.8(2).

b. Fringe or built-up area.

(1) The beginning of the curb drop for an entrance to a primary highway shall be no closer than 15 feet to an intersecting street's curb tangent point. No portion of the entrance along the primary highway should extend beyond the property line as extended or into a crosswalk.

(2) The beginning of the curb drop for an entrance to a street should be no closer than 15 feet to an intersecting primary highway's curb tangent point. No portion of the entrance along the street should extend beyond the property line as extended or into a crosswalk.

(3) If an intersection does not have an existing or a planned curb and gutter to define the radius, the following assumptions shall be applied to the above requirements for determining the location of an entrance:

Minimum width of the traveled way of the primary highway is assumed to be 53 feet back to back of curbs.

However, if the platted width of the primary highway right-of-way is less than 66 feet, the width of the traveled way is assumed to be 75 percent of the platted width.

Minimum width of the traveled way of an intersecting local public road or street is assumed to be 31 feet back to back of curbs.

112.9(3) *Channelized intersection or divided highway.* When there is a median in a primary road or intersecting street, or both, the curb drop for an entrance to the primary road or intersecting street shall be determined as stated in subrule 112.9(2), except that at the beginning or end of the median, or at a median break, the nearest edge of the curb drop for the entrance shall be no closer than 20 feet to the end of the median as measured at a right angle to the median. This does not apply to access centered on a median break.

112.9(4) *Median openings.*

a. When a divided primary highway has been constructed with a median, crossovers or median breaks shall not be permitted if there are frequent openings for local street intersections or traffic conditions do not make median breaks advisable. The layout of entrances to adjacent properties along the primary highway shall be designed to take advantage of existing or planned median crossovers.

b. When a crossover or median break is deemed necessary by the department as a result of traffic generated by a business or other development, the required improvements shall be constructed by the property owner as a part of a permit process. The department shall bear no part of the construction costs.

c. The permit authorizing a new crossover shall specify the exact location, design, and construction requirements. Any drainage facilities required by the construction shall be installed by the permit holder at the permit holder's expense.

d. The minimum width of a new median crossover is 40 feet. In a rural-designed area, the width of a median crossover shall be measured at the normal culvert line. In an urban-designed area, the width of a median crossover shall be measured parallel to the highway centerline between the curbed noses of the median.

e. Upon completion of construction of the improvements as provided by this subrule, the department shall assume ownership of the improvements and shall be responsible for their future maintenance.

112.9(5) *Property lines.*

a. Rural area. Same as subrule 112.8(3).

b. Fringe or built-up area. The beginning of an entrance radius return or flare shall be no closer than 1 foot to the property line as extended on an interior lot line to intersect the primary road centerline at a right angle. An entrance to serve two properties abutting the primary road may be centered on the property line by mutual agreement between the property owners.

761—112.10 Reserved.

761—112.11(306A) Policy on acquisition of access rights.

112.11(1) *General.* It is necessary that every effort be made to preserve the public investment in the primary highway system. Where efficiency of traffic movement is desired, this investment is preserved by acquiring the adjacent property's access rights and limiting or prohibiting direct access to the primary highway. This provides a safer environment for the highway user, increases the free and efficient movement of through traffic, and reduces highway accidents by minimizing the number of conflict points or entrances located along the highway.

112.11(2) *Project development.* During the initial stages of project development for a highway improvement project, the department shall determine if access rights to the primary highway will be acquired and the applicable access priority classification to be applied.

The department shall consider average daily traffic, proposed design features of the facility, terrain, the function of the particular section in relation to the total highway system, the commercial/industrial network of highways, service level, continuity of the system and sound engineering judgment.

112.11(3) *Access rights at at-grade intersections with city streets and secondary roads.* When access rights to a primary highway are acquired, the department may also acquire access rights along a city street or secondary road where an at-grade intersection with the highway exists or is proposed. If access rights are acquired, they will be acquired along the city street or secondary road for a distance of 150 feet from the near edge of the primary highway traveled way. However, the department may acquire more or less than 150 feet of access rights after considering the severity of damage to adjacent properties and traffic volumes and other safety factors.

112.11(4) *Access rights at at-grade primary intersections.*

a. When access rights to a primary highway in a rural area are acquired, the department may also acquire access rights along an intersecting at-grade primary highway for a minimum distance from the intersection of the centerlines of the two primary highways as follows:

1. 150 feet when the intersecting primary highway carries less than 2,500 vehicles per day.
2. 300 feet when the intersecting primary highway carries 2,500 or more vehicles per day.

However, the department may acquire more or less than the specified access rights after considering the severity of damage to adjacent properties and traffic volumes and other safety factors.

b. If the intersection is channelized, access rights shall be acquired and no access shall be permitted along the channelized primary highway for a minimum distance of 100 feet beyond the beginning or end of the median. For the purpose of access control, the beginning or end of a median is the point where the distance between the edges of the opposing traveled lanes is 4 feet.

112.11(5) *Access rights along intersecting roadways at interchanges.*

a. When an interchange is constructed on a primary road, the department shall acquire access rights along the public road or street intersecting the primary road. Once access rights are acquired, no access is allowed. The following are the minimum distances where access rights shall be acquired along the intersecting public road or street; in each case, the greater distance shall prevail.

1. 600 feet from the point of ramp bifurcation in a rural or fringe area.
2. 300 feet desired, 150 feet minimum, from the point of ramp bifurcation in a built-up area.
3. 150 feet from the beginning of a deceleration lane or taper.
4. 100 feet from the beginning or end of a median.

However, the department may acquire more or less than the specified access rights after considering the severity of damage to adjacent properties and traffic volumes and other safety factors.

b. When an interchange is constructed as a half-diamond or partial cloverleaf, the department may permit an access directly opposite a ramp connection to the primary road.

112.11(6) *Agreement with city or county.* When access rights are acquired along a city street or secondary road, the department shall negotiate an agreement with the city or county which states that access rights shall be acquired by the department in the state's name or in the name of the city or county and that the city or county shall not permit any third party to use the controlled portion of the street or road without the prior written consent of the department.

761—112.12(306A) Policy on location of predetermined access locations.

112.12(1) *General.* At the time access rights are acquired, existing entrances shall be removed or relocated to connect to predetermined access locations. These locations shall thereafter be defined as the adjacent properties' access locations.

a. The department is responsible for the construction of entrances at predetermined access locations, either as a part of the project or at a future date when requested by the property owners. Entrances not constructed as a part of the project will be designated on the construction plans as predetermined access locations that are reserved for the property.

b. Any alteration or relocation of an access location requires the written approval of the department, and the property owner is responsible for all costs incurred. See subrule 112.12(5), revision of access.

112.12(2) *Establishing predetermined access locations.* The department realizes that these rules cannot reasonably be expected to address every situation or issue that may arise when developing plans for a proposed highway improvement project. It is foreseeable that not all access locations will comply strictly with the required or recommended spacing standards set out in these rules; however, all reasonable efforts shall be made to establish predetermined access locations that meet these spacing standards.

a. The department shall establish predetermined access locations by considering the following:

(1) Zoning and intended land use, as reviewed with city and county officials.

(2) Potential adverse impacts on adjacent property if spacing standards are applied strictly, such as but not limited to an unreasonable restriction on the property due to a unique physical situation that cannot be remedied or an unreasonable damage to the property.

(3) Environmental, social, or economic constraints that prevent the application of spacing standards.

(4) Federal, state, or local standards that conflict with these rules and take precedence.

(5) Sound engineering judgment consistent with the goals of the department.

b. When establishing predetermined access locations, the department may conduct a field examination, giving consideration to information received from city and county officials, sight distance availability, natural barriers, property ownership, proposed roadway design, and development of future frontage roads.

c. A predetermined access location that does not meet required spacing standards is not a waiver or variance of these rules if justification for the access location is based on one or more of the considerations listed in paragraph *"a"* of this subrule. The final access review letter must include this justification.

112.12(3) *Spacing.* Spacing between predetermined access locations shall conform to the following requirements:

a. Priority I highway. Access is allowed only at interchange locations.

b. Priority II highway. One mile is desirable. One-half mile is the minimum.

c. Priority III highway. One-quarter mile is desirable. 1,000 feet is the minimum.

d. Priority IV highway.

(1) Priority IV(a). 600 feet is the minimum.

(2) Priority IV(b). 300 feet is the minimum.

112.12(4) *Entrances constructed after project completion.* After completion of a highway project, a property owner may request the department to construct an entrance at a predetermined access location. Unless otherwise specified in the right-of-way acquisition contract or in the condemnation documents:

a. The department is responsible for constructing, at the department's expense, a granular-surfaced entrance that does not exceed the maximum width for a Type "C" entrance.

b. The department may approve modifications, such as widening or paving the entrance. In this instance, the property owner is responsible for constructing the entrance. After the property owner has constructed the entrance, the department will compensate the property owner for the cost of constructing a granular-surfaced Type "C" entrance. The property owner is responsible for the remainder of the costs.

112.12(5) *Revision of access.* After an entrance has been constructed at a predetermined access location, no change in entrance type or location may be made unless a revision of access has been approved by the department. The property owner is responsible for the cost of altering or relocating the entrance.

a. A request for revision of access shall be submitted by the property owner to the appropriate district representative upon the prescribed application form furnished by the department.

b. The application shall be approved or denied by the department's access policy administrator.

c. If the access policy administrator denies the application, the applicant may appeal the decision by submitting to the appropriate district engineer the application along with background information and an explanation of the need for access.

d. If the district engineer denies the application, the applicant may appeal the decision by submitting to the director of transportation the application along with background information and an explanation of the need for access. The director's decision is final agency action.

761—112.13(306A) Policy on special access connections where access rights have been previously acquired.

112.13(1) *General.* An additional entrance to a property from which access rights have been previously acquired may be permitted only as a special access connection.

a. An applicant for a special access connection should be aware the state of Iowa has previously acquired the rights of direct access to the primary highway from the applicant's highway frontage and, therefore, the applicant has no remaining right of additional direct access to the highway.

This acquisition of access rights is recorded in the local county courthouse and is a restriction placed upon the property.

b. The department realizes there may be locations where granting an entrance within an area where access rights were previously acquired may be consistent with the department's current rules.

In these special cases, the department may authorize a special access connection upon such terms and conditions as may be determined by the department.

c. In an area where access rights were acquired after July 1, 1966, an applicant may be required to reimburse the state for the increase in land value resulting from the new connection, as determined by a department appraisal.

112.13(2) *Application.*

a. A request for the establishment of a special access connection shall be submitted by the property owner to the appropriate district representative upon the prescribed application form furnished by the department.

b. The application shall be approved or denied by the department's access policy administrator.

c. If the access policy administrator denies the application, the applicant may appeal the decision by submitting to the appropriate district engineer the application along with background information and an explanation of the need for access.

d. If the district engineer denies the application, the applicant may appeal the decision by submitting to the director of transportation the application along with background information and an explanation of the need for access. The director's decision is final agency action.

112.13(3) *Requirements.*

a. Whenever possible, a special access connection should be established as a joint access location to serve more than one property ownership.

b. A special access connection is a special permit for access and is not a permanent right of access to the highway.

c. The property owner is responsible for all costs incurred for the construction of the approved connection, including any required drainage structure.

d. A special access connection shall be recorded by the department in the county recorder's office and will be a restriction placed upon the property. All provisions of the special access connection shall be binding on successors or assigns of the applicant property owner.

e. Special access connections shall be constructed in compliance with rules 761—112.4(306A), 761—112.5(306A) and 761—112.6(306A).

f. The department shall approve spacing for special access connections in accordance with subrules 112.12(2) and 112.12(3).

112.13(4) *Temporary access.*

a. The department realizes temporary access may be needed in emergency situations or for highway construction or maintenance purposes. In these cases, a temporary connection may be allowed, but is subject to special stipulations as may be determined by the department.

b. Temporary access shall be authorized for a determinable period of time. The access need not comply with paragraph 112.13(3)*"a"* (joint access) or 112.13(3)*"f"* (spacing). The applicant is responsible for all costs incurred, including removal of the access and restoration of the right-of-way.

c. The granting of temporary access to the interstate highway system requires the concurrence of the Federal Highway Administration.

d. A separate application for temporary access is not needed if the temporary access is for a construction or maintenance project, it is shown on the original plan, and it has been approved previously by the department and, when required, the Federal Highway Administration.

761—112.14(306A) Recreational trail connections. This rule establishes requirements for access to the primary road system from recreational trails.

112.14(1) *General.*

a. No access to a Priority I highway from a recreational trail is allowed.

b. Reserved.

112.14(2) *Application.*

a. An application for access to a Priority II, III, or IV highway shall be submitted and processed in accordance with subrule 112.13(2).

b. An application for access to a Priority V or VI highway shall be submitted and processed in accordance with subrule 112.4(1).

c. The applicant shall submit with the application a detailed plan sufficient for departmental review. The plan shall include an appropriate recreational trail signing layout.

d. The applicant may contact the appropriate district representative for assistance in preparing the application.

112.14(3) *Requirements.*

a. Spacing.

(1) Spacing for a Priority II, III, or IV highway shall conform to subrule 112.12(3). It is preferable that an entrance provide access to adjacent properties as well as to the recreational trail.

(2) Spacing for a Priority V or VI highway shall conform to rule 761—112.8(306A) or 761—112.9(306A) as applicable.

b. Sight distance. Sight distance for a recreational trail connection shall conform to the desirable sight distance as listed in rule 761—112.2(306A).

c. Entrance width and radius return. The entrance width and radius return of a recreational trail connection shall conform to the design standards adopted for the Statewide Iowa Trails Plan.

d. Entrance angle. The entrance angle for a recreational trail connection shall be established as near to 90 degrees to the centerline of the primary highway as site conditions will allow.

e. Slope and cross section. The slope and cross section of a recreational trail connection shall conform to subrule 112.4(10).

f. Drainage. Drainage for a recreational trail connection shall conform to rule 761—112.6(306A).

g. Construction. The permit holder shall be responsible for constructing the recreational trail connection in compliance with the approved permit and at no cost to the department. The department reserves the right to inspect any work performed within the primary highway right-of-way. See subrule 112.3(3).

h. Maintenance. Maintenance responsibilities shall conform to subrule 112.3(4).

These rules are intended to implement Iowa Code sections 306.19, 306A.1 to 306A.8, and 319.14.

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CHAPTER 115
UTILITY ACCOMMODATION

[Prior to 6/3/87, Transportation Department[820]—(06,D) Ch 1]

761—115.1(306A) General information.

115.1(1) *Scope of chapter.* This chapter covers initial placement, adjustment and maintenance of utility facilities in, on, above or below the right-of-way of primary highways, including attachments to primary highway structures. It embodies the basic specifications and standards needed to ensure the safety of the highway user and the integrity of the highway.

115.1(2) *Information and forms.* Information and forms regarding this chapter may be obtained from any of the department's six district offices; the Office of Traffic and Safety, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; or the Internet Web site: http://www.iowadot.gov/traffic/index.htm.

115.1(3) *Considerations.* If the department determines that the literal application of these rules to a specific situation will create or result in an unsafe situation or an unreasonable design, the department shall use sound engineering practices to determine the appropriate design for the specific situation. The appropriate district office shall include justification for the design in the permit or the highway project file, as applicable. The appropriate design shall address:

a. Safety of motorists, pedestrians, construction workers and other highway users.

b. Integrity of the highway.

c. Protection of the rights of the traveling public and of property owners, including the rights of abutting property owners.

d. Topography and geometric limitations and constraints affecting typical engineering standards.

115.1(4) *Permit approval process.*

a. A district representative may, in response to an application for a utility accommodation on the primary highway system grant approval for a utility permit. The process for inquiring about and applying for a utility accommodation on the primary highway system is through one of the department's six district offices. All applications for utility permits must be applied for in the particular district where the utility accommodation is proposed. A district representative will do one of the following: approve the application for a utility permit, approve the application for a utility permit with conditions, or deny the application for a utility permit. The district representative may use the considerations set forth in subrule 115.1(3) in making the decision. The district representative shall notify the applicant of the determination in writing.

b. Upon receipt of a denial letter or if the permit was approved with conditions, the applicant may choose to pursue a waiver from the director of transportation, pursuant to subrule 115.1(5).

115.1(5) *Waivers.* The director of transportation may, in response to a written petition, waive provisions of this chapter in accordance with 761—Chapter 11. The written petition must contain the information as required in 761—subrule 11.5(2) and shall be submitted to the Office of Policy and Legislative Services, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

115.1(6) *Additional requirement for waivers involving interstate highways.* The director of transportation shall not waive these rules in utility accommodation and adjustment situations involving the interstate highway system, including its ramps, without the approval of the Federal Highway Administration.

[**ARC 9873B**, IAB 11/30/11, effective 1/4/12]

761—115.2(306A) Definitions.

"Adjustment" means a physical change to an existing utility facility including improvement, rearrangement, reinstallation, protection, relocation or removal of the utility facility.

"Agreement" means a contract between the department and a utility owner.

"Appurtenance" means a utility facility-related feature such as a vent, drain, utility access or marker.

"Backfill" means placement of suitable material and compaction of the material as specified in these rules.

"Breakaway" means designed to shatter, bend easily or separate from a solid foundation.

"Cable" means an insulated conductor or a combination of insulated conductors.

"Carrier" means a pipe directly enclosing a transmitted fluid (liquid or gas) or slurry. "Carrier" also means an electric or communication cable, wire or line.

"Casing" means an oversize load-bearing pipe, conduit, duct, or structure through which a carrier or cable is inserted.

"Cell" means a conduit.

"Clear zone" means that roadside border area, starting at the edge of the traveled way, available for use by errant vehicles.

"Communication line" or *"communication cable"* means a circuit for telephone, telegraph, alarm system, television transmission or traffic control purposes.

"Conduit" means an enclosed tubular runway for protecting wires or cables. A conduit may also be referred to as a "cell" or "duct."

"Cover" means depth from the grade of a roadway or ditch to the top of an underground utility facility.

"District representative" means a department employee who processes utility accommodation requests in an assigned geographical area.

"Duct" means a conduit.

"Emergency" means an unplanned situation that presents a danger to the life, safety or welfare of motorists, persons working within the right-of-way or the general public and that requires immediate attention. The emergency may be the result of storm damage and may involve disruption of utility service to customers. Work on a utility facility due to an emergency is unplanned work and may be necessary at any time of the day or night. The emergency work operation usually involves a small crew and a work vehicle for a short period of time.

"Encasement" means placing a casing around a utility facility.

"FHWA" means the Federal Highway Administration.

"Foreslope" means the sloping surface of an embankment, ditch, or borrow pit of which the downward inclination is away from the traveled way.

"Freeway" means a fully controlled access primary highway. The rights of ingress and egress from abutting properties have been legally eliminated by the department. Permanent access to the highway is allowed only at interchange locations. A freeway is generally five or more miles in length.

"Highly energized" means an electrical energy level that could be hazardous if the utility facility is struck or exposed. For purposes of this chapter, voltage exceeding 60 volts is considered to be highly energized.

"Highway," "street" or *"road"* means a public way for the purpose of vehicular travel, including the entire area between the right-of-way lines.

"Interchange" means a system that provides for the movement of traffic between intersecting roadways via one or more grade separations.

"Maintenance" as the term is used in conjunction with a utility facility means any repair or replacement of the utility facility that is not an adjustment and that does not increase the capacity of the original installation. The term "maintenance" when used in conjunction with a highway means repair or other operational activities performed by the department within the highway right-of-way to preserve the function of the highway and its structures.

"Median" means that portion of a divided highway separating traffic moving in opposite directions.

"Multiduct" means a system comprised of two or more conduits.

"MUTCD" means the Manual on Uniform Traffic Control Devices, as adopted in 761—Chapter 130.

"Nonfreeway primary highway" means a primary highway that is not a freeway.

"Occupy the primary highway right-of-way" means located or to be located in, on, above or below the primary highway right-of-way. The term includes attachments to primary highway structures.

"Pavement" means that portion of a roadway used for the movement of vehicles, excluding shoulders.

"Permit" means a utility accommodation permit issued by the department. The term "permit" includes any attachments to the permit.

"Pipe" means a tubular product used to transport solids, liquids or gases.

"Pipeline" means a carrier system used to transport liquids, gases, or slurries.

"Plowing" means the installation of a utility line in the ground by means of a plow-type mechanism that breaks the ground, places the utility line and closes the break in the ground in a single operation.

"Primary highway" means a road or street designated as a "primary road" in accordance with Iowa Code subsection 306.3(6). This definition includes primary highway extensions in cities and primary highways under construction.

"Right-of-way" means the land for a public highway, street or road, including the entire area between the property lines. For purposes of this chapter, the right-of-way line for a freeway is the access control line.

"Roadway" means that portion of a highway used for the movement of vehicles, including shoulders and auxiliary lanes. A divided highway has two or more roadways.

"Rural-type roadway" means a roadway that does not have as its outside extremities a curb and gutter section.

"Service connection" means a water, gas, power, communication, sanitary sewer or storm sewer line that extends from the main or primary utility facility into an adjacent property and that is used to serve the property.

"Shoulder" means that portion of a roadway contiguous to the traveled way for the accommodation of disabled vehicles, for emergency use and for the lateral support of the pavement base and surface courses.

"Toe of foreslope" means the intersection of the foreslope and the natural ground or ditch bottom.

"Traveled way" means that portion of a roadway used for the movement of vehicles, excluding shoulders and auxiliary lanes.

"Trenched" means installed in a narrow open excavation.

"Trenchless" means installed without breaking the ground or the pavement surface, such as by jacking, boring, tunneling or mechanical compaction.

"Urban-type roadway" means a roadway that has as its outside extremities a curb and gutter section.

"Utility" means a system for supplying water, gas, power, or communications; a storm sewer, sanitary sewer, drainage tile or other system for transmitting liquids; a pipeline system; or like service systems. The term "utility" includes traffic signal systems and street and intersection lighting systems.

"Utility access" means an opening in an underground utility system through which workers or others may enter for the purpose of making installations, inspections, removals, repairs, connections or tests.

"Utility facility" means any pole, pipe, pipeline, pipeline company facility, sewer line, drainage tile, conduit, cable, aqueduct or other utility-related structure or appurtenance. However, the term does not include department facilities or the utility lines that service them.

"Utility owner" means the owner of a utility facility.

"Vent" means an appurtenance used to ventilate or to discharge gaseous contaminants from casings.

761—115.3 Reserved.

761—115.4(306A) General requirements for occupancy of the right-of-way.

115.4(1) *Permit required and exceptions to permit.*

a. Permit required.

(1) A utility owner shall obtain permission from the department in the form of a utility accommodation permit before it places its utility facilities in, on, above or below the primary highway right-of-way; attaches its utility facilities to a primary highway structure; or adjusts existing utility facilities occupying the right-of-way.

(2) The purpose of the permit process is to ensure the safety of motorists, pedestrians, construction workers and other highway users; to ensure the integrity of the highway; and to document the location of utility facilities for use in managing the highway right-of-way and in locating the facilities in the future.

b. Exceptions to required permit.

(1) A permit is not required for storm sewers, subdrains, and lighting designed and constructed as part of a department highway construction project.

(2) A permit is not required for service connections within the corporate limits of a city. These connections require city approval rather than department approval; the utility owner shall apply to the city. However, service connections shall meet all other requirements of this chapter.

115.4(2) *Agreement required.* For certain utility facility adjustments, the department may require an agreement between the department and the utility owner. However, the agreement by itself does not constitute a permit nor does it grant permission to occupy the primary highway right-of-way. The utility owner is responsible for obtaining a permit prior to commencing work within the right-of-way. The agreement shall then be attached to and become a part of the permit.

115.4(3) *Compliance with requirements.* It is the responsibility of the utility owner to ensure that its utility facility complies with all applicable federal, state, local and franchise requirements and meets generally accepted industry standards at the time of installation.

115.4(4) *Performance bond.* The department may require a performance bond for utility work within the highway right-of-way under the following circumstances: the installation is unusual; abnormal site conditions exist, such as but not limited to unstable soil or unique vegetation; or the utility owner has a history of performance problems. A performance bond is required for longitudinal freeway occupancy; see subrule 115.16(9) for specific requirements.

a. If a performance bond is required, the utility owner shall file the bond with the department prior to commencing work within the right-of-way.

b. The minimum amount of a required performance bond is $5,000 per permit. Depending on the type and extent of the facility installed, the department may require a higher bond amount. The bond shall be in force for the duration of the permit. The department shall have the right to file a claim against the bond for two years thereafter.

c. The department may accept an annual performance bond in the amount of $50,000 for statewide activities in lieu of an individual bond for each permit. The statewide performance bond shall be kept in force for as long as the utility owner's facilities occupy the primary highway right-of-way anywhere within the state of Iowa. The department shall have the right to file a claim against the bond for two years thereafter.

d. A performance bond shall guarantee prompt restoration of any damage that is the result of the utility facility's occupancy of the highway right-of-way.

115.4(5) *Execution of work.* Utility construction and maintenance work within the primary highway right-of-way shall be executed in a satisfactory manner and in accordance with good construction practices.

115.4(6) *Disturbance of other contractors.* Utility construction and maintenance work within the primary highway right-of-way shall be accomplished in a manner that minimizes disturbance to any other contractor working within the right-of-way. It is the responsibility of the utility owner to coordinate work with other contractors.

115.4(7) *No adverse effect on highway.* A utility facility shall not adversely affect the safety, design, construction, operation, maintenance or stability of the present use or future expansion of a primary highway.

115.4(8) *Safety, health and sanitation.* Construction and maintenance of a utility facility shall be accomplished in a manner that minimizes disruption of primary highway traffic and other hazards to the highway user. The utility owner shall comply with the MUTCD and all applicable federal, state and local statutes, ordinances and regulations governing safety, health and sanitation. The owner shall furnish such additional safeguards, safety devices and protective equipment and shall take such actions as are reasonably necessary to protect the life and health of the public.

115.4(9) *Parking or storage in clear zone or median.* When not in actual use, vehicles, equipment and materials shall not be parked or stored within the clear zone or median.

115.4(10) *Protection of landscaped or planted areas.* A landscaped or planted area that is disturbed shall be restored as nearly as practical to its original condition. Specific authorization must be obtained from the district representative prior to trimming trees or spraying within the right-of-way.

115.4(11) *Noncompliance.* The department may take any or all of the following actions for noncompliance with any provision of this chapter or any term of a permit:

a. Halt utility construction or maintenance activities within the right-of-way.

b. Withhold an adjustment reimbursement until compliance is ensured.

c. Revoke the permit.

d. Remove the noncomplying construction or maintenance work, restore the area to its previous condition, and assess the removal and restoration costs to the utility owner.

e. Place all pending and future permits on hold until the issue is resolved.

115.4(12) *Private utility facility.* A utility facility that is dedicated to private use shall be accommodated in accordance with this chapter. However, the district representative may, when necessary, allow an exception to the cover requirements of subrule 115.13(1) for tile lines and sewer lines.

115.4(13) *Insufficient capacity of right-of-way.* The department shall deny issuance of a permit if it determines there is insufficient room for additional utility facilities within the right-of-way.

761—115.5(306A) General design provisions.

115.5(1) *Plans.* Design plans for a utility facility shall be prepared by a person knowledgeable in highway design and in work zone traffic control and shall include the measures to be taken to preserve the safe and free flow of traffic, structural integrity of the roadway and highway structures, ease of highway maintenance, appearance of the highway and integrity of the utility facility.

115.5(2) *Materials.* All utility facilities shall consist of durable materials designed for long service life expectancy and be relatively free from routine servicing and maintenance.

115.5(3) *Number of crossings.* The number of utility facilities crossing the primary highway right-of-way shall be kept to a minimum. The department may require distribution facilities to be installed on each side of the highway to minimize the number of crossings and service connections. In individual cases, the department may require several facilities to cross in a single conduit or structure. Crossings should be as near to perpendicular to the highway alignment as practical.

115.5(4) *Aboveground facilities.* The design of aboveground utility facilities shall be compatible with the visual quality of the specific highway section being traversed. See rule 761—115.6(306A).

115.5(5) *Clear zone requirements and aboveground obstructions.* Highway roadsides shall be as free from physical obstructions above the ground as practical. The department shall determine the clear zone distance.

a. The clear zone distance on rural-type roadways is based on present day traffic and the existing foreslope adjacent to and preceding the utility facility.

b. Unless otherwise specified, the clear zone shall be measured from the edge of the traveled way.

c. In rural areas with rural-type roadways, a permanent, aboveground obstruction is restricted to an area beyond the clear zone or the highway foreslope, whichever area locates the obstruction a greater distance from the edge of the traveled way.

d. If sufficient right-of-way is not available to accommodate the clear zone distance, the department may require the utility facility to have a breakaway design, require regrading of the right-of-way, require the utility facility to be located underground, or authorize the facility to be placed near the right-of-way line.

761—115.6(306A) Scenic enhancement.

115.6(1) *Introduction.* The type and size of a utility facility and the manner in which it is installed can materially alter the scenic quality, appearance and view of highway roadsides and adjacent areas. For these reasons, additional controls are applicable in areas that have been acquired or set aside for their scenic quality. Such areas may include, but are not limited to, scenic strips, scenic overlooks, rest areas, recreation areas, public parks and historic sites, aesthetically enhanced corridors, and the

right-of-way of primary highways that pass through or are adjacent to these areas. These additional controls are addressed in this rule.

115.6(2) *Underground installations.* The department may permit a new underground installation if it does not require extensive removal or alteration of trees or other natural features visible to the highway user and if it does not impair the visual quality of the area being traversed.

115.6(3) *Aboveground installations.* The department may permit a new aboveground installation only if the following three conditions are met:

a. Other locations for an aboveground installation are unusually difficult, are unreasonably costly, or are less desirable from the standpoint of visual quality.

b. Underground installation is not technically feasible or is unreasonably costly.

c. The location, design and materials to be used for the proposed aboveground installation will give adequate attention to the visual qualities of the area being traversed.

761—115.7(306A) Liability.

115.7(1) Liability under a permit. The following are conditions of a utility accommodation permit.

a. The owner of the utility facility shall indemnify and save harmless the state of Iowa, its agencies and employees from any and all causes of action, suits at law or in equity, for losses, damages, claims or demands, and from any and all liability and expense of whatsoever nature (including reasonable attorney fees), arising out of or in connection with the owner's use or occupancy of the primary highway right-of-way.

b. The state of Iowa, its agencies or employees, will be liable for expense incurred by the permit holder in its use and occupancy of the primary highway right-of-way only when negligence of the state, its agencies or employees, is the sole proximate cause of such expense. Whether in contract, tort or otherwise, the liability of the state, its agencies, and employees is limited to the reasonable, direct expenses to repair damaged utilities, and in no event will such liability extend to loss of profits or business, indirect, special, consequential or incidental damages.

115.7(2) Reserved.

761—115.8(306A) Utility accommodation permit.

115.8(1) *Application for permit.*

a. To apply for a utility accommodation permit, the utility owner shall submit an application to the appropriate district representative on a form prescribed by the department.

b. If the utility facility will cross or impact a county road connection, the application must be approved by the county. If the facility is within corporate limits of a city, the application must be approved by the city. The utility owner is responsible for obtaining these approvals prior to submitting the application to the department.

115.8(2) *Permit.*

a. At a minimum, a utility accommodation permit allows:

(1) The applicant (the utility owner) or its representative to perform the work covered by the permit.

(2) The utility facility described in the permit to occupy the right-of-way.

(3) The utility facility to be operated and maintained.

b. A utility accommodation permit does not convey a permanent right of occupancy.

115.8(3) *Plan.* Each permit application shall be accompanied by a plan showing the following:

a. Location of the utility facility by route, county, section, township, range, milepost and highway stationing, where these references exist.

b. Highway centerline and right-of-way limits.

c. Location of the utility facility by distance to the nearest foot at each point where the facility's location changes alignment, as measured from the:

(1) Centerline of the highway on nonfreeway installations.

(2) Right-of-way fence on freeway installations.

d. All construction details including the:

(1) Depth of burial.

(2) Types of materials to be used in the installation.

(3) Operating pressures and voltages.

(4) Vertical and horizontal clearances.

(5) Traffic control plan prepared by a person knowledgeable in work zone traffic control, or a reference to a standard traffic control plan of the department.

115.8(4) *Discharging into waterways.*

a. A permit application for the placement of a utility facility that will discharge materials into the nation's waters must be accompanied by satisfactory evidence of compliance with all applicable federal, state and local environmental statutes, ordinances and regulatory standards.

b. The utility owner is responsible for obtaining all necessary approvals from the appropriate agencies. The department will not issue a permit until these approvals are obtained.

115.8(5) *Department action on permit application.*

a. The department shall act on the permit application within 30 days after its filing with the appropriate district representative. If an emergency should exist, the department shall act on the application as expeditiously as practical.

b. Failure on the part of the utility owner to provide complete information may result in a delay in the department's taking final action on the application.

115.8(6) *Changes to work.* Changes in the work as described in the original permit require the prior approval of the department.

115.8(7) *Copy of permit at job site.* The utility owner or its contractor shall have a copy of the permit on the construction site at all times for examination by highway officials.

115.8(8) *As-built plans.*

a. Within 90 days after completion of construction, the utility owner shall submit to the district representative an as-built plan or a letter certifying that the actual placement of the utility facility is as described in the original permit.

b. If the utility owner fails to submit the as-built plan or letter within the time required, the department may hire an independent contractor to locate the utility facility and prepare an as-built drawing. All costs associated with this activity are the responsibility of the utility owner.

c. Any costs incurred by the department or its contractors due to incorrect as-built information supplied by the utility owner or deviations in actual placement from that described in the original permit are the responsibility of the utility owner.

115.8(9) *Transfer of permit.* A new utility accommodation permit is not needed when a utility facility is transferred or leased in its entirety. The requirements of the permit and this chapter remain in force for as long as the utility facility continues to occupy the right-of-way and serve its intended purpose. The transferee or lessee shall submit the following information to the appropriate district representative:

a. The name and address of the transferee or lessee.

b. Geographical area involved in the transaction.

c. Designated telephone number for notification purposes.

115.8(10) *Expiration of certain permits.* See subrule 115.16(12) for permits covering longitudinal occupancy of freeways.

761—115.9(306A) Traffic protection.

115.9(1) *Traffic control for all work.*

a. When performing work within the right-of-way, the utility owner is responsible for providing, installing, maintaining and cleaning warning signs and protective devices; removing warning signs and protective devices when the work is complete; and providing flaggers.

b. Flagging operations and the placement of warning signs, protective devices, barricades and channelizing devices shall comply with the MUTCD and department requirements for the protection of the traveling public and workers on the site.

c. Flaggers are required at work sites to stop traffic intermittently as necessitated by work progress or to maintain continuous traffic past a work site at reduced speeds to help protect the work crew. For both of these functions the flagger must, at all times, be clearly visible to approaching traffic for a distance

sufficient to permit proper response by motorists to the flagging instructions, and to permit traffic to reduce speed before entering the work site. In positioning flaggers, consideration must be given to maintaining color contrast between the work area background and the flaggers' protective garments.

d. The utility owner shall provide additional protection when special complexities and hazards exist.

115.9(2) *Traffic control for construction and maintenance work that is not emergency work.*

a. The utility owner is responsible for using the types of traffic controls that are adequate for the nature, location and duration of work, type of roadway, traffic volume and speed, and potential hazards.

b. Where high traffic volumes cause frequent congestion, routine scheduled maintenance and construction should be avoided during hours of peak traffic.

c. Work areas should be occupied for only as long as it is necessary to safely move in, finish the work, remove all utility work signs and move out.

d. Special care should be taken to clearly mark suitable boundaries for the workspace with channelizing devices so that pedestrians and drivers can see the workspace. If any of the traveled lanes are closed, tapers shall be used as required by the MUTCD.

e. Pedestrians should not be expected to walk on a path that is inferior to the previous path. Loose dirt, mud, broken concrete or steep slopes may force pedestrians to walk on the roadway rather than the sidewalk. Repairs (temporary or permanent) to damaged sidewalks should be made quickly. This may include bridging with steel plates or good quality wood supports.

f. Work areas involving excavations on the roadway should not exceed the width of one traffic lane at a time. The work should be staged and, if needed, approved bridging should be used. The utility owner should fully coordinate this type of activity with the district representative or, in a city, with the city's traffic or public works office.

115.9(3) *Traffic control for emergency work.*

a. The extent of traffic control used for emergency work may be less than that used for longer-term construction or maintenance. However, the utility owner shall provide for the safety of pedestrians, motorists and workers. It may be necessary for the utility owner to contact local law enforcement officials to assist in securing the safety of the traveling public.

b. The work vehicle should be equipped with an amber revolving light or amber strobe light, portable signs and channelizing devices, and necessary equipment for flagging operations.

761—115.10(306A) Construction responsibilities and procedures.

115.10(1) *Permit required before work may begin.* The utility owner shall not commence construction work in the primary highway right-of-way until it has received a utility accommodation permit from the department for the work.

115.10(2) *Notice of construction.* The utility owner shall give the district representative at least 48 hours' prior notice of its intent to start construction within the right-of-way.

115.10(3) *Authority of the district representative.*

a. The district representative has the authority to resolve any issues or concerns that arise regarding the intent of the permit and compliance therewith, as they relate to the condition of the highway.

b. During the progress of the work, the district representative may approve minor alterations in the plans or character of the work, as they relate to the condition of the highway, that the district engineer deems necessary or desirable to satisfactorily complete the work. Such an alteration is not a waiver of the permit nor does it invalidate any provision of the permit.

115.10(4) *Work in progress.* The utility owner is responsible for the care and maintenance of partially completed work within the right-of-way. Unless otherwise authorized by the permit or the district representative, all work performed within the right-of-way is restricted to a time frame of 30 minutes after sunrise to 30 minutes before sunset.

115.10(5) *Authority of department to inspect and approve.*

a. The department may inspect and approve any construction work performed within the right-of-way as it relates to the condition of the highway.

b. The utility owner shall provide reasonable cooperation.

115.10(6) *Department inspectors.* The department may appoint inspectors to represent the department in the inspection of construction. Inspectors are placed on the job to keep the district representative informed of the progress of the work and the manner in which it is being performed, and to call to the utility owner's attention any infringements of the permit. The inspectors shall not:

a. Modify in any way the provisions of the permit.

b. Delay the work by failing to inspect the work with reasonable promptness.

c. Act as a supervisor for the work or perform any other duties for the utility owner or its contractor.

d. Improperly interfere with the management of the work.

e. Approve or accept any portion of the work on behalf of the department.

115.10(7) *Repair and cleanup.* Prior to the department's final inspection, the utility owner shall:

a. Upon notification by the department, immediately make any repairs to the right-of-way that are necessary due to the construction work.

b. Remove from the right-of-way all unused materials and rubbish resulting from the work and leave the right-of-way in a clean, presentable condition.

115.10(8) *Final inspection.*

a. Upon notification by the owner of the utility facility or its authorized representative that the work is complete, the district representative may inspect each item of work included in the permit as it relates to the condition of the highway.

b. If the district representative finds that the work is not in compliance with the permit, the district representative shall provide to the utility owner written notice of the particular defects found. The owner is responsible for remedying these defects in a timely manner.

761—115.11(306A) Vertical overhead clearance requirements.

115.11(1) *Conformance to standards.* The vertical clearance for overhead utility facilities and the lateral and vertical clearances for bridges shall conform to accepted industry standards as well as applicable codes and regulations.

115.11(2) *Minimum vertical clearance.* In no event shall the vertical clearance be less than 20 feet above the roadway for all overhead utilities.

761—115.12(306A) Utility facility attachments to bridges.

115.12(1) *Electrical power and communication cable attachments.*

a. An electrical power or communication cable may be attached to an existing primary highway bridge if the department determines that the attachment is in the best interests of the public. The department may accommodate an electrical power or communication cable attachment in its design for a new bridge if the department determines that the accommodation is in the best interests of the public.

b. The permit application shall include a detailed sketch showing the method of attachment and weights of attachment. A separate permit is required for each bridge.

c. All attachments shall be placed in conduits, pipes or trays; beneath the bridge's floor; and above low steel or masonry of the bridge. Department-approved clamps shall be used for any attachment to structural steel.

d. Expansion devices are required. Cables in cells or casings shall be grounded wherever necessary. Carrier pipe shall be suitably insulated from electrical power line attachments.

e. All costs attributable to the installation of an attachment to a bridge shall be paid by the utility owner unless the attachment is installed pursuant to a utility agreement.

f. Welding or drilling holes in structural steel primary members is prohibited.

g. Utility facilities may be attached to noncritical concrete areas.

h. Holes should not be cut in wing walls, abutments or piers.

115.12(2) *Pipeline attachments.*

a. Pipelines may be attached to primary highway bridges when installation below ground is not feasible, the design of the bridge can accommodate the attachment, and space is available.

b. The permit application shall include a detailed sketch showing the method of attachment and weights of attachment. A separate permit is required for each bridge.

c. Pipes shall be placed beneath the bridge's floor, inside the outer girders or beams (or in cells specifically designed for the installation), and above low steel or masonry of the bridge.

d. Pipes shall be designed to withstand expected expansion or contraction forces. If necessary, expansion devices such as expansion joints, offsets or loops shall be used.

e. Pipelines in cells or casings shall be vented and grounded whenever necessary.

f. Pipelines that have an operating pressure of more than 75 pounds per square inch or that are larger than two inches in diameter shall have shutoffs not more than 300 feet from each end of the bridge.

g. The department shall consider casing requirements on an individual basis. In some instances, thicker-walled or extra-strength pipe may be considered in lieu of encasement. Encasement is required for plastic pipe attachments to bridges.

h. All costs attributable to the installation of an attachment to a bridge shall be paid by the utility owner unless the attachment is installed pursuant to a utility agreement.

i. Welding or drilling holes in or attaching to structural steel primary members is prohibited.

j. Utility facilities may be attached to noncritical concrete areas.

k. Holes should not be cut in wing walls, abutments or piers.

l. The utility owner shall provide an indemnity bond to be executed by either itself or by a responsible bonding company, at the department's option.

(1) The indemnifier under the bond shall, in the event of damage resulting from any cause whatsoever arising out of or from permission to attach a pipeline, indemnify the department against all loss or damage to it or any third party therefrom, including but not limited to the expense of repairing or replacing the bridge and the cost of alternate highway facilities for traffic during the period when the bridge is being repaired or replaced.

(2) The indemnity bond shall be kept in force for as long as the pipeline is attached to the bridge. The department may periodically review the amount of the bond and require adjustments in the bond amount.

115.12(3) *Attachment fee.*

a. The utility owner shall pay to the department an attachment fee for attaching its utility facility to a primary highway bridge. The attachment fee is $100 per bridge plus $0.55 times the weight of the attachment in pounds per foot times the length of bridge in feet. The fee shall increase 3 percent per year after the base year of 2004.

b. The attachment fee is due before any construction work commences within the right-of-way.

c. Utility facilities belonging to or exclusively serving a city may, if the department considers it desirable, be attached to a primary highway bridge without assessment of an attachment fee.

115.12(4) *Engineering fee.* When a primary highway bridge is in the planning stages and the department designs the bridge to accommodate a requested attachment, the department shall assess to the utility owner an engineering fee. The engineering fee shall reimburse the department for the department's increased costs of design, construction and inspection due to the attachment. The department shall bill the fee to the utility owner when the department's work is complete.

115.12(5) *Utility attachments to freeway border bridges.* The department may permit a utility facility to be attached to an existing or planned freeway border bridge if the following conditions are met:

a. The appropriate state agency of the adjoining state approves the attachment.

b. Except for communication cable, the facility exits the freeway right-of-way as soon as physically practical after crossing the state line into Iowa.

c. The attachment otherwise complies with this chapter, specifically including this rule on attachments and rule 761—115.16(306A) on longitudinal freeway occupancy.

761—115.13(306A) Underground utility facilities.

115.13(1) *Depth requirements.*

a. Minimum cover—roadway. The minimum required cover under a roadway is 48 inches.

b. Minimum cover—other portions of right-of-way. The minimum required cover under other portions of the right-of-way is:

(1) 48 inches for electrical cable.

(2) 30 inches for communication cable except that 36 inches is required for longitudinal occupancy under freeway right-of-way.

(3) 36 inches for all other underground facilities.

c. Rocky terrain. The department may allow an exception to the minimum depth requirement where rocky terrain makes it difficult to obtain the required depth. The department shall determine the minimum depth in these situations; however, no installation shall be authorized with less than 24 inches of cover.

d. Other protective measures. In critical situations where the necessary cover cannot be obtained, the department may approve other protective measures.

115.13(2) *Measurement of cover.* The cover is measured from one of the following:

a. On rural-type roadways, the lowest pavement surface edge.

b. On urban-type roadways, the gutter flow line, excluding local depressions at inlets.

c. Where longitudinal installations will be behind the curb, the top of the curb.

d. The surface of the surrounding ground or the low point of the ditch.

115.13(3) *Casing.* A casing shall:

a. Protect the highway from damage.

b. Protect the carrier pipe from external loads or shock, either during or after construction of the highway.

c. Convey leaking liquids or gases away from the area directly beneath the traveled way.

d. Provide for repair, removal and replacement of the utility facility without interference to the highway.

115.13(4) *Seals.* Casing pipe shall be sealed at both ends with a suitable material to prevent water or debris from entering the annular space between the casing and the carrier, in accordance with generally accepted industry standards.

115.13(5) *Transverse occupancy—encasement and related requirements.*

a. Trenchless construction. Underground transverse crossings of existing paved roadways shall be made by trenchless construction whenever practical. Any exception to this requirement must be specifically authorized by the district representative and noted in the permit.

b. Electrical service. Underground electrical service must be placed in a conduit from right-of-way line to right-of-way line and shall be clearly marked by the utility owner at the outer limits of the right-of-way.

c. Pipelines.

(1) Except as set out in 115.13(5)*"c"*(2), a pipeline carrying natural gas at an operating pressure of greater than 60 pounds per square inch, liquid petroleum products, ammonia, chlorine or other hazardous or corrosive products shall be encased from right-of-way line to right-of-way line.

(2) Encasement of a pipeline carrying a product listed in 115.13(5)*"c"*(1) is not required if the pipeline meets all of the following requirements and the utility owner certifies as a part of the permit that these requirements are met:

- It is welded steel pipeline.
- It is cathodically protected.
- It is coated in accordance with accepted industry standards.
- It complies with federal, state and local requirements and meets accepted industry standards regarding wall thickness and operating stress levels.

(3) A pipeline carrying a product listed in 115.13(5)*"c"*(1) shall be vented and marked at the outer right-of-way limits. The markers shall comply with accepted industry standards and include the following information: name and address of the owner, telephone number to contact in case of an emergency, and type of product carried.

(4) Encasement of a natural gas pipeline with an operating pressure that is not greater than 60 pounds per square inch is not required if the pipeline is made of copper, steel or plastic; the pipeline is protected and installed in accordance with accepted industry standards; and the utility owner certifies as a part of the permit that these standards are met. Otherwise, encasement is required.

d. Communication cable. The department may require encasement of communication cable.

e. Sanitary sewer lines. Sanitary sewer lines, both gravity and force mains, shall be encased from right-of-way line to right-of-way line. Exception: A gravity flow line that is installed subsequent to highway construction need not be encased if it will meet all of the following requirements:

(1) The opening is cut to the size of the carrier pipe so that there are no excessive voids around the pipe.

(2) The pipe is of sufficient strength to withstand the external loads created by the vehicular traffic on the roadway being traversed.

(3) Lines beyond the toe of foreslope are properly embedded.

f. Waterlines. Waterlines shall be encased from right-of-way line to right-of-way line. Exceptions:

(1) Encasement is not required where it is impractical due to existing conditions, as determined by the district representative. As a minimum, waterlines shall be encased from toe of foreslope to toe of foreslope.

(2) Waterlines with an inside diameter of two inches or less need be encased only from toe of foreslope to toe of foreslope. Venting and sealing of the encasement are not required.

(3) Properly embedded waterlines that are installed prior to highway construction need not be encased if extra strength cast iron or ductile iron pipe with mechanical joints and seals, or equivalent, is used from right-of-way line to right-of-way line.

g. Installations vulnerable to damage. Utility facilities that by reason of shallow depth or location are vulnerable to damage from highway construction or maintenance operations shall be protected with a casing, suitable bridging, concrete slabs or other appropriate measures.

h. Other installations. When it is acceptable to both the utility owner and the department, an underground utility facility not otherwise addressed in this subrule may be installed without protective casing if the installation involves trenched construction or small bores. Encasement requirements will be determined on an individual basis.

115.13(6) *Longitudinal occupancy—encasement and related requirements.*

a. Utility lines installed longitudinally to the primary highway right-of-way shall be encased at crossings of hard-surfaced side roads, streets and entrances in accordance with subrule 115.13(5).

b. Reserved.

115.13(7) *Multiduct systems.* The department may require installation of a multiduct system to be shared with others. Details of the installation are subject to department approval.

a. The department shall designate a "lead company" for the system. The lead company is generally the first utility owner requesting occupancy. The lead company is responsible for:

(1) Design and construction of the multiduct system.

(2) Maintenance of the multiduct system.

(3) Providing all capital required to construct the multiduct system.

b. Once a multiduct system has been established, the department shall require future occupancies to be located within one of the unoccupied inner ducts of the system. If all inner ducts are occupied, the department may require the establishment of an additional multiduct system.

c. Each occupant of a multiduct system shall share equally in the entire capital costs of the facility. As each new occupant is added to an existing system, the department shall require the new occupant to pay its proportionate share based on the number of inner ducts it occupies.

d. See subrule 115.16(8) for occupancy fees for longitudinal installations on freeways.

115.13(8) *Procedures for backfilling trenched construction and jacking or boring pits.*

a. When a carrier, pipe, conduit, or cable is placed by trenched construction, the backfill shall be placed and compacted so that there is no settlement or erosion. If settling or erosion of a trench is observed, it is the responsibility of the utility owner to correct the problem.

b. Jacking or boring pits shall be backfilled in the same manner as that described in paragraph *"a"* of this subrule.

c. Backfill under roadways or entrances shall be of a suitable material to minimize settlement. Examples of suitable material include granular backfill or flowable mortar.

115.13(9) *Procedures for trenchless construction.*

a. When trenchless construction techniques are used, the bore shall be as small as practical and in no case more than four inches larger than the facility or casing inserted.

b. Grout backfill is required for all unused holes and abandoned pipes. Grout or sand backfill is required for any borehole more than two inches larger than the installed casing or other facility. All bored facilities shall be constructed in such a manner that surface water is not transported to or otherwise allowed access to groundwater.

115.13(10) *Procedures for pavement removal.*

a. When the existing pavement must be cut to accommodate a utility installation, the cut shall be made with a concrete saw.

b. The width of the pavement removal shall be a minimum of six feet. If the distance from the specified cut to any adjacent longitudinal or transverse joint or crack is less than four feet, the pavement shall be removed to that joint or crack.

c. The district representative shall make the final determination on the required depth and width of cut.

115.13(11) *Procedures for pavement replacement.*

a. Restoration of pavement shall be accomplished in accordance with methods approved by the district representative.

b. The district representative may authorize temporary repair with bituminous material.

c. A permanent patch shall be placed as soon as conditions permit.

115.13(12) *Clear zone for pits.*

a. On freeways, jacking or boring pits are not allowed within the median. A jacking or boring pit shall be located in an area beyond the clear zone or the highway foreslope, whichever area locates the pit a greater distance from the edge of the traveled way, right-of-way width permitting.

b. On rural-type, nonfreeway primary highways, jacking or boring pits are not allowed within the median. A jacking or boring pit shall normally be located in an area beyond the clear zone or the highway foreslope, whichever area locates the pit a greater distance from the edge of the traveled way, right-of-way width permitting. However, a jacking or boring pit may be allowed within the foreslope if it is specifically authorized by the district representative and noted in the permit.

c. On urban-type, nonfreeway primary highways, jacking or boring pits should be located at least two feet back from the curb.

d. Jacking or boring pits authorized within the clear zone shall be protected at all times. Protection may include backfilling of the pit, temporary barrier rail, reflective fence, or other measures. All measures must be approved by the district representative.

115.13(13) *Construction methods.* Casing and pipeline installations shall be accomplished by dry boring, tunneling, jacking, trenching, directional drilling or other approved methods.

a. The use of water under pressure (jetting) or puddling to facilitate boring, pushing or jacking operations is not allowed.

b. However, a boring operation that requires the use of water only to lubricate the cutter and pipe is considered dry boring and is allowed.

115.13(14) *Encasement material.* It is the responsibility of the utility owner to ensure that it complies with all applicable federal, state, local and franchise requirements and meets generally accepted industry standards in the selection of encasement materials.

761—115.14(306A) Freeways.

115.14(1) *Access to utility facilities occupying freeway right-of-way.*

a. Except for emergency work, access shall not be obtained from the freeway or its ramps during utility construction or maintenance operations. This means that access must be obtained from intersecting, adjacent or nearby public highways, streets, roads or trails or from private property. See subrules 115.9(3) and 115.19(2) for emergency work.

b. Fence removal and replacement are subject to the limitations imposed by the permit.

c. No gates or ladders shall be placed in or upon the right-of-way fence.

d. The department shall notify the FHWA of any access it authorizes to the interstate system for utility work.

115.14(2) *Freeway clear zone requirements.* The clear zone requirements of subrule 115.5(5) apply to freeways. In addition:

a. On freeways open to traffic, personnel, equipment or materials are not allowed in the median or within the clear zone area, right-of-way width permitting, during utility facility construction or maintenance operations, except for the stringing of transverse overhead conductors.

b. In the interest of safety and when considered advisable, the district representative may authorize the placement of temporary poles in the median during cable or conductor stringing operations.

115.14(3) *Aboveground appurtenances.* Unless otherwise provided, aboveground appurtenances are not allowed within the right-of-way of freeways.

115.14(4) *Existing facilities.*

a. A utility facility occupying land that subsequently becomes freeway right-of-way may remain within the right-of-way if the facility:

(1) Can be accessed from other than the freeway or its ramps.

(2) Does not adversely affect the safety, design, construction, operation, maintenance or stability of the freeway.

b. If these conditions are not met, the facility shall be relocated.

761—115.15(306A) Transverse installations on freeways.

115.15(1) *Interchange areas.*

a. Utility facilities are not allowed within the interchange area of intersecting freeways unless they are highway-related.

b. In other interchange areas, the department may permit occupancy if access to the utility facility can be obtained from other than the freeway or its ramps. If a utility facility cannot reasonably be accessed from an intersecting, adjacent or nearby public highway, street, road or trail, the utility facility shall be installed on private property outside the interchange area.

115.15(2) *Aboveground installations.*

a. Poles, guys and other supporting structures and related aboveground facilities should be located outside the freeway right-of-way. A single span shall be used to cross the freeway where the width of freeway right-of-way permits.

b. Within interchange areas:

(1) Single-pole construction shall be used, with the number of poles kept to a minimum.

(2) Overhead lines shall be constructed on tangent, parallel to the intersecting road, without guys or anchors being placed in the areas between the ramps and the main roadways of the freeway. Guy poles shall be located as near to the freeway right-of-way line as practical.

(3) Poles should be located as close to the toe of foreslope of the intersecting road as practical, but shall remain outside the clear zone.

(4) Poles should be located as far from the main roadways and ramps of the freeway as practical. No poles are allowed within the median or within the clear zone along the ramp pavement and the freeway pavement.

(5) The use of self-supporting poles or towers, double arming and insulators, breakaway devices and dead-end construction should be considered.

115.15(3) *Encasement requirements.* Underground facilities crossing the freeway shall be encased from right-of-way-line to right-of-way line. Exception: Encasement of a pipeline carrying natural gas at an operating pressure of greater than 60 pounds per square inch, liquid petroleum products, ammonia, chlorine or other hazardous or corrosive products is not required if the pipeline meets the requirements of subparagraph 115.13(5)*"c"*(2).

761—115.16(306A) Longitudinal installations on freeways.

115.16(1) *Type of installation permitted.*

a. The department may permit the installation of an underground utility facility if, in addition to complying with other provisions of this chapter, the facility specifically complies with this rule.

b. Except as provided in this rule, no aboveground installations other than those needed to serve highway facilities are allowed.

115.16(2) *Prohibitions on longitudinal occupancy.*

a. A utility facility shall not be used for transmitting gases or liquids or for transmitting products that are flammable, corrosive, expansive, highly energized or unstable.

b. A utility facility shall not present a hazard to life, health or property if it fails to function properly, is severed or is otherwise damaged.

c. No direct service connection to adjacent properties is allowed.

d. No utility facility is allowed in or on a structure carrying a freeway roadway or ramp, except for freeway border bridges, as provided in subrule 115.12(5).

115.16(3) *Minimal maintenance.* Once installed, the utility facility shall require minimal maintenance.

115.16(4) *Location and depth.* The utility facility shall be located on uniform alignment, preferably within eight feet of the freeway right-of-way line, and at a location approved by the department.

a. See subrule 115.13(1) for minimum depth requirements.

b. Except for multiduct systems, borings and isolated locations as determined by the department, cable shall be installed by the plowing method.

c. Utility accesses and splice boxes may be placed below the existing ground line. The location and number of installations are subject to department approval.

115.16(5) *Identification signs, pedestals and repeater stations.*

a. The utility owner shall place identification signs within 12 inches of the right-of-way fence, at the line of sight, along the entire occupancy route. These signs shall identify the owner/operator's name, telephone number to contact in case of an emergency, and the type of buried utility.

(1) The signs shall be composed of an ultraviolet-resistant material.

(2) Each sign shall be no larger than 200 square inches.

(3) The interval between signs shall not exceed one-quarter mile in rural areas and 500 feet in urban areas, or as designated by the department.

(4) Additional signs shall be placed on each side of a public highway, road or street intersecting or crossing the freeway at points where the freeway right-of-way line intersects the public highway, road or street right-of-way line.

(5) The utility owner is responsible for installing and maintaining these identification signs.

b. Aboveground pedestals are permissible. Pedestals should be placed one foot from the right-of-way fence. The number of installations is subject to department approval.

c. Repeater stations are not allowed in the right-of-way.

115.16(6) *Metallic warning tape.* Metallic warning tape shall be installed a minimum of 12 inches below the existing grade and above the utility installation to facilitate locating the installation in the future.

115.16(7) *Engineering.* The utility owner shall retain the services of a licensed, professional engineer.

a. The engineer is responsible for overseeing continuous on-site inspection of the installation of the facility including all provisions pertaining to access to the work site and traffic control.

b. Upon completion of the project, the engineer shall certify to the department on the appropriate forms that the installation, traffic control, and access to the work site were accomplished in accordance with the permit.

c. Any change to the alignment as described in the original permit requires the prior approval of the department and the submission of as-built plans.

115.16(8) *Occupancy fee.* The utility owner shall pay to the department an annual fee for longitudinal occupancy of the freeway right-of-way. The initial fee is due before any construction work commences within the right-of-way.

a. Unless otherwise specified, the annual fee shall be as follows:

(1) When a multiduct system is required by the department: flat fee of $14,500 per cable installation or $7,250 per mile of cable, whichever is greater. These fees shall increase 3 percent per year after the base year of 2004.

(2) All other installations: flat fee of $12,000 per cable installation or $2,500 per mile of cable, whichever is greater. These fees shall increase 3 percent per year after the base year of 2004.

b. When the department requires the installation of a multiduct system, the department may enter into an agreement with the lead company for a discounted fee payment schedule to be in effect until the company has recovered all or an agreed upon portion of its cost of installing the system. Subsequent occupants of the multiduct system shall pay the full annual fee.

c. The department may negotiate an annual fee for occupancy dedicated solely to state government use.

115.16(9) *Performance bond.* The utility owner shall file a performance bond with the department prior to commencing work within the freeway right-of-way.

a. The bond shall be in the amount of $100,000 per permit and shall guarantee prompt restoration of any damage caused during the installation of the utility facility.

b. The bond shall be in force for the duration of the construction. The department shall have the right to file a claim against the bond for two years thereafter.

115.16(10) *Insurance.*

a. The utility owner shall maintain the following insurance for bodily injury, death and property damage arising out of or in connection with the construction, maintenance and operation of the facility:

(1) General public liability insurance with limits of not less than $500,000 for injury to or death of a single person, or not less than $1,000,000 for any one accident, and not less than $250,000 per accident for property damage.

(2) Comprehensive automobile liability insurance with limits of not less than $500,000 for injury to or death of a single person, or not less than $1,000,000 for any one accident, and not less than $250,000 per accident for property damage.

(3) Excess liability coverage with limits of not less than $5,000,000.

(4) Statutory workers' compensation coverage.

b. This insurance shall be in effect before the utility owner commences any work within the freeway right-of-way.

c. Coverage may be provided by blanket policies of insurance covering other property or risks.

d. The department shall be named as an additional insured party in the general public liability and excess liability insurance policies.

115.16(11) *Future adjustment.*

a. As a condition of the permit, the utility owner shall agree to waive all future rights to be reimbursed for adjustment costs incurred should maintenance or construction of the freeway system require adjustment of the utility facility.

b. Should adjustment of the utility facility be required, the department makes no assurance nor assumes any liability to the utility owner that the facility will again be allowed to occupy the freeway right-of-way.

115.16(12) *Term of permit.* The term of the permit shall not exceed 20 years. When the permit expires, the department may extend it in writing or renegotiate its terms.

115.16(13) *Utilities for highway facilities.* Longitudinal occupancy of utility facilities that service highway-related facilities are permissible upon such terms and conditions as the department may determine.

761—115.17(306A) Nonfreeway primary highways.

115.17(1) Clear zone requirements and aboveground obstructions. Subrule 115.5(5) applies. In addition:

a. In urban areas with rural-type roadways and speed limits of 45 miles per hour or lower, a permanent, aboveground obstruction shall be located at least 15 feet from the edge of the paved traveled way or beyond the highway foreslope, whichever location is farther from the traveled way.

b. On urban-type roadways, the face of a permanent, aboveground obstruction shall be located no closer than ten feet from the back of the curb. In areas with parking or auxiliary lanes, aboveground obstructions shall be located no closer than two feet behind the back of the curb or a minimum of ten feet from the edge of the traveled way, whichever location is farther from the traveled way.

c. In rural areas with rural-type roadways, poles, guys and other supporting structures and related aboveground facilities should be located as near to the right-of-way line as practical.

(1) These aboveground obstructions shall be located in an area beyond the clear zone or the highway foreslope, whichever area locates the obstruction a greater distance from the edge of the traveled way, right-of-way width permitting.

(2) In individual cases, the department may require the use of self-supporting poles or towers, double arming and insulators, breakaway devices and dead-end construction.

d. In suburban areas with rural-type roadways and speed limits of 45 miles per hour or lower, utility poles shall be located at least 15 feet from the edge of the paved traveled way or beyond the highway foreslope, whichever location is farther from the traveled way. The preferred location is near the right-of-way line.

e. Poles, guys, anchors and other appurtenances shall not be located in ditches, at drainage structure openings or on roadway shoulders. All poles, guys, anchors and other appurtenances shall be located to minimize interference with the maintenance operations of the department.

f. The district representative may approve the adjustment of minimum setback distances for poles and other appurtenances that have a breakaway design.

115.17(2) Reserved.

761—115.18(306A) Longitudinal installations on nonfreeway primary highways.

115.18(1) *Location.* Longitudinal utility facility installations should be located on uniform alignment as near as practical to the right-of-way line so as to provide a safe environment for traffic operations and to preserve space for future highway improvements and other utility installations.

115.18(2) *Underground installations.*

a. No carrier of flammable, corrosive, expansive or unstable material shall be placed longitudinally within the right-of-way of a nonfreeway primary highway. Exceptions:

(1) A natural gas line with an operating pressure that is no greater than 150 pounds per square inch is permissible.

(2) The department may permit the placement of a natural gas line with an operating pressure that is greater than 150 pounds per square inch only if a suitable alternate location cannot be found.

b. On rural-type roadways, utility facilities shall be located in an area beyond the highway foreslope, right-of-way width permitting, except at locations where this is not acceptable, such as deep ravines or ditches.

c. On urban-type roadways, utility facilities should be located as near to the right-of-way line as practical and preferably not within the traveled way. A utility access placed within the right-of-way shall not protrude above the surrounding surface.

d. In general, utility facilities are not allowed in the median. However, in special cases the district representative may approve such an installation.

761—115.19(306A) Maintenance and emergency work.

115.19(1) *Maintenance responsibilities.* The owner of a utility facility is responsible for its maintenance. The owner shall:

a. Maintain the facility in a good state of repair in accordance with applicable federal, state and local statutes, ordinances and regulatory standards.

b. Replace and stabilize all earth cover and vegetation where they have eroded over an underground utility facility when the erosion is due to or caused by the placement or existence of the facility.

c. Give the department's district representative 48 hours' prior notice of its intent to perform predictable routine maintenance within the right-of-way. Exception: Notice is not required if the predictable routine maintenance is for a service connection located beyond the clear zone of a nonfreeway primary highway.

115.19(2) *Utility emergency work.*

a. Access to the worksite is permissible from the freeway roadways and ramps when an emergency exists.

b. The utility owner shall take all necessary, appropriate and reasonable measures to protect the safety of the traveling public and cooperate fully with the state highway patrol and the department in completing the emergency work.

c. The utility owner shall notify the department of the emergency as soon as practical, describing the steps being taken to protect the traveling public, the extent of the emergency, and the steps being taken to address the emergency.

d. If the nature of the emergency is such that it interferes with the free movement of traffic, the utility owner shall immediately notify the state highway patrol and the department.

e. When an emergency occurs on the interstate system, the department shall notify the FHWA as soon as practical, describing the steps being taken to protect the traveling public and the steps being taken to address the emergency.

115.19(3) *Department emergency work.* There will be times when the department performs highway-related emergency work. Examples include but are not limited to stop sign replacement, handling hazardous material spills, and addressing natural disasters and acts of terrorism. If utility facilities are affected, the department shall as soon as practical notify the utility owner of the emergency condition and what steps are necessary to protect the utility facility.

761—115.20(306A) Abandonment or removal of utility facilities.

115.20(1) Notice to department. Within 90 days after the abandonment or removal of all or a portion of an existing utility facility that occupies the primary highway right-of-way, the utility owner shall submit a written notice of abandonment or removal to the department. The notice shall include:

a. Type of facility.

b. Location of the utility facility by route, county, section, township, range, milepost and highway stationing, where these references exist.

c. Name of the original utility owner if different than the current owner.

d. Original utility permit number and date of approval, if known.

115.20(2) Reserved.

761—115.21 to **115.24** Reserved.

761—115.25(306A) Utility facility adjustments for highway improvement projects. Rules 761—115.26(306A) to 761—115.30(306A) establish administrative procedures for utility facility adjustments made necessary by state highway improvement projects. The purpose of these procedures is to adjust utility facilities with minimal delays or added expense. Rules 761—115.26(306A) to 761—115.30(306A) apply to all state highway improvement projects with the following exceptions:

1. Projects the department develops on an accelerated schedule.
2. Projects with no anticipated utility adjustments.

115.25(1) Should the department be responsible for the cost of a utility facility adjustment required for highway work, the department shall not pay for any betterment that results in an increase in the capacity of the facility or for any other adjustment not required by highway construction. The department

is entitled to receive credit for the accrued depreciation on replaced facilities and the salvage value of any materials or parts salvaged and retained or sold by the utility owner.

115.25(2) Adjustment costs for which the department is responsible shall be paid on a cost reimbursement basis.

115.25(3) If adjustment of an existing utility facility occupying the right-of-way is required due to highway construction, the utility owner shall adjust the facility without cost to the state and, whenever possible, in advance of the highway work.

761—115.26(306A) Notice of project.

115.26(1) *Determining affected utilities.* The department shall make a reasonable effort to determine what utility facilities are located within the project limits of a state highway improvement project by researching permit files, through field investigations or contacts with one-call locating services, and through contacts with local government units.

115.26(2) *Notifying utilities.* The department shall identify by name the owner of each known utility facility that is located within the project limits. The department shall send to each utility owner a notice of the improvement project, including the route number of the highway, the geographical limits of the project and a general description of the highway work to be done.

115.26(3) *Responding to notice.* The utility owner shall:

a. Within seven calendar days after the date of the notice, reply to the department, acknowledging receipt of the notice.

b. Within 90 calendar days after the date of the notice, provide to the department information about its utility facilities that are in the vicinity of the improvement project, including the name of any company that has utility facilities which coexist with the utility owner's facilities. The utility owner shall reply regardless of whether or not it has facilities in the project's vicinity.

761—115.27(306A) First plan submission, preliminary work plan and agreement.

115.27(1) *First plan.* The department shall submit its first plan to the owner of each known utility facility within the project limits. The first plan shall contain information the owner needs in order to design and lay out the adjustment of its utility facilities, including the placement of adjusted or additional facilities, within the project limits.

115.27(2) *Preliminary work plan.* Within 90 calendar days after the date the department submits its first plan, the utility owner shall provide to the department a preliminary work plan.

a. The preliminary work plan shall include the following:

(1) A narrative description of what work the utility owner will do.

(2) A drawing showing the present and proposed locations of the utility owner's facilities in relation to the highway plan.

(3) Whether the work is dependent on work by another utility owner.

(4) Whether the work can be done prior to highway construction or must be coordinated with the highway contractor.

(5) The number of working days required to complete the work.

(6) A list of permits and approvals the utility owner is required to obtain from governmental agencies and railroad companies for the work, and the expected time schedule to obtain them.

b. If the utility adjustment work is reimbursable, the utility owner shall submit with the preliminary work plan the following:

(1) Copies of documents verifying real estate interests.

(2) A detailed cost estimate for the adjustment, including appropriate credits for betterments or salvage.

115.27(3) *Department review of preliminary work plan.* The department shall review each utility owner's preliminary work plan to ensure compatibility with utility accommodation permit requirements, the plans for the highway improvement project, and the construction schedule.

115.27(4) *Conflict between preliminary work plans.* When requested by the utility owners or when the department determines there is potential for conflict between preliminary work plans, the department

shall schedule a coordination meeting. All affected utility owners shall attend the meeting to coordinate their work plans. The department may allow a utility owner an additional 30 calendar days to submit its preliminary work plan if coordination is required with other utility owners.

115.27(5) *Acceptance of preliminary work plan.* The department shall notify the utility owner of the department's acceptance of the utility owner's preliminary work plan.

a. If the preliminary work plan is not acceptable to the department, the department shall notify the utility owner that the plan is not acceptable and provide a detailed explanation of the problem.

b. The utility owner shall submit a revised preliminary work plan to the department within 30 calendar days after its receipt of notice from the department that the plan was not acceptable.

c. The department shall review the revised preliminary work plan. If the work plan is acceptable, the department shall notify the utility owner of the department's acceptance of the plan.

d. If the work plan is still not acceptable, the process set out in 115.27(5)*"a"* to *"c"* shall be repeated.

115.27(6) *Agreement.*

a. The department shall enter into an agreement with the utility owner if the adjustment is eligible for reimbursement.

b. The agreement by itself does not constitute a permit nor does it grant permission to occupy the primary highway right-of-way. The utility owner is responsible for obtaining a utility accommodation permit prior to commencing work within the right-of-way. The agreement will then be attached to and become part of the permit.

761—115.28(306A) Second plan submission, final work plan and permit application.

115.28(1) *Second plan.* After the final public information meeting, the department shall submit its second plan to the owner of each known utility facility within the project limits. The second plan shall show any additional plan information or design changes the owner needs in order to complete its design and layout for the adjustment. The department shall clearly identify to the utility owner the differences between the first and second plans.

115.28(2) *Final work plan.* Within 60 calendar days after the date the department submits the second plan, the utility owner shall provide to the department a final work plan.

a. The final work plan shall include the anticipated starting date for the utility owner's work within the primary highway right-of-way.

b. A completed application for a utility accommodation permit must accompany the final work plan for work within the primary highway right-of-way. The work plan by itself does not constitute a permit nor does it grant permission to occupy the primary highway right-of-way.

c. When requested by the utility owner, the department may allow additional time to complete the final work plan if the second plan requires extensive modifications to the preliminary work plan.

d. If there are no changes to the preliminary work plan, the utility owner need only notify the department that the preliminary work plan is now the final work plan.

115.28(3) *Department review of final work plan.* The department shall review each utility owner's final work plan to ensure compatibility with utility accommodation permit requirements, the plans for the highway improvement project, and the construction schedule.

115.28(4) *Acceptance of final work plan.* The department shall notify the utility owner of the department's acceptance of the utility owner's final work plan.

a. If the final work plan is not acceptable to the department, the department shall notify the utility owner that the plan is not acceptable and provide a detailed explanation of the problem.

b. The utility owner shall submit a revised final work plan to the department within 30 calendar days after its receipt of notice from the department that the plan was not acceptable.

c. The department shall review the revised final work plan. If the work plan is acceptable, the department shall notify the utility owner of the department's acceptance of the plan.

d. If the work plan is still not acceptable, the process set out in 115.28(4)*"a"* to *"c"* shall be repeated.

761—115.29(306A) Notice of work.

115.29(1) *Notice of receipt of permits and approvals.* The utility owner shall notify the department within 14 calendar days after the utility owner has received all required permits and approvals from government agencies and railroad companies.

115.29(2) *Notice to utility owner to begin work.*

a. The department shall send a notice to proceed to the utility owner not less than 30 calendar days before the utility owner is required to begin the work provided for in its work plan.

b. If the utility owner's work plan is dependent upon work by the highway contractor, the contractor shall provide the department and the utility owner a good faith notice 14 calendar days before the contractor's work is expected to be complete and ready for the utility owner to begin its work. The highway contractor shall follow up with a confirmation notice to the department and the utility owner not less than three working days before the contractor's work will be complete and ready for the utility owner to begin its work.

115.29(3) *Notice to department of commencement and completion of work.* The utility owner shall give the department 48 hours' prior notice, excluding weekends and holidays, of its intent to start utility adjustment work within the project limits. The utility owner shall also notify the department immediately upon completion of the work.

761—115.30(306A) Miscellaneous adjustment provisions.

115.30(1) *Work plan compliance.* The utility owner shall complete its utility adjustment work within the time frame of the work plan accepted by the department. Upon completion of the work, the utility owner shall certify to the department that the adjustment of its facilities is in accordance with the accepted work plan.

115.30(2) *Project changes prior to the letting.* If, prior to the letting date of the highway improvement project, changes to the project result in the need for additional utility adjustment work, the department shall furnish a revised project plan to each affected utility owner. The department shall clearly identify to the utility owner those portions of the project that have been revised. Within 60 calendar days after the date the department submits the revised project plan, the utility owner shall provide to the department a revised work plan.

115.30(3) *Project changes after the letting.* If, after the letting date of the highway improvement project, changes to the project result in the need for additional utility adjustment work, the department shall notify each affected utility owner. The department and the owner shall agree on a revised work plan.

115.30(4) *Work plan changes.* If a utility owner needs to change its work plan after its adjustment work begins, the utility owner shall notify the department. Once the department approves a modified work plan, the utility owner may make the necessary changes and perform the work.

115.30(5) *Cost allocation.*

a. If the department requires the adjustment of a utility facility that was originally determined, per the notice and work plan processes, to not need adjustment:

(1) The utility owner shall bear the cost of the adjustment if the work is otherwise not reimbursable.

(2) The department shall bear the reasonable cost of the adjustment if the work is otherwise reimbursable.

b. If the department requires additional adjustment to a utility facility after the facility has been adjusted in accordance with a work plan accepted by the department, the department shall bear the reasonable cost of the additional work. This applies to all utility facilities, whether the original adjustment work was reimbursable or not reimbursable.

c. The utility owner shall bear the cost of additional adjustment work performed after its facilities have been adjusted in accordance with a work plan accepted by the department if the additional work is due to the utility owner's error.

115.30(6) *Failure to provide a work plan or to adjust utility facilities.* If a utility owner fails to provide a work plan, fails to comply with the accepted work plan, or fails to complete the adjustment of its facilities, and its failure to perform results in a delay to the highway project or causes damages to

be incurred by the department or the department's highway contractor, the utility owner is liable for all costs and damages incurred as a result of its failure to perform. The department may withhold approval of permits for failure to comply with the requirements of these rules.

These rules are intended to implement Iowa Code chapters 306A and 319, section 314.20, and sections 320.4 to 320.8.

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