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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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CHAPTER 29
JUMP-START HOUSING ASSISTANCE PROGRAM

265—29.1(16) Purpose. This chapter defines and structures the jump-start housing assistance program to aid individuals whose homes, located in parts of Iowa declared by the President of the United States to be disaster areas, were destroyed or damaged by the natural disasters of 2008. Under the program, the authority may grant funds in accordance with this chapter to local government participants, including certain Iowa councils of governments, cities, and counties. The local government participants shall, in turn, loan funds to eligible residents under the conditions specified in this chapter to assist those eligible residents in purchasing homes generally comparable to those they lived in prior to the occurrence of the natural disasters of 2008, in repairing or rehabilitating disaster-affected homes, and in making mortgage payments and paying for other eligible property-carrying costs while the eligible residents await a property acquisition of their disaster-affected homes.

265—29.2(16) Definitions. For purposes of this chapter, the following definitions apply.

"Authority" means the Iowa finance authority.

"COG" means an Iowa council of governments as identified by Iowa Code chapter 28H.

"Disaster-affected home" means a primary residence that was destroyed or damaged by the natural disasters of 2008.

"Disaster compensation" means moneys received by an eligible resident as a result of damage caused to the eligible resident's disaster-affected home by the natural disasters of 2008 from any of the following sources: (1) FEMA, (2) any other governmental assistance, or (3) proceeds of any insurance policy. "Disaster compensation" shall not include rental assistance received from FEMA or other sources.

"Eligible energy-efficient home appliances and improvements" means energy-efficient furnaces, boilers, appliances, air conditioners, hot water heaters, windows, and insulation that meet standards set by the office of energy independence.

"Eligible property-carrying costs" means the following expenses associated with the ownership of a disaster-affected home: liability insurance premiums, flood insurance premiums, property tax payments, installment payments on a real estate purchase contract for the disaster-affected home provided that the real estate purchase contract was executed prior to the first date on which the disaster-affected home sustained damage as a result of the natural disasters of 2008, and special assessments.

"Eligible repair expenses" means the reasonable cost of repairing damage to a disaster-affected home necessitated by the natural disasters of 2008. "Eligible repair expenses" shall not include additions to or expansions of a disaster-affected home or the purchase or installation of luxury items that were not part of the disaster-affected home prior to the natural disasters of 2008.

"Eligible resident" means an individual or family who resided in a disaster-affected home at the time of the natural disasters of 2008 and who:

1. Is the owner of record of a right, title or interest in the disaster-affected home; and
2. Has been approved by FEMA for housing assistance as a result of the natural disasters of 2008.

In cases where multiple persons own a disaster-affected home together, such as by a tenancy in common or joint tenancy, such persons will generally be deemed collectively to be the "eligible resident," provided the requirements set forth above are met. In the event that multiple persons assert inconsistent claims as to who the owner of a disaster-affected home is, the local government participant shall review the facts and, if necessary, make an allocation among the various applicants.

"FEMA" means the Federal Emergency Management Agency.

"Forgivable loan" means a loan made to an eligible resident pursuant to the requirements of this chapter.

"Local government participant" means:

1. Any of the following Iowa cities: Ames, Cedar Falls, Cedar Rapids, Council Bluffs, Davenport, Des Moines, Dubuque, Iowa City, Waterloo, and West Des Moines;

2. Any COG whose territory encompasses one or more Iowa counties that have been declared by the President of the United States to be disaster areas; and

3. Any county that is not part of any Iowa council of governments and has been declared by the President of the United States to be a disaster area.

"Natural disasters of 2008" means the severe storms, tornadoes, and flooding that occurred in Iowa between May 25, 2008, and August 13, 2008, and designated by FEMA as FEMA-1763-DR.

"Program" means the jump-start housing assistance program described in this chapter.

"Retention agreement" means an agreement, to be recorded as a lien against the property for which assistance is provided, requiring that if an eligible resident sells a home that was purchased or repaired or for which a mortgage loan was paid with the assistance of a loan made under this chapter, then that portion of the original principal amount that has not been forgiven, if any, shall be repaid.

265—29.3(16) Grants to local government participants.

29.3(1) *Allocation criteria.*

a. Initial allocation, loans to local government participants. The authority shall make an initial allocation of the funds made available for the program to the local government participants pro rata based on the funds awarded by FEMA under its housing assistance program to each local government participant's jurisdiction as a percentage of the total amount of funds awarded as a result of the natural disasters of 2008. The authority shall enter into a grant agreement with each local government participant, pursuant to which the authority may disburse funds to the local government participant for the purposes described in this chapter. The grant agreement shall be prepared by the authority and may contain such terms and conditions, in addition to those specified in this chapter, as the executive director may deem to be necessary and convenient to the administration of the program and to the efficient and responsible use of the granted funds.

b. Funds made available pursuant to 2009 Iowa Acts, Senate File 376. The authority shall allocate program funds made available under 2009 Iowa Acts, Senate File 376, section 29, Disaster Damage Housing Assistance Grant Fund [creating Iowa Code section 16.186], by inviting local government participants to submit an application for funding. The authority shall award program funding made available under this paragraph based upon priority criteria to be specified in the application form including, but not limited to, the following:

(1) The applicant's demonstrated maximum use and leverage of other disaster recovery resources; and

(2) Provision of program assistance to the maximum number of potential eligible residents with priority given to eligible residents who:

1. Have not received any moneys under the program;

2. Are in need of an interim mortgage assistance extension meeting the conditions specified in subrule 29.5(2); and

3. Are not eligible for assistance under the requirements of other available disaster recovery assistance programs.

29.3(2) *Review of requests for assistance.* The local government participant shall accept and review each request for assistance and shall determine whether the requesting party is an eligible resident. If the requesting party is determined an eligible resident, the local government participant shall determine whether the funds are being requested for a use permitted under the program and the amount available to the eligible resident under the terms of the program.

29.3(3) *Coordination with the jump-start business assistance program.* For presidentially declared disaster areas outside a COG region, counties may elect to apply singly, join with other counties, or join with an adjacent COG region. Likewise, a city named in the definition of "local government participant" in rule 265—29.2(16) may join with a COG, county, or multicounty entity. To the extent local government participants act jointly or cooperatively in their participation in the small business disaster recovery financial assistance program administered by the Iowa department of economic development pursuant to 261—Chapter 78, Iowa Administrative Code, the authority may require the

local government participants to similarly act jointly or cooperatively in their participation under this chapter.

29.3(4) *Reallocation of unused funds.* Following one year, or following any three-month period during which a local government participant has requested no draws, the authority may reallocate all or part of any remaining portion of funds allocated to that local government participant to another local government participant with a demonstrated need for program funds.

29.3(5) *Administrative fees.* Each local government participant shall be entitled to receive an administrative fee equal to 5 percent of its initial disbursement, which shall consist of 30 percent of the local government participant's initial allocation. Subsequent thereto, each local government participant shall receive 5 percent of the funds loaned by the local government participant to eligible residents under the program from subsequent disbursements. The administrative fee shall be paid from the allocation made to each such local government participant by the authority pursuant to subrule 29.3(1).

29.3(6) *Proceeds of repayments.* All loan amounts repaid to a local government participant by an eligible resident pursuant to this chapter shall be returned to the authority's housing assistance fund created by Iowa Code Supplement section 16.40.

[**ARC 7899B**, IAB 7/1/09, effective 6/10/09; **ARC 8074B**, IAB 8/26/09, effective 9/30/09]

265—29.4 Reserved.

265—29.5(16) Eligible uses.

29.5(1) *Forgivable loans.* Local government participants may make forgivable loans, pursuant to the conditions set forth in rule 265—29.7(16), to eligible residents for the following eligible uses:

a. Down payment assistance. An eligible resident whose disaster-affected home was destroyed or damaged beyond reasonable repair may be provided down payment assistance for the purchase of replacement housing located within the local government participant's jurisdiction and, if necessary, for the cost of making reasonable repairs to the home being purchased to make it safe, decent, and habitable. The amount of down payment assistance available to an eligible resident shall generally not exceed 25 percent of the purchase price of the home being purchased and, in no event, shall the down payment assistance and any amount allowed for repairs collectively exceed $50,000.

(1) For purposes of calculating the amount of down payment assistance available to the eligible resident, the amount of the down payment assistance shall be reduced by the amount of any disaster compensation received by the eligible resident in excess of any amount necessary to pay off a mortgage or real estate purchase contract on the disaster-affected home.

(2) As a condition of receiving down payment assistance, the eligible resident shall agree that any disaster compensation received subsequent to the closing of the forgivable loan, if not applied toward repayment of a mortgage on the disaster-affected home, shall be used by the eligible resident to pay down the balance of the forgivable loan outstanding at the time the eligible resident receives such disaster compensation.

(3) Down payment assistance shall be allowed only for the purchase of a primary residence by means of a fully amortized mortgage loan from a regulated lender featuring a rate of interest that is fixed for at least 5 years and that has a term not to exceed 30 years.

(4) Eligible residents who receive down payment assistance under this subrule may also receive the assistance available under subrule 29.5(2), but not the assistance available under paragraph 29.5(1)*"b."*

(5) An eligible resident shall not use the assistance allowed under this subrule for the purchase of more than one home.

b. Housing repair or rehabilitation. An eligible resident whose disaster-affected home is not proposed, or located in an area proposed, by a municipality or county to the Iowa homeland security and emergency management division for property acquisition under the hazard mitigation grant program set forth in Iowa Code chapter 29C (or under any other comparable program implemented in whole or in part to assist in recovery from the natural disasters of 2008) may receive financial assistance to pay for eligible repair expenses up to an amount not to exceed the lesser of $50,000 or 60 percent of the latest available assessed value of the disaster-affected home, not including the assessed value of the land on

which it is situated, dated prior to the natural disasters of 2008; provided, however, that for application purposes under paragraph 29.3(1)*"b"* allocating program funds under 2009 Iowa Acts, Senate File 376, section 29, the local government participant may elect to establish its own measure of housing repair or rehabilitation financial feasibility in lieu of 60 percent of the latest available assessed value of the disaster-affected home, not including the assessed value of the land on which it is situated, dated prior to the natural disasters of 2008. The eligible resident shall establish the necessity and reasonable cost of the repairs or rehabilitation to the reasonable satisfaction of the local government participant.

(1) For purposes of calculating the amount of assistance available to the eligible resident pursuant to this paragraph, the cost of repairs to, or rehabilitation of, the disaster-affected home shall be reduced by the amount of any disaster compensation received.

(2) As a condition of receiving assistance pursuant to this paragraph, the eligible resident shall agree that any disaster compensation received subsequent to the closing of the forgivable loan shall be used by the eligible resident to pay down the balance of the forgivable loan outstanding at the time the eligible resident receives such disaster compensation.

(3) An eligible resident who receives assistance pursuant to this paragraph shall not be eligible for assistance under either paragraph 29.5(1)*"a"* or subrule 29.5(2).

29.5(2) *Interim mortgage assistance loans.* An eligible resident whose disaster-affected home is proposed, or is located in an area proposed, by a municipality or county to the Iowa homeland security and emergency management division for property acquisition under the hazard mitigation grant program set forth in Iowa Code chapter 29C (or any other comparable program implemented in whole or in part to assist in recovery from the natural disasters of 2008) may receive financial assistance equivalent to an amount of up to $1,000 per month for the purpose of paying mortgage payments and other eligible property-carrying costs for the disaster-affected home for a period not to exceed 12 months. An eligible resident who receives assistance pursuant to this subrule shall not be eligible for assistance under paragraph 29.5(1)*"a."* If, however, it subsequently is determined by the Iowa homeland security and emergency management division that the disaster-affected home of the eligible resident will not be acquired under the hazard mitigation grant program, then the eligible resident shall be eligible for assistance under paragraph 29.5(1)*"a"* on the condition that the amount of assistance available under that paragraph shall be reduced by the amount of assistance received by the eligible resident under subrule 29.5(2). Financial assistance provided pursuant to this subrule shall be in the form of a forgivable loan.

a. Notwithstanding the foregoing, with the approval of the applicable local government participant, an eligible resident may receive financial assistance under this subrule for up to an additional 6 months (beyond the usual 12-month limit set forth above), provided that all of the following conditions are met:

(1) The eligible resident must reapply for or request an extension of financial assistance on forms to be provided by the applicable local government participant;

(2) The disaster-affected home for which an extension of financial assistance is sought must continue to be on the current hazard mitigation grant program (or comparable program) property acquisition list (i.e., it must continue to be proposed for buyout);

(3) The disaster-affected home for which an extension of financial assistance is sought must have been destroyed or damaged beyond reasonable repair such that the eligible resident is displaced from the home;

(4) The eligible resident must have contacted or must agree to contact the mortgage holder or an Iowa Mortgage Help counseling agency (Web site: www.iowamortgagehelp.com) to discuss the situation and, if possible, negotiate better terms.

b. Local government participants may fund extensions of financial assistance only from funds already allocated to their region. Local government participants shall give priority for extensions of financial assistance to those eligible residents who are supporting the costs of both the disaster-affected home and a new primary residence through a second mortgage payment or a rental payment.

29.5(3) *Energy efficiency assistance.* An eligible resident who receives either down payment assistance pursuant to paragraph 29.5(1)*"a"* or housing repair or rehabilitation assistance pursuant to

paragraph 29.5(1)*"b"* shall also be eligible to receive an additional loan amount, up to a maximum of $10,000, as reimbursement for the purchase and installation costs for eligible energy-efficient home appliances and improvements. Any amount allowed pursuant to this subrule shall be added to the principal balance of the forgivable loan. Amounts loaned pursuant to this subrule may be loaned either at the time the forgivable loan is first made or subsequent thereto within three months.

29.5(4) *Expenses incurred prior to September 19, 2008.* In the event an eligible resident purchased a home, made or caused to be made repairs to a disaster-affected home, or made mortgage payments (or paid for other eligible property-carrying costs) for a disaster-affected home located within the jurisdiction of a local government participant prior to September 19, 2008 (the effective date of this chapter), the eligible resident shall be eligible for reimbursement therefor under this chapter as though the purchase, repairs, or payments had taken place following September 19, 2008.

29.5(5) *Applications for assistance.* To apply for down payment assistance or down payment assistance plus interim mortgage assistance, the eligible resident shall apply to the local government participant in whose jurisdiction the home being purchased is located. To apply for assistance for repair or rehabilitation of a disaster-affected home, the eligible resident shall apply to the local government participant in whose jurisdiction the disaster-affected home is located. To apply for interim mortgage assistance only, the eligible resident shall apply to the local government participant in whose jurisdiction the disaster-affected home is located.

[**ARC 7842B**, IAB 6/17/09, effective 5/14/09; **ARC 7899B**, IAB 7/1/09, effective 6/10/09; **ARC 8074B**, IAB 8/26/09, effective 9/30/09; **ARC 8075B**, IAB 8/26/09, effective 9/30/09]

265—29.6(16) Loan terms. Loans made under the program shall, at a minimum, contain the following terms:

29.6(1) *Forgivability.* Forgivable loans made pursuant to the program shall be forgivable over a five-year period. One-fifth of the total principal amount loaned shall be forgiven following each full year the eligible resident owns the home for which the loan was made, beginning on the date of the final disbursement of forgivable loan proceeds.

29.6(2) *Zero percent interest.* Loans made pursuant to the program shall bear no interest.

29.6(3) *Five-year term.* All loans made pursuant to the program shall be for a term of five years.

29.6(4) *Repayment due upon sale of home.* Any principal of a forgivable loan that has not yet been forgiven at the time the home for which the forgivable loan was made is sold by the eligible resident (including property acquisitions) shall be due and payable upon such sale.

29.6(5) *Retention agreement.* Each loan made pursuant to this program shall be secured by a retention agreement which shall constitute a lien on the title of the real property for which the forgivable loan is made until such time as the forgivable loan has either been fully forgiven or paid in full; provided, however, that in the case of a property acquisition under the hazard mitigation grant program set forth in Iowa Code chapter 29C (or under any other comparable program implemented in whole or in part to assist in recovery from the natural disasters of 2008), payment of the following shall be waived:

a. That portion of the repayment due for a down payment assistance loan made under paragraph 29.5(1)*"a"* or an interim mortgage assistance loan made under subrule 29.5(2), provided that the amount so waived shall not exceed $25,000; and

b. That portion of the repayment due for a housing repair or rehabilitation assistance loan made under paragraph 29.5(1)*"b"* for which the eligible resident provides documentation that the assistance was expended for the purpose for which it was awarded.

[**ARC 7842B**, IAB 6/17/09, effective 5/14/09; **ARC 8075B**, IAB 8/26/09, effective 9/30/09; **ARC 8323B**, IAB 12/2/09, effective 11/4/09]

265—29.7(16) Financial assistance subject to availability of funding. All financial assistance authorized pursuant to this chapter shall be subject to funds being made available to the authority for the purposes set forth herein.

265—29.8(16) Funds allocated pursuant to 2009 Iowa Acts, House File 64, division I. Notwithstanding the foregoing, the following additional restrictions shall apply to loans made pursuant to program funding allocated under 2009 Iowa Acts, House File 64, division I:

29.8(1) *Income.* An eligible resident must have a family income equal to or less than 150 percent of the area median family income.

29.8(2) *Application deadline.* An eligible resident must submit an application for assistance by September 1, 2009.

29.8(3) *Priorities.* Forgivable loans awarded under this rule shall be awarded pursuant to the following priorities:

a. First priority. First priority shall be given to eligible residents who have not received any moneys under the program.

b. Second priority. Second priority shall be given to eligible residents who have received less than $24,999 under the program.

c. Third priority. Third priority shall be given to eligible residents who have received $24,999 under the program and who continue to have unmet needs for down payment assistance, emergency housing repair or rehabilitation, interim mortgage assistance, or energy efficiency assistance. An eligible resident shall not receive more than an additional $24,999 under this paragraph.

29.8(4) *Maximum assistance.* Except as provided in paragraph 29.8(3)*"c,"* an eligible resident who meets the area median family income requirement shall not receive more than $24,999 under the program.
[**ARC 7899B**, IAB 7/1/09, effective 6/10/09; **ARC 8074B**, IAB 8/26/09, effective 9/30/09]

These rules are intended to implement Iowa Code sections 16.5(1)*"r"* and 16.40, 2009 Iowa Acts, Senate File 376, section 29, and 2009 Iowa Acts, House File 64, division I.

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CHAPTER 32
IOWA JOBS PROGRAM

265—32.1(16,83GA,SF376) Purpose. The Iowa jobs board is charged by the Iowa legislature and the governor with establishing, overseeing and providing approval of the administration of the Iowa jobs program. The board will encourage and support public construction projects relating to disaster relief and mitigation and to local infrastructure.
[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

265—32.2(16,83GA,SF376) Definitions. When used in this chapter, the following definitions apply unless the context otherwise requires:

"Authority" or *"IFA"* means the Iowa finance authority.

"Board" means the Iowa jobs board as established in 2009 Iowa Acts, Senate File 376, section 5.

"Disaster" means the severe storms, tornadoes, and flooding that occurred in Iowa between May 25, 2008, and August 13, 2008, and designated by FEMA as FEMA-1763-DR; additionally, the Iowa jobs board may, by resolution, designate an event that occurs subsequent to June 15, 2009, as a disaster.

"Financial feasibility" means the ability of a project, once completed, to be maintained and operated for its useful life with funds either generated by the project itself or from an identifiable source of funds available for such purpose.

"Future flood prevention" means measures intended to mitigate or lessen the damages caused by future flooding.

"Indirect jobs" means jobs created by suppliers of materials used in the construction or operation of the project.

"Induced jobs" means jobs collaterally created throughout the economy by a project as employed workers and firms buy other goods and services.

"Iowa jobs program review committee" or *"review committee"* means the committee established by 2009 Iowa Acts, Senate File 376, section 9(2), and constituted as described in this chapter.

"Local infrastructure" means:

1. Projects relating to disaster rebuilding;
2. Reconstruction and replacement of local public buildings;
3. Flood control and flood protection; and
4. Future flood prevention.

"Local infrastructure" does not include routine, recurring maintenance or operational expenses or leasing of a building, appurtenant structure, or utility without a lease-purchase agreement.

"Local support" means endorsement of a proposed project by local individuals, organizations, or governmental bodies that have a substantial interest in a project.

"Program" means the Iowa jobs program established in 2009 Iowa Acts, Senate File 376, sections 5 to 12.

"Public construction project" means a project for the construction of local infrastructure by a county, city, or public organization.

"Public organization" means a nonprofit organization that sponsors or supports the public needs of one or more local Iowa communities and that was in operation prior to January 1, 2009; provided that (1) such organization is described in Section 501(c)(3) or 501(c)(4) of the Internal Revenue Code and is exempt from federal tax under Section 501(a) of the Internal Revenue Code, and (2) such organization is determined by the board not to be affiliated with or controlled by a for-profit organization.

"Recipient" means an entity under contract with the Iowa jobs board to receive Iowa jobs funds and undertake a funded project.

"Sustainability" means the use, development, and protection of resources at a rate and in a manner that enables people to meet their current needs while allowing future generations to meet their own needs; "sustainability" requires simultaneously meeting environmental, economic and community needs.
[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

265—32.3(16,83GA,SF376) Allocation of funds. All Iowa jobs funds shall be awarded and used as specified in 2009 Iowa Acts, Senate File 376, and these rules. Any portion of an amount allocated for projects that remains unexpended or unencumbered one year after the allocation has been made by the board may be reallocated by the board to another project category, at the discretion of the board. All bond proceeds shall be expended within three years from when the allocation was initially made. The total amount of allocations for future flood prevention, reconstruction and replacement of local public buildings, disaster rebuilding, flood control and flood protection projects (pursuant to the local infrastructure competitive grant program) shall not exceed $165 million for the fiscal year beginning July 1, 2009.
[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

265—32.4(16,83GA,SF376) Local infrastructure competitive grant program. The board shall assist in the development and completion of public construction projects relating to disaster relief and mitigation and to local infrastructure by overseeing and providing approval of the administration of a local infrastructure competitive grant program, as set forth herein.

32.4(1) *Iowa jobs program review committee.* The Iowa jobs program review committee shall comprise five members, consisting of the following members of the Iowa jobs board: three of the general public members, as appointed to the review committee by the Iowa jobs chair, the executive director of the Iowa finance authority (or designee), and the director of Iowa workforce development (or designee). The review committee shall comply with Iowa Code chapter 21 and with Iowa Code sections 69.16 and 69.16A. From its public members, the review committee shall elect a chair and a vice chair. Two-thirds of the review committee members eligible to vote shall constitute a quorum authorized to act in the name of the review committee.

32.4(2) *Eligible applicants.* Eligible applicants for Iowa jobs local infrastructure competitive grant program funds shall be Iowa cities, Iowa counties, and public organizations.

32.4(3) *Eligible projects and forms of assistance.* For a project to be eligible to receive a competitive grant from the board, the project must be a public construction project in the state of Iowa with a demonstrated substantial local, regional, or statewide economic impact. Financial assistance shall be awarded only in the form of grants. An applicant for a competitive grant shall not receive more than $50 million in financial assistance from the Iowa jobs restricted capitals fund.

a. Any award of a competitive grant to a project shall be limited as follows:

(1) Up to 75 percent of the total cost of a project for replacing or rebuilding existing disaster-related damaged property; or

(2) Up to 50 percent of the total cost for all other projects.

b. The authority, with the approval of the chair and vice chair of the Iowa jobs board, shall have the ability to make technical corrections to an award that are within the intent of the terms of a board-approved award.

32.4(4) *Ineligible projects.* The board shall not approve an application for a competitive grant for either of the following purposes:

a. To refinance a loan existing prior to the date of the initial financial assistance application.

b. For a project that has previously received financial assistance under the local infrastructure competitive grant program, unless the applicant demonstrates that the financial assistance would be used for a significant expansion of such a project.

32.4(5) *Threshold application requirements.* To be considered for a competitive grant, an application shall meet all of the following threshold requirements:

a. Prior to filing an application, the applicant must file, on the form and in the manner prescribed by the authority, a notice of intent to apply not less than 20 days prior to submitting its application;

b. The application must be submitted by an eligible applicant, must be complete and on forms or in the format specified for such purpose by the authority (the authority may, in its discretion, require the use of a Web-based application format), and must be received by the authority by the applicable deadline;

c. The proposed project must be for the development and completion of one or more public construction projects relating to disaster relief and mitigation or to local infrastructure;

d. There must be demonstrated local support for the proposed project;

e. The proposed public construction project must have a demonstrated substantial local, regional, or statewide economic impact; and

f. The application must coordinate any federal funds with state, local, and private funds and shall avoid any duplication of benefits that would limit or cause the loss of federal funding.

Prior to submitting an application to the review committee, the authority may contact the applicant to clarify information contained in the application. An application may be amended one time prior to being sent to the review committee. Applications may be otherwise amended with the approval of a majority of the review committee.

32.4(6) *Application procedure.*

a. Applications shall be reviewed and scored in rounds. The deadline for submission for the first round of applications shall be August 3, 2009. Subsequent rounds shall be at the discretion of the board as funding is available. Applications for each such round shall be due not later than January 1, April 1, July 1, and October 1 of each year, respectively.

b. Subject to availability of funds, applications will be reviewed by IFA staff on an ongoing basis. Applications will be reviewed by staff for completeness and eligibility. If additional information is required, the applicant shall be requested, in writing, to submit additional information. For applications that meet the threshold requirements, authority staff shall submit to the members of the review committee a copy of the application along with a review, analysis, and evaluation of complete applications.

c. The review committee members will score the applications according to the criteria set forth in subrule 32.4(7), and IFA staff shall compile the scores. To be eligible for a grant, a proposed project must receive a minimum score of at least 100 points. The review committee shall meet to review the ratings for each round of applications. Those applications meeting the minimum criteria shall be referred to the Iowa jobs board with a recommendation of final approval, denial, or deferral.

d. Once an application has been referred to the Iowa jobs board, the applicant may, upon request of the applicant and at the discretion of the chair of the board, make a presentation to the board. The board may impose reasonable limitations on the length and format of such presentations.

e. If the board determines that an application should be approved, the board shall send the application to negotiations. Negotiations shall be conducted by IFA staff, who may work in cooperation with members of the Iowa jobs board. The negotiators shall negotiate the terms and conditions of a grant agreement to recommend to the board.

f. Following negotiations, the negotiating team shall report back to the Iowa jobs board as to whether it was able to agree with the applicant on the terms of a proposed grant agreement and, if so, the proposed terms and conditions resulting from the negotiations. The Iowa jobs board shall then vote, without further substantive revision, on whether to agree to the negotiated terms.

g. If the negotiated terms are agreed to by the Iowa jobs board, a grant agreement memorializing the negotiated terms shall be executed by the chair or vice chair of the Iowa jobs board.

h. Application resources for the Iowa jobs program are available at the Iowa jobs Web site: www.ijobsiowa.gov.

i. IFA may provide technical assistance as necessary to applicants. IFA staff may conduct on-site evaluations of proposed projects.

j. A denied or deferred application may be revised and resubmitted as a new application in a subsequent round, if any. Unless a deferred application is withdrawn by the applicant or revised and resubmitted as a new application, the authority shall keep it on file, and its score shall automatically be ranked among new applications submitted for the next round, if any, once such new applications have been scored.

32.4(7) *Application review criteria.* The Iowa jobs program review committee shall evaluate and rank applications based on the following criteria:

a. The total number and quality of jobs to be created and the benefits likely to accrue to areas distressed by high unemployment (0-40 points). The number of jobs created and other measures of economic impact to areas distressed by high unemployment, including long-term tax generation, shall be evaluated. Rating factors for this criterion include, but are not necessarily limited to, the following:

(1) Number of jobs. The number of jobs reasonably projected to be created or retained and the number of hours anticipated for each such job shall be compared and ranked.

(2) Quality of jobs. The wages to be paid for each position to be created or retained, the average benefits (including health benefits) to be provided, as well as other subjective qualitative factors, such as work conditions and safety, shall be compared and ranked.

(3) Other benefits likely to accrue to areas distressed by high unemployment, such as the degree to which the project enhances the quality of life in a region and contributes to the community's efforts to retain and attract a skilled workforce.

In order to be eligible for funding, proposals must score at least 20 points on this criterion.

b. Financial feasibility, including the ability of projects to fund depreciation costs or replacement reserves, and the availability of other federal, state, local, and private sources of funds (0-40 points). The feasibility of the proposed project shall be evaluated. Rating factors for this criterion include, but are not limited to, the following:

(1) A financial analysis of the project, which shall include a description of sources of funding, project budget, and detailed projections of the project's revenues and expenses for the projected useful life of the project;

(2) An analysis of the operational plan, which shall provide detailed information about how the proposed project will be operated and maintained, including a time line for implementing the project;

(3) The availability of other federal, state, local, and private sources of funds for the project.

In order to be eligible for funding, proposals must score at least 20 points on this criterion.

c. Sustainability and energy efficiency. The sustainability and energy efficiency of the proposed project shall be evaluated. Rating factors for this criterion include, but are not limited to, the following:

(1) Sustainability (0-20 points). The extent to which the project has taken sustainability planning principles into consideration.

1. The project shall be evaluated based on the following specific factors:

- Efficient and effective use of land resources and existing infrastructure by encouraging compact development in areas with existing infrastructure or capacity to avoid costly duplication of services and costly use of land; conservation of open space and farmland and preservation of critical environmental areas; and promotion of the safety, livability, and revitalization of existing urban and rural communities. Compact development maximizes public infrastructure investment and promotes mixed uses, greater density, bicycle and pedestrian networks, and interconnection with the existing street grid.
- Provision for a variety of transportation choices, including public transit and pedestrian and bicycle traffic.
- Construction and promotion of developments, buildings, and infrastructure that conserve natural resources by reducing waste and pollution through efficient use of land, energy, water, and materials.
- Capture, retention, infiltration and harvesting of rainfall using storm water best management practices such as permeable pavement, bioretention cells, bioswales, and rain gardens to protect water resources.
- The extent to which project design, construction, and use incorporate renewable energy sources including, but not limited to, solar, wind, geothermal, and biofuels, and support the following state of Iowa plans and goals: (1) office of energy independence's Iowa energy independence plan; and (2) general reduction of greenhouse gas emissions.

2. Alternatively, in lieu of being evaluated on each of the criteria set forth above, projects which are designed to receive certification (either platinum level, gold level, silver level, or basic LEED certification) from the United States Green Building Council in the Leadership in Energy and Environmental Design (LEED) Green Building Rating System version 3.0, and which comply with the requirements of ASHRAE 90.1-2007, Energy Standard for Buildings Except Low-Rise Residential Buildings, published by the American Society of Heating, Refrigerating and Air-Conditioning Engineers, 1791 Tullie Circle, N.E., Atlanta, GA 30329, shall receive 20 points.

(2) Energy efficiency (0-20 points). The extent to which the project has taken energy efficiency planning principles into consideration.

1. In the case of new construction, whether the project is designed to meet the current state building energy code. The application for the project must include a letter from the engineer or architect to IFA certifying whether the proposed construction meets the current state building energy code. Additionally, the application should address whether the proposed project is designed to meet energy star standards. If the project is of such a nature that the current state building energy code does not apply to it, the letter shall so state.

2. In the case of rehabilitation of existing structures, an energy audit conducted by a certified energy rater should be provided on each building prior to the preparation of the final work rehabilitation order to determine the feasibility of meeting the requirements of the current state building energy code and energy star standards prior to the start of the rehabilitation. If it is determined to be feasible to meet the current state building energy code standards and energy star standards, appropriate specifications will be written into the work order. If it is not feasible to meet the requirements of the current state building energy code and energy star standards (or either of them), the application will provide information indicating what effective and cost-effective energy improvements will be included as a part of the rehabilitation project.

d. Benefits for disaster recovery (0-40 points). The likely benefits for disaster recovery of the proposed project shall be evaluated. Wherever applicable, rating factors for this criterion include, but are not limited to, the following:

(1) Whether the proposed project replaces or repairs a structure or facility damaged by the disaster and incorporates measures for reducing or eliminating future disaster losses;

(2) Whether the proposed project would help achieve the community's or region's overall post-disaster recovery vision;

(3) Whether the proposed project benefits the economic recovery of individuals, businesses, or nonprofit organizations.

e. The project's readiness to proceed (0-40 points). The readiness of the project to proceed shall be evaluated. Wherever applicable, rating factors for this criterion include, but are not limited to, the following:

(1) Whether all engineering and architectural work required for construction to begin has been completed;

(2) Whether all financing for the project (other than competitive grant funds awarded under this chapter) has been committed and is available;

(3) Whether all real property interests (including easements and temporary construction easements) necessary for the construction of the project have been acquired;

(4) Whether all necessary governmental approvals, at the federal, state, and local levels (including, but not limited to, zoning variances, building permits, approval from the Army Corps of Engineers, etc.), have been obtained;

(5) Whether the project has demonstrated a reasonable likelihood of incurring at least 10 percent of the project's total projected development cost within three months of execution of the grant award agreement.

f. General scoring criteria.

(1) In instances where a given criterion is not applicable to a proposed project due to the nature of the project, the review committee members may adjust scoring so that the project is not disadvantaged as a result of the inapplicable criterion. For example, if an earthen levee is proposed as a means of flood control, it should not lose points relative to other proposed projects because it does not comply with the current state building energy code (which does not apply to earthen levees).

(2) Any proposed project that is identified in an Iowa great places agreement, pursuant to Iowa Code section 303.3C, shall have an additional two points added to its cumulative point total.

[**ARC 7941B**, IAB 7/15/09, effective 6/15/09; **ARC 8103B**, IAB 9/9/09, effective 8/19/09; **ARC 8327B**, IAB 12/2/09, effective 11/4/09]

265—32.5(16,83GA,SF376) Noncompetitive grants.

32.5(1) The board shall award $46,500,000 as follows for disaster relief and mitigation and local infrastructure grants for the following renovation and construction projects, notwithstanding

any limitation on the state's percentage participation in funding as contained in Iowa Code section 29C.6(17):

a. For grants to a county with a population between 189,000 and 196,000 in the latest preceding certified federal census, to be distributed as follows:

(1) Ten million dollars for the construction of a new, shared facility between nonprofit human service organizations serving the public, especially the needs of low-income Iowans, including those displaced as a result of the disaster of 2008.

(2) Five million dollars for the construction or renovation of a facility for a county-funded workshop program serving the public and particularly persons with mental illness or developmental disabilities.

b. For grants to a city with a population between 110,000 and 120,000 in the latest preceding certified federal census, to be distributed as follows:

(1) Five million dollars for an economic redevelopment project benefiting the public by improving energy efficiency and the development of alternative and renewable energy technologies.

(2) Ten million dollars for a museum serving the public and dedicated to the preservation of an eastern European cultural heritage through the collection, exhibition, preservation, and interpretation of historical artifacts.

(3) Five million dollars for a theater serving the public and promoting culture, entertainment, and tourism.

(4) Five million dollars for a public library.

(5) Five million dollars for a public works building.

c. One million five hundred thousand dollars, to be distributed as follows:

(1) Five hundred thousand dollars to a city with a population between 600 and 650 in the latest preceding certified federal census, for a public fire station.

(2) Five hundred thousand dollars to a city with a population between 1,400 and 1,500 in the latest preceding certified federal census, for a public fire station.

(3) Five hundred thousand dollars for a city with a population between 7,800 and 7,850, for a public fire station.

32.5(2) Noncompetitive grant awards are contingent upon submission of a plan for each project by the applicable county or city governing board or, in the case of a project submitted pursuant to subparagraph 32.5(1)*"b"*(2), by the board of directors, to the Iowa jobs board no later than September 1, 2009, detailing a description of the project, the plan to rebuild, and the amount or percentage of federal, state, local, or private matching moneys which will be or have been provided for the project. Funds not utilized in accordance with this rule due to failure to submit a plan by the September 1 deadline shall revert to the Iowa jobs restricted capitals fund to be available for local infrastructure competitive grants.

32.5(3) A grant recipient under subparagraph 32.5(1)*"b"*(2) shall not be precluded from applying for a local infrastructure competitive grant pursuant to this rule and 2009 Iowa Acts, Senate File 376, section 9.

[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

265—32.6(16,83GA,SF376) General grant conditions. As a condition of receipt of Iowa jobs funds, recipients shall agree, at a minimum, to all of the following:

32.6(1) *Documentation of jobs created or retained.* Following the receipt of grant funds pursuant to this chapter and for two years following the completion of the project, each recipient shall report to the authority quarterly the actual number of jobs created as a result of the project along with other information relating to the quality of such jobs, including hours and wages, as requested by the authority.

32.6(2) *Recipient obligations.* In the event a recipient fails to comply with the requirements of this program or the recipient's grant agreement, the board may cancel the recipient's grant and require the return of any grant funds previously disbursed pursuant to this program. Recipients shall agree to hold harmless and to indemnify the Iowa jobs board, the authority, the state of Iowa, and their officers, employees and agents from any claims, costs or liabilities arising out of the development or operation of the project.

32.6(3) *Grant acknowledgment.* Each project shall recognize in a prominent location and manner the fact that the project was made possible, in part, through a grant from the Iowa jobs program. During the construction period the recognition (including a display of the Iowa jobs logo) may be located on temporary signage. The completed project shall feature a permanent acknowledgment, such as a plaque or a similar commemoration. Other benefactors of the project may be similarly acknowledged as well.

32.6(4) *Use of Iowa jobs Web site.* All positions that need to be filled for a project shall be posted on Iowa workforce development's Iowa jobs Web site: www.iowajobs.org/.
[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

265—32.7(16,83GA,SF376) Calculation of jobs created. For purposes of this chapter, new employment positions created and filled (or to be created and filled) as a result of the project and existing positions that would not have been continued were it not for Iowa jobs funding shall be counted when estimating the number of jobs to be created during the application process and when counting the number of actual jobs created in post-grant reporting. Both permanent and temporary positions filled by the grantee, a contractor, or a subcontractor (or sub-subcontractor, etc.), including construction work, shall be counted. To be counted, a position must be compensated. Indirect jobs and induced jobs shall not be counted.
[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

265—32.8(16,83GA,SF376) Grant awards. The Iowa jobs board may fund a component of a proposed project if the entire project does not qualify for funding. The board shall review awards made to ensure geographic diversity. In order to promote geographic diversity, the board may defer grant decisions on applications from areas which have received previous grant awards to allow applications from other parts of the state to be considered.
[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

265—32.9(16,83GA,SF376) Administration of awards.

32.9(1) A grant agreement shall be executed between successful applicants (under both the competitive and noncompetitive grant programs) and the Iowa jobs board. These rules and applicable state laws and regulations shall be part of the contract. The board reserves the right to negotiate wage rates as well as other terms and conditions of the contract.

32.9(2) The recipient must execute and return the contract to the Iowa jobs board within 45 days of transmittal of the final contract from the Iowa jobs board. Failure to do so may be cause for the Iowa jobs board to terminate the award.

32.9(3) Certain projects may require that permits or clearances be obtained from other state, local, or federal agencies before the activity may proceed. Awards may be conditioned upon the timely completion of these requirements.

32.9(4) Awards may be conditioned upon commitment of other sources of funds necessary to complete the project.

32.9(5) Any substantive change to a contract shall be considered an amendment. Substantive changes include time extensions, budget revisions, and significant alterations that change the scope, location, objectives or scale of an approved project. Amendments must be requested in writing by the recipient and are not considered effective until approved by the Iowa jobs board and confirmed in writing by IFA staff following the procedure specified in the contract between the recipient and the Iowa jobs board.
[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

These rules are intended to implement Iowa Code section 16.5(1)*"r"* and 2009 Iowa Acts, Senate File 376, sections 5 to 12.

[Filed Emergency ARC 7941B, IAB 7/15/09, effective 6/15/09]
[Filed Emergency ARC 8103B, IAB 9/9/09, effective 8/19/09]
[Filed Emergency ARC 8327B, IAB 12/2/09, effective 11/4/09]

CHAPTER 35
AFFORDABLE HOUSING ASSISTANCE GRANT FUND

265—35.1(16,83GA,SF376) Affordable housing assistance grant fund allocation plan. The affordable housing assistance grant fund allocation plan entitled Iowa Finance Authority Affordable Housing Assistance Grant Fund Allocation Plan dated November 2009 shall be the allocation plan for the award, pursuant to the affordable housing assistance grant fund program, of funds held within the affordable housing assistance grant fund established in 2009 Iowa Acts, Senate File 376, section 30. The allocation plan for the affordable housing assistance grant fund program is incorporated by reference pursuant to Iowa Code section 17A.6 and 265—subrules 17.4(2) and 17.12(2).
[**ARC 7897B**, IAB 7/1/09, effective 6/10/09; **ARC 8076B**, IAB 8/26/09, effective 9/30/09; **ARC 8325B**, IAB 12/2/09, effective 11/4/09]

265—35.2(16,83GA,SF376) Location of copies of the plan. The allocation plan for the affordable housing assistance grant fund program may be reviewed and copied in its entirety on the authority's Web site at www.iowafinanceauthority.gov. Copies of the allocation plan for the affordable housing assistance grant fund program, the application forms, and all related attachments and exhibits, if any, shall be deposited with the administrative rules coordinator and at the state law library. The plan incorporates by reference 2009 Iowa Acts, Senate File 376, section 30.
[**ARC 7897B**, IAB 7/1/09, effective 6/10/09; **ARC 8076B**, IAB 8/26/09, effective 9/30/09]

These rules are intended to implement Iowa Code section 16.5(1)*"r"* and 2009 Iowa Acts, Senate File 376, section 30.

[Filed Emergency ARC 7897B, IAB 7/1/09, effective 6/10/09]
[Filed ARC 8076B (Notice ARC 7898B, IAB 7/1/09), IAB 8/26/09, effective 9/30/09]
[Filed Emergency ARC 8325B, IAB 12/2/09, effective 11/4/09]

CHAPTER 8
ALL IOWA OPPORTUNITY SCHOLARSHIP PROGRAM

283—8.1(261) Basis of aid. Tuition assistance available under the all Iowa opportunity scholarship program is based on the financial need of Iowa residents enrolled at eligible Iowa colleges and universities.

283—8.2(261) Definitions. As used in this chapter:

"Eligible college or university" means an Iowa community college, an institution of higher education governed by the state board of regents, or an accredited private institution located in Iowa that meets all eligibility requirements set forth in Iowa Code section 261.9. All eligible colleges and universities must submit annual reports which include student and faculty information, enrollment and employment information, and other information required by the commission as described in Iowa Code sections 261.9 through 261.16.

"Expected family contribution (EFC)" is the means by which the commission ranks the relative need of an applicant for financial assistance. Expected family contribution shall be evaluated annually on the basis of a confidential statement of family finances filed on a form designated by the commission. The commission has adopted the use of the Free Application for Federal Student Aid (FAFSA), a federal form used to calculate a formula developed by the U.S. Department of Education, the results of which are used to determine expected family contribution. Relative need will be ranked based on the applicant's expected family contribution (EFC) provided by the U.S. Department of Education. The FAFSA must be received by the processing agent by the date specified in the application instructions.

"Full-time" means enrollment at an eligible college or university in a course of study including at least 12 semester hours or the trimester or quarter equivalent.

"Iowa resident" means a person who meets the criteria used by the state board of regents to determine residency for tuition purposes as described in 681—1.4(262) or a person who meets the criteria defined by the Iowa department of education's "Iowa community college uniform policy on student residency status."

"Part-time" means enrollment at an eligible college or university in a course of study including at least three semester hours or the trimester or quarter equivalent.

283—8.3(261) Eligibility requirements.

8.3(1) Applicants for the all Iowa opportunity scholarship program must complete the Free Application for Federal Student Aid (FAFSA) by the date specified in the application instructions and any additional applications or documents required by the commission. In addition to completing the FAFSA, an applicant must be:

a. An Iowa resident who begins his or her initial period of postsecondary enrollment within two academic years of graduation from high school;

b. An Iowa high school student with at least a 2.5 cumulative grade point average on a 4.0 scale or its equivalent; and

c. Enrolled for at least three semester hours, or the trimester or quarter equivalent, in a program eligible for federal student aid under Title IV of the federal Higher Education Act leading to an undergraduate degree, diploma, or certificate from an eligible college or university.

8.3(2) To maintain eligibility, recipients must maintain satisfactory academic progress as defined by the eligible college or university.

8.3(3) Individuals who have military obligations may delay the initial period of enrollment for up to four academic years beyond high school graduation or must begin postsecondary enrollment within two academic years of discharge. Exceptions for health or other personal reasons for delaying the initial period of enrollment will be reviewed by commission staff on a case-by-case basis.

[**ARC 8333B**, IAB 12/2/09, effective 1/6/10]

283—8.4(261) Awarding of funds.

8.4(1) *Selection criteria.* All applicants who submit applications that are received on or before the published deadline will be considered for funding.

8.4(2) *Priority for grants.* Only applicants with expected family contributions (EFCs) at or below the average tuition and fees for regent university students for the academic year for which awards are being made will be considered for awards.

a. All eligible renewal applicants will be funded prior to new applicants. In the event that all renewal applicants cannot be funded, applicants will be awarded based on EFC and application date.

b. Priority will be given to students who participated in federal TRIO programs or alternative programs in high school and to students who graduated from alternative high schools. Awards will be made to students in this category based on EFC levels within the parameters defined by the commission, with students in the lowest EFC levels awarded first and at increasing EFC levels until the maximum EFC level is reached.

c. If sufficient funding is not available to make awards to all remaining eligible applicants, awards will be made only to those students whose EFCs combined with federal Pell grants, Iowa vocational-technical tuition grants, and Iowa tuition grants total less than the designated EFC level. Students will be awarded by EFC level beginning with the lowest EFC levels until all funds have been expended.

8.4(3) *Maximum award.* The maximum award for full-time students will be the average tuition and fees for regent university students for the award year or the tuition and fees paid by the student, whichever is less. The maximum award for a full-time recipient will not be affected by the ranking system used to prioritize grants. A part-time recipient will receive a prorated award, as defined by the commission, based on the number of hours for which the student is enrolled.

8.4(4) *Awarding process.*

a. College and university officials will provide information about eligible students to the commission in a format specified by the commission.

b. The commission will designate recipients until all funding has been expended.

c. The commission will notify recipients and college and university officials of the awards, clearly indicating the award amount and the state program from which funding is being provided and stating that funding is contingent on the availability of state funds.

d. The college or university will apply awards directly to student accounts to cover tuition and fees.

e. The college or university is responsible for completing necessary verification and for coordinating other aid to ensure compliance with student eligibility requirements and allowable award amounts. The college or university will report changes in student eligibility to the commission.

8.4(5) *Award transfers and adjustments.* Recipients are responsible for promptly notifying the appropriate college or university of any change in enrollment or financial situation. The college or university will make necessary changes and notify the commission.

8.4(6) *Academic-year awards.* All Iowa opportunity scholarships are provided during the traditional nine-month academic year, which is generally defined as September through May. Students attending eligible community colleges may receive no more than four semesters of full-time all Iowa opportunity scholarships or eight part-time semesters. Students attending eligible regent universities and other eligible colleges and universities may receive no more than two semesters of full-time all Iowa opportunity scholarships or four part-time semesters.

8.4(7) *Renewal.* Applicants must complete and file annual applications (FAFSAs) for the all Iowa opportunity scholarship program by the deadline established by the commission. If funds remain available after the application deadline, the commission will continue to accept applications. To be eligible for renewal, a recipient must maintain satisfactory academic progress as defined by the eligible college or university and must not have exceeded the funding limit as described in 8.4(6).

283—8.5(261) Restrictions. A student who is in default on a Stafford Loan, SLS Loan, or a Perkins/National Direct/National Defense Student Loan or who owes a repayment on any Title IV grant

assistance or state award shall be ineligible for assistance under the all Iowa opportunity scholarship program. Eligibility for state aid may be reinstated upon payment in full of the delinquent obligation or by commission ruling on the basis of adequate extenuating evidence presented in an appeal under the procedures set forth in 283—Chapters 4 and 5. Credits that a student receives through "life experience credit" and "credit by examination" are not eligible for funding.

These rules are intended to implement Iowa Code Supplement section 261.87.

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HUMAN SERVICES DEPARTMENT[441]

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

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CHAPTER 15
RESOLUTION OF LEGAL SETTLEMENT DISPUTES

These rules provide a mechanism for resolution of legal settlement disputes related to county liability for the cost of care provided in a state mental health institute, in a state resource center, or through the state medical assistance program. When a county and the department cannot agree on a legal settlement determination, the matter shall be resolved through a contested case hearing before an administrative law judge.

441—15.1(225C) Definitions. The following definitions apply within this chapter.

"Certification" means the process of accepting or rejecting a determination of legal settlement, as defined in rules 441—29.4(230) and 441—30.3(222).

"Department" means the Iowa department of human services.

"Legal settlement" means a person's status as defined in Iowa Code sections 252.16 and 252.17.

"Notice" or *"notification"* includes written or electronic mailing.

"Services" means mental health, mental retardation, developmental disability, brain injury, or substance abuse services.

"State case" means a person who does not have a county of legal settlement as defined in Iowa Code sections 252.16 and 252.17.

441—15.2(225C) Assertion of legal settlement dispute.

15.2(1) *Notification of dispute.*

a. By county. A county shall provide written notice of dispute to the department when the county objects to a billing for services rendered on or after July 1, 2004, that are a county obligation under Iowa Code chapter 222, 230, or 249A or objects to a certification of legal settlement made by the department or another county.

(1) The county shall provide the notice within 120 days of receipt of the billing or certification. A billing shall be considered received 5 days after mailing by the department, unless the county affirmatively shows that the billing was received later. If notification of a dispute does not occur within 120 days of the receipt date, the dispute shall not be eligible for resolution pursuant to subrule 15.3(2).

(2) The notice of dispute may be mailed to Administrator, DHS Division of Fiscal Management, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114; faxed to (515)281-6237; or sent by E-mail to LegalSettlementCases@dhs.state.ia.us.

(3) When a county asserts that a person has legal settlement in another county, the written notice of dispute shall also be given to that county at the same time as notice is given to the department.

b. By department. Within 120 days of receipt of a certification of a legal settlement, the department shall notify all affected counties when the department objects to the certification of legal settlement.

15.2(2) *Supporting evidence.* A notification of a legal settlement dispute pursuant to subrule 15.2(1) shall be accompanied by evidence supporting the determination. The evidence shall include all available information used to make a determination of legal settlement as defined in Iowa Code sections 252.16 and 252.17.

a. Supporting evidence shall include, but need not be limited to:

(1) The current and former addresses of the person, including the dates for the period when the person resided at each address;

(2) The person's current services and service history, including the name and location of the provider and the dates when services were received;

(3) The history of addresses and services received by the person's custodial parent or guardian (when the person takes the legal settlement of the custodial parent or guardian as defined in Iowa Code section 252.16);

(4) Copies of any court orders affecting a minor's custody or guardianship; and

(5) Any other information needed to make a determination of legal settlement.

b. Copies of the following forms may be submitted as supportive evidence, if properly completed:

(1) Form 470-3439, Legal Settlement Worksheet.

(2) A county central point of coordination application.

(3) Form 470-4160, Notice of Court Action on Mental Health Hospitalization.

c. If a county asserts that a person's legal settlement is unknown so that the person is deemed a state case, the county that makes the assertion shall provide documentation of all attempts made by the county to ascertain the facts necessary to make a legal settlement determination. Documentation shall include:

(1) Information about each person contacted during the investigation, including the person's name, address, telephone number, and E-mail address if available;

(2) The information obtained during the investigation; and

(3) Identification of the person conducting the investigation.

[**ARC 8341B**, IAB 12/2/09, effective 11/10/09]

441—15.3(225C) Response to dispute notification.

15.3(1) *Verification of receipt.* Within 45 days of receipt of a notification of dispute, the department and the county shall each verify the date of receipt by responding to the party providing the notification.

15.3(2) *Failure to resolve dispute.* Any of the affected counties or the department may request a contested case hearing conducted under Iowa Code chapter 17A if:

a. The dispute is not resolved within 90 days of receipt of the notification of dispute; or

b. The affected counties and the department agree at any time that the dispute cannot be resolved within the 90-day period.

15.3(3) *Preparation of motion.* The party requesting the contested case hearing shall:

a. Prepare a written motion that the matter be referred to the department of inspections and appeals for a contested case hearing; and

b. Submit copies to all affected counties and the department's division of fiscal management.

15.3(4) *Response to motion.* The division of fiscal management shall certify the matter to the department of inspections and appeals, division of appeals, for a contested case hearing by an administrative law judge to determine the person's legal settlement status.

15.3(5) *Motion not submitted.* If a party does not submit a motion for a contested case hearing within 120 days after receipt of the notification of dispute, the matter shall be closed and the person's legal settlement shall be in the county that was billed for services provided to the person.

441—15.4(225C) Contested case hearing. The determination of legal settlement by the administrative law judge is considered a final agency action.

15.4(1) *Application of hearing decision.* The decision of the administrative law judge shall include an order for payment for services as follows:

a. If legal settlement is found to be with a county, the county shall pay amounts due for the person's services and shall reimburse the department or another county for amounts that were paid for the person's services before the issuance of the decision. If payment is not made within 45 days of the date of decision, a penalty may be applied pursuant to Iowa Code section 222.68, 222.75, or 230.22.

b. If the person is deemed a state case, the department shall credit the county for any amounts paid for the person's services before the issuance of the decision. The credit shall be issued on a county billing no later than the end of the quarter following the date of decision.

15.4(2) *Judicial review.* Any of the parties may file an application for rehearing in accordance with Iowa Code section 17A.16(2). Judicial review of the determination may be filed in district court in accordance with Iowa Code section 17A.19. The party that does not prevail in the determination or in a judicial review is liable for costs associated with the proceeding. The costs of the judicial review process, including reimbursement of the actual costs to the department of inspections and appeals, shall be assessed against the losing party.

441—15.5(225C) Change in determination. If, after a determination of legal settlement by mutual agreement or by decision of an administrative law judge, additional evidence becomes available that could change the outcome of the determination, the procedures in rule 441—15.2(225C) apply.

15.5(1) The affected counties or the department may change the determination by mutual agreement.

15.5(2) A party may make a motion for reconsideration by the department of inspections and appeals.

These rules are intended to implement Iowa Code section 225C.8.

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CHAPTER 76
APPLICATION AND INVESTIGATION

[Ch 76, 1973 IDR, renumbered as Ch 911]
[Prior to 7/l/83, Social Services[770] Ch 76]
[Prior to 2/11/87, Human Services[498]]

441—76.1(249A) Application. Each person wishing to do so shall have the opportunity to apply for assistance without delay.

76.1(1) *Application forms.* The applicant shall immediately be given an application form to complete. When the applicant requests that the form be mailed, the department shall send the necessary form in the next outgoing mail.

a. An application for family medical assistance-related Medicaid programs shall be submitted on the Health and Financial Support Application, Form 470-0462 or Form 470-0466 (Spanish); the Health Services Application, Form 470-2927 or Form 470-2927(S); the HAWK-I Application, Comm. 156; or the HAWK-I Electronic Application Summary and Signature Page, Form 470-4016.

b. An application for SSI-related Medicaid shall be submitted on the Health Services Application, Form 470-2927 or Form 470-2927(S), or the Health and Financial Support Application, Form 470-0462 or Form 470-0466 (Spanish).

c. A person who is a recipient of supplemental security income (SSI) benefits shall not be required to complete a separate Medicaid application. If the department does not have all information necessary to establish that an SSI recipient meets all Medicaid eligibility requirements, the SSI recipient may be required to complete Form 470-2304, 470-2304(S), 470-0364, or 470-0364(S), SSI Medicaid Information, and may be required to attend an interview to clarify information on this form.

d. An application for Medicaid for persons in foster care shall be submitted on Form 470-2927 or Form 470-2927(S), Health Services Application.

e. The department shall initiate a medical assistance application for a person whose application data is received from the federal Social Security Administration pursuant to 42 U.S.C. 1320b-14(c)(3).

(1) The Social Security Administration transmits data from Form SSA 1020B-OCR-SM, Application for Extra Help with Medicare Prescription Drug Plan Costs, to the department. The date that the Social Security Administration transmits its application data to the department shall be treated as the date of application for medical assistance.

(2) The department shall mail Form 470-4846, Medicare Savings Program and Food Assistance Application, to the person whose data was transmitted to gather the rest of the information needed to determine eligibility.

76.1(2) *Place of filing.* An application may be filed over the Internet or in any local office of the department or in any disproportionate share hospital, federally qualified health center or other facility in which outstationing activities are provided. The hospital, health center, or facility shall forward the application to the department office responsible for completing the eligibility determination.

a. The Health Services Application, Form 470-2927 or Form 470-2927(S), may also be filed at the office of a qualified provider of presumptive Medicaid eligibility, a WIC office, a maternal health clinic, or a well child clinic. The office or clinic shall forward the application within two working days to the department office responsible for completing the eligibility determination.

b. The HAWK-I Application, Comm. 156, and the HAWK-I Electronic Application Summary and Signature Page, Form 470-4016, shall be filed with the third-party administrator as provided at 441—subrule 86.3(3). If it appears that the family is Medicaid-eligible, the third-party administrator shall forward the application to the department office responsible for determining Medicaid eligibility.

c. Those persons eligible for supplemental security income and those who would be eligible if living outside a medical institution may make application at the social security district office.

d. Women applying for medical assistance for family planning services under 441—subrule 75.1(41) or 441—Chapter 87 may also apply at any family planning agency as defined in rule 441—87.1(82GA,ch1187).

76.1(3) *Date and method of filing application.* An application is considered filed on the date an identifiable application, Form 470-0462, 470-0466 (Spanish), 470-2927, or 470-2927(S), is received and date-stamped in any place of filing specified in subrule 76.1(2).

a. When an application is delivered to a closed office, it will be considered received on the first day that is not a weekend or state holiday following the day that the office was last open.

b. An identifiable application, Form 470-2927 or 470-2927(S), which is filed to apply for FMAP or FMAP-related Medicaid at a WIC office, well child health clinic, maternal health clinic, or the office of a qualified provider for presumptive eligibility, shall be considered filed on the date received and date-stamped in one of these offices.

c. When a HAWK-I Application, Comm. 156, or HAWK-I Electronic Application Summary and Signature Page, Form 470-4016, is filed with the third-party administrator and subsequently referred to the department for a Medicaid eligibility determination, the date the application is received and date-stamped by the third-party administrator shall be the filing date.

d. A copy of an application received by fax or electronically at one of the places described above shall have the same effect as an original application.

e. An identifiable application is an application containing a legible name, address, and signature.

f. If an authorized representative signed the application on behalf of an applicant, the signature of the applicant or the responsible person must be on the application before the application can be approved. For FMAP and FMAP-related Medicaid, the signature of a parent or stepparent in the home must be on the application before the application can be approved.

76.1(4) *Applicant cooperation.* An applicant must cooperate with the department in the application process, which may include providing information or verification, attending a scheduled face-to-face interview, or signing documents. Failure to cooperate in the application process shall serve as a basis for rejection of an application.

76.1(5) *Application not required.* For family medical assistance-related programs, a new application is not required when an eligible person is added to an existing Medicaid eligible group or when a responsible relative becomes a member of a Medicaid eligible household. This person is considered to be included in the application that established the existing eligible group. However, in these instances the date of application to add a person is the date the change is reported. When it is reported that a person is anticipated to enter the home, the date of application to add the person shall be no earlier than the date of entry or the date of report, whichever is later.

a. In those instances where a person previously ineligible for Medicaid for failure to cooperate in obtaining medical support or establishing paternity as described at 441—subrule 75.14(2) is to be granted Medicaid benefits, the person shall be granted Medicaid benefits effective the first of the month in which the person becomes eligible by cooperating in obtaining medical support or establishing paternity.

b. In those instances where a person previously ineligible for Medicaid for failure to provide a social security number or proof of application for a social security number as described at rule 441—75.7(249A) is to be granted Medicaid benefits, the person shall be granted Medicaid benefits effective the first of the month in which the person becomes eligible by providing a social security number or proof of application for a social security number.

c. In those instances where a person who has been voluntarily excluded from the eligible group in accordance with the provisions of rule 441—75.59(249A) is being added to the eligible group, the person shall be added effective the first of the month after the month in which the household requests that the person no longer be voluntarily excluded.

76.1(6) *Right to withdraw the application.* After an application has been filed, the applicant may withdraw the application at any time before the eligibility determination. The applicant may request that the application be withdrawn entirely or may, before the date the application is processed, request withdrawal for any month covered by the application process except as provided in the medically needy program in accordance with the provisions of 441—subrule 75.1(35). Requests for voluntary withdrawal of the application shall be documented in the case record and a Notice of Decision, Form 470-0485, 470-0486, 470-0486(S), or 470-0490, shall be sent to the applicant confirming the request.

76.1(7) *Responsible persons and authorized representatives.*

a. Responsible person. If the applicant or member is unable to act on the applicant's or member's behalf because the applicant or member is incompetent, physically incapacitated, or deceased, a responsible person may act responsibly for the applicant or member. The responsible person shall be a family member, friend or other person who has knowledge of the applicant's or member's financial affairs and circumstances and a personal interest in the applicant's or member's welfare or a legal representative such as a conservator, guardian, executor or someone with power of attorney. The responsible person shall assume the applicant's or member's position and responsibilities during the application process or for ongoing eligibility. The responsible person may designate an authorized representative as provided for in paragraph 76.1(7)*"b"* to represent the incompetent, physically incapacitated, or deceased applicant's or member's position and responsibilities during the application process or for ongoing eligibility. This authorization does not relieve the responsible person from assuming the incompetent, physically incapacitated, or deceased applicant's or member's position and responsibilities during the application process or for ongoing eligibility.

(1) When there is no person as described above to act on the incompetent, physically incapacitated, or deceased applicant's or member's behalf, any individual or organization shall be allowed to act as the responsible person if the individual or organization conducts a diligent search and completes Form 470-3356, Inability to Find a Responsible Person, attesting to the inability to find a responsible person to act on behalf of the incompetent, physically incapacitated, or deceased applicant or member.

(2) The department may require verification of incompetence or death and the person's relationship to the applicant or member or the legal representative status.

(3) Copies of all department correspondence that would normally be provided to the applicant or member shall be provided to the responsible person and the representative if one has been authorized by the responsible person.

b. Authorized representative. A competent applicant or member or a responsible person as described in paragraph 76.1(7)*"a"* may authorize any individual or organization to represent the applicant or member in the application process or for ongoing eligibility.

(1) The authorization must be in writing, and signed and dated by the applicant or member or a responsible person before the department shall recognize the authorized representative.

(2) If the authorization indicates the time period or dates of medical services it is to cover, this stated period or dates of medical services shall be honored and may include subsequent applications, if necessary, that relate to the time period or dates of medical services indicated on the authorization. If the authorization does not indicate the time period or dates of medical services it is to cover, the authorization shall be valid for any applications filed within 120 days from the date the authorization was signed and all subsequent actions pertaining to the applications filed within the 120-day period.

(3) Anytime an applicant or member or a responsible person notifies the department in writing that the applicant or member or a responsible person no longer wants an authorized representative to act on the applicant's or member's behalf, the department shall no longer recognize that person or organization as the applicant's or member's representative.

(4) Designation of an authorized representative does not relieve a competent applicant or member or a responsible person as defined in 76.1(7)*"a"* of the primary responsibility to cooperate with the department in the determination of initial and ongoing eligibility, which may include providing information or verification, attending a scheduled face-to-face interview, or signing documents on which the authorized representative's signature would be inadequate.

(5) Copies of all departmental correspondence shall be provided to the client and the representative if one has been authorized by the applicant or member.

[**ARC 7544B**, IAB 2/11/09, effective 1/14/09; **ARC 8260B**, IAB 11/4/09, effective 1/1/10]

441—76.2(249A) Information and verification procedure. The decision with respect to eligibility shall be based primarily on information and verification furnished by the applicant or member. The department shall notify the applicant or member in writing of additional information or verification that is required to establish eligibility. This notice shall be provided to the applicant or member personally,

or by mail or facsimile. Applicants for whom eligibility is determined in whole or in part by the Social Security Administration (SSA) shall make application to the SSA within five working days of referral by the department. If, by the due date, the department does not receive the information or verification requested, an authorization to obtain the specific information or verification requested, or a request for an extension of the due date, the application shall be denied or assistance canceled. Signing a general authorization for release of information to the department does not meet this responsibility. Five working days shall be allowed for the applicant or member to supply and the department to receive the information or verification requested. The department may extend the deadline for a reasonable period of time when the applicant or member is making every effort but is unable to secure the required information or verification from a third party.

76.2(1) *Interviews.*

a. In processing applications for Medicaid for adults, the department may require a face-to-face or telephone interview upon written notice to the applicant. An interview is not required as a condition of eligibility for children.

b. For SSI-related Medicaid for adults, the department may require a face-to-face or telephone interview at the time of review.

c. The department shall notify the applicant in writing of the date, time and method of an interview. This notice shall be provided to the applicant personally or by mail or facsimile. Interviews that are rescheduled at the request of the applicant or authorized representative may be agreed upon verbally; a written confirmation is not required.

d. Failure of the applicant or member to attend a scheduled interview shall serve as a basis for rejection of an application or cancellation of assistance for adults. Failure of the applicant or member to attend an interview shall not serve as a basis for rejection of an application or cancellation of assistance for children.

76.2(2) *Choice of coverage groups.* An applicant who meets the eligibility requirements of more than one coverage group shall be given the choice of coverage group under which eligibility shall be determined.

76.2(3) *Conditional benefits granted previous to October 1, 1993.* When the client is receiving Medicaid under the conditional benefit policy of the SSI program pursuant to subrule 75.13(2), the client shall be required to describe the efforts that are made to sell the property on Form 470-2908, Description of Efforts to Sell Property, as requested by the department. The department shall request that the form be completed no more often than specified. For personal property being sold Form 470-2908 shall be completed no more often than every 30 days during the conditional benefit period. For real property being sold Form 470-2908 shall be completed beginning 35 days after conditional benefits are granted and no more often than every 60 days thereafter for nine months. If eligibility continues and the real property is not sold, the form shall be completed no more often than every 90 days.

76.2(4) *Monthly reporting.* Rescinded IAB 10/4/00, effective 10/1/00.

76.2(5) *Reporting of changes.* The applicant shall report any change as defined at 441—paragraph 75.52(4)*"c"* which occurs during the application process within five working days of the change. Changes that occur after approval for benefits shall be reported in accordance with paragraph 75.52(4)*"c."*

[**ARC 7740B**, IAB 5/6/09, effective 6/10/09]

441—76.3(249A) Time limit for decision. Applications shall be investigated by the county department of human services. A determination of approval, conditional eligibility, or denial shall be made as soon as possible, but no later than 30 days following the date of filing the application unless one or more of the following conditions exist.

76.3(1) The application is being processed for eligibility under the medically needy coverage group as defined in 441—subrule 75.1(35). Applicants for medically needy shall receive a written notice of approval, conditional eligibility, or denial as soon as possible, but no later than 45 days from the date the application was filed.

76.3(2) An application on the client's behalf for supplemental security income benefits is pending.

76.3(3) The application is pending due to completion of the requirement in 441—subrule 75.1(7).

76.3(4) The application is pending due to nonreceipt of information which is beyond the control of the applicant or department. It is the responsibility of the applicant to provide information to the department timely or to ask for an extension of time before the due date when additional time is needed to secure the information or verification.

76.3(5) The application is pending due to the disability determination process performed through the department.

76.3(6) Unusual circumstances exist which prevent a decision from being made within the specified time limit. Unusual circumstances include those situations where the department and the applicant have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit has expired or because of emergency situations such as fire, flood, or other conditions beyond the administrative control of the department.

441—76.4(249A) Notification of decision. The applicant or member will be notified in writing of the decision of the department regarding the applicant's or member's eligibility for Medicaid. If the applicant or member has been determined to be ineligible an explanation of the reason will be provided.

76.4(1) The member shall be given a timely and adequate written notice as provided in 441—subrule 7.7(1) when any decision or action is being taken by the department which adversely affects Medicaid eligibility or the amount of benefits.

76.4(2) Timely notice may be dispensed with but adequate notice shall be sent, no later than the effective date of action, when one or more of the conditions in 441—subrule 7.7(2) are met.

76.4(3) A written notice of decision shall be issued to the applicant the next working day following a determination of eligibility, conditional eligibility or ineligibility.

441—76.5(249A) Effective date.

76.5(1) *Three-month retroactive eligibility.*

a. Medical assistance benefits shall be available for all or any of the three months preceding the month in which the application is filed to persons who meet both of the following conditions:

(1) Have medical bills for covered services which were received during the three-month retroactive period.

(2) Would have been eligible for medical assistance benefits in the month services were received, if application for medical assistance had been made in that month.

b. The applicant need not be eligible in the month of application to be eligible in any of the three months prior to the month of application.

c. Retroactive medical assistance benefits shall be made available when an application has been made on behalf of a deceased person if the conditions in paragraph *"a"* are met.

d. Persons receiving only supplemental security income benefits who wish to make application for Medicaid benefits for three months preceding the month of application shall complete Form 470-2304, 470-2304(S), 470-0364, or 470-0364(S), SSI Medicaid Information.

e. Rescinded IAB 10/8/97, effective 12/1/97.

76.5(2) *First day of month.*

a. For persons approved for the family medical assistance-related programs, medical assistance benefits shall be effective on the first day of a month when eligibility was established anytime during the month.

b. For persons approved for supplemental security income, programs related to supplemental security income, or state supplementary assistance, medical assistance benefits shall be effective on the first day of a month when the individual was resource eligible as of the first moment of the first day of the month and met all other eligibility criteria at any time during the month.

c. When a request is made to add a new person to the eligible group, and that person meets the eligibility requirements, assistance shall be effective the first of the month in which the request was made.

d. When a request is made to add a person to the eligible group who previously was excluded, in accordance with the provisions of rule 441—75.59(249A), assistance shall be effective no earlier than the first of the month following the month in which the request was made.

76.5(3) *Care prior to approval.* No payment shall be made for medical care received prior to the effective date of approval.

441—76.6(249A) Certification for services. The department of human services shall issue a Medical Assistance Eligibility Card, Form 470-1911, to persons who have been determined to be eligible for the benefits provided under the Medicaid program unless one of the following situations exists:

76.6(1) *Pregnant woman.* The eligible person is a pregnant woman determined presumptively eligible in accordance with 441—subrule 75.1(30). These persons shall be issued a Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), by the provider.

76.6(2) *IowaCare.* A person who is enrolled in the IowaCare program shall be issued an IowaCare Medical Card, Form 470-4164.

76.6(3) *Breast and cervical cancer.* The eligible person is one who has been determined presumptively eligible for treatment of breast or cervical cancer or a precancerous condition in accordance with 441—paragraph 75.1(40)*"c."* These persons shall be issued a Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), by the provider.

441—76.7(249A) Reinvestigation. Reinvestigation shall be made as often as circumstances indicate but in no instance shall the period of time between reinvestigations exceed 12 months.

76.7(1) The member shall supply, insofar as the member is able, additional information needed to establish eligibility within five working days from the date a written request is issued.

a. The member shall give written permission for the release of information when the member is unable to furnish information needed to establish eligibility.

b. Failure to supply the information or verification requested or refusal to request assistance and authorize the department to secure the requested information from other sources shall serve as a basis for cancellation of Medicaid. Signing a general authorization for release of information to the department does not meet this responsibility.

76.7(2) Eligibility criteria for persons whose eligibility for Medicaid is related to the family medical assistance program shall be reviewed according to policies found in rule 441—75.52(249A).

76.7(3) Persons whose eligibility for Medicaid is related to supplemental security income shall complete Form 470-3118 or 470-3118(S), Medicaid Review, as part of the reinvestigation process when requested to do so by the department.

76.7(4) The review for foster children or children in subsidized adoption or subsidized guardianship shall be completed on Form 470-2914, Foster Care, Adoption, and Guardianship Medicaid Review, according to the schedule of the family medical assistance program or supplemental security income program for disabled children, as applicable.

76.7(5) Women eligible for family planning services only shall complete Form 470-4071, Family Planning Medicaid Review, as part of the reinvestigation process. Form 470-4071 shall be issued at least 30 days before the end of the eligibility period. The woman must submit the completed review form before the end of the eligibility period to any location specified in paragraph 76.1(2)*"d."* Women who fail to submit Form 470-4071 before the end of the eligibility period must reapply as directed in rule 441—76.1(249A).

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441—76.8(249A) Investigation by quality control or the department of inspections and appeals. The client shall cooperate with the department when the client's case is selected by quality control or the department of inspections and appeals for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect medical assistance eligibility. (See department of inspections and appeals rules in 481—Chapter 72.) Failure to do so shall serve as a basis for cancellation of assistance unless the Medicaid eligibility is determined

by the Social Security Administration. Once a person's eligibility is denied or canceled for failure to cooperate, the person may reapply but shall not be determined eligible until cooperation occurs.

441—76.9(249A) Member lock-in. In order to promote high quality health care and to prevent harmful practices such as duplication of medical services, drug abuse or overuse, and possible drug interactions, recipients that utilize medical assistance services or items at a frequency or in an amount which is considered to be overuse of services as defined in subrule 76.9(7) may be restricted (locked-in) to receive services from a designated provider(s).

76.9(1) A lock-in or restriction shall be imposed for a minimum of 24 months with longer restrictions determined on an individual basis.

76.9(2) Provider selection. The member may select the provider(s) from which services will be received. The designated providers will be identified on the department's eligibility verification system (ELVS). Only prescriptions written or approved by the designated primary physician(s) will be reimbursed. Other providers of the restricted service will be reimbursed only under circumstances specified in subrule 76.9(3).

76.9(3) Payment will be made to provider(s) other than the designated (lock-in) provider(s) in the following instances:

a. Emergency care is required and the designated provider is not available. Emergency care is defined as care necessary to sustain life or prevent a condition which could cause physical disability.

b. The designated provider requires consultation with another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 76.9(5).

c. The designated provider refers the recipient to another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 76.9(5).

76.9(4) When the recipient fails to choose a provider(s) within 30 days of the request, the division of medical services will select the provider(s) based on previously utilized provider(s) and reasonable access for the recipient.

76.9(5) Recipients may change designated provider(s) when a change is warranted, such as when the recipient has moved, the provider no longer participates, or the provider refuses to see the patient. The worker for the recipient shall make the determination when the recipient has demonstrated that a change is warranted. Recipients may add additional providers to the original designation with approval of a health professional employed by the department for this purpose.

76.9(6) When lock-in is imposed on a recipient, timely and adequate notice shall be sent and an opportunity for a hearing given in accordance with 441—Chapter 7.

76.9(7) Overuse of services is defined as receipt of treatments, drugs, medical supplies or other Medicaid benefits from one or multiple providers of service in an amount, duration, or scope in excess of that which would reasonably be expected to result in a medical or health benefit to the patient.

a. Determination of overuse of service shall be based on utilization data generated by the Surveillance and Utilization Review Subsystem of the Medicaid Management Information System. The system employs an exception reporting technique to identify the recipients most likely to be program overutilizers by reporting cases in which the utilization exceeds the statistical average.

b. In addition to referrals from the Surveillance and Utilization Review Subsystem described in paragraph *"a,"* referrals for utilization review shall be made when utilization data generated by the Medicaid Management Information System reflects that utilization of Medicaid recipient outpatient visits to physicians, advanced registered nurse practitioners, federally qualified health centers, rural health centers, other clinics, and emergency rooms exceeds 24 visits in any 12-month period. This utilization review shall not apply to Medicaid recipients who are enrolled in the MediPASS program or a health maintenance organization, or who are children under 21 years of age or residents of a nursing facility. For the purposes of this paragraph, the term "physician" does not include a psychiatrist.

c. An investigation process of Medicaid recipients determined in paragraphs *"a"* or *"b"* to be subject to a review of overutilization shall be conducted to determine if actual overutilization exists

by verifying that the information reported by the computer system is valid and is also unusual based on professional medical judgment. Medical judgments shall be made by physicians, pharmacists, nurses and other health professionals either employed by, under contract to, or consultants for the department. These medical judgments shall be made by the health professionals on the basis of the body of knowledge each has acquired which meets the standards necessary for licensure or certification under the Iowa licensing statutes for the particular health discipline.

441—76.10(249A) Client responsibilities.

76.10(1) In coverage groups for which Medicaid eligibility is determined using income and resource policies related to the supplemental security income (SSI) program, clients shall timely report any changes in the following circumstances to the department. EXCEPTION: Persons actually receiving SSI benefits are exempted from these reporting requirements unless they have a trust or are applying for or receiving home- and community-based waiver services.

a. Income from all sources.

b. Resources.

c. Membership of the household.

d. Recovery from disability.

e. Mailing or living address.

f. Health insurance premiums or coverage.

g. Medicare premiums or coverage.

h. Receipt of social security number.

i. Gross income of the community spouse or dependent children, parents or siblings of the institutionalized or community spouse living with a community spouse when a diversion is made to the community spouse or family. (See definitions in rule 441—75.25(249A).)

j. Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation or spenddown.

k. Residence in a medical institution for other than respite care for more than 15 days for home and community-based recipients.

76.10(2) In coverage groups for which Medicaid eligibility is determined using the family medical assistance program (FMAP) income and resource policies, clients shall report changes in accordance with 441—paragraphs 75.52(4)*"c"* through *"e."* After assistance has been approved, changes occurring during the month are effective the first day of the next calendar month, provided the notification requirements at rule 441—76.4(249A) can be met.

76.10(3) A report shall be considered timely when received by the department:

a. Within ten days from the date the change is known to the member or authorized representative; or

b. Within five days from the date the change is known to the applicant or authorized representative.

76.10(4) When a change is not timely reported, any incorrect program expenditures shall be subject to recovery from the client.

76.10(5) Effective date of change. When a request is made to add a new person to the eligible group, and that person meets the eligibility requirements, assistance shall be effective the first day of the month in which the request was made unless otherwise specified at rule 441—76.5(249A). After assistance has been approved, changes reported during the month 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).

b. The certification has expired for persons receiving assistance under the medically needy program in accordance with the provisions of 441—subrule 75.1(35).

c. Rescinded IAB 10/31/01, effective 1/1/02.

441—76.11(249A) Automatic redetermination. Whenever a Medicaid member no longer meets the eligibility requirements of the current coverage group, an automatic redetermination of eligibility for other Medicaid coverage groups shall be made. If the reason for ineligibility under the initial coverage

group pertained to a condition of eligibility which applies to all coverage groups, such as failure to cooperate, no further redetermination shall be required. When the redetermination is completed, the member shall be notified of the decision in writing. The redetermination process shall be completed as follows:

76.11(1) *Information received by the tenth of the month.* If information that creates ineligibility under the current coverage group is received in the department by the tenth of the month, the redetermination process shall be completed by the end of that month unless the provisions of subrule 76.11(3) apply. The effective date of cancellation for the current coverage group shall be the first day of the month following the month the information is received.

76.11(2) *Information received after the tenth of the month.* If information that creates ineligibility under the current coverage group is received in the department after the tenth of the month, the redetermination process shall be completed by the end of the following month unless the provisions of subrule 76.11(3) apply. The effective date of cancellation for the current coverage group shall be the first day of the second month following the month the information is received.

76.11(3) *Change in federal law.* If a change in federal law affects the eligibility of large numbers of Medicaid members and the Secretary of Health and Human Services has extended the redetermination time limits, in accordance with 42 CFR Sec. 435.1003 as amended to January 13, 1997, the redetermination process shall be completed within the extended time limit and the effective date of cancellation for the current coverage group shall be no later than the first day of the month following the month in which the extended time limit expires.

76.11(4) *Referral for HAWK-I program.* When the only coverage group under which a child will qualify for Medicaid is the medically needy program with a spenddown as provided in 441—subrule 75.1(35), a referral to the Hawk-I program shall be made in accordance with 441—subrule 86.4(4) as part of the automatic redetermination process when it appears the child is otherwise eligible.

441—76.12(249A) Recovery.

76.12(1) *Definitions.*

"Administrative overpayment" means medical assistance incorrectly paid to or for the client because of continuing assistance during the appeal process or allowing a deduction for the Medicare part B premium in determining client participation while the department arranges to pay the Medicare premium directly.

"Agency error" means medical assistance incorrectly paid to or for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Misfiling or loss of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the department.
6. Failure to make prompt revisions in medical payment following changes in policies requiring the changes as of a specific date.

"Client" means a current or former Medicaid member.

"Client error" means medical assistance incorrectly paid to or for the client because the client or client's representative failed to disclose information, or gave false or misleading statements, oral or written, regarding the client's income, resources, or other eligibility and benefit factors. It also means assistance incorrectly paid to or for the client because of failure by the client or client's representative to timely report as defined in rule 441—76.10(249A).

"Department" means the department of human services.

76.12(2) *Amount subject to recovery.* The department shall recover from a client all Medicaid funds incorrectly expended to or on behalf of the client. The incorrect expenditures may result from client or agency error, or administrative overpayment.

76.12(3) *Notification.* All clients shall be promptly notified when it is determined that assistance was incorrectly expended. Notification shall include for whom assistance was paid; the time period during which assistance was incorrectly paid; the amount of assistance subject to recovery; and the reason for the incorrect expenditure.

76.12(4) *Source of recovery.* Recovery shall be made from the client or from parents of children under age 21 when the parents completed the application and had responsibility for reporting changes. Recovery may come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

76.12(5) *Repayment.* The repayment of incorrectly expended Medicaid funds shall be made to the department.

However, repayment of funds incorrectly paid to a nursing facility, a Medicare-certified skilled nursing facility, a psychiatric medical institution for children, an intermediate care facility for the mentally retarded, or mental health institute enrolled as an inpatient psychiatric facility may be made by the client to the facility. The department shall then recover the funds from the facility through a vendor adjustment.

76.12(6) *Appeals.* The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

76.12(7) *Estate recovery.* Medical assistance is subject to recovery from the estate of a Medicaid member, the estate of the member's surviving spouse, or the estate of the member's surviving child as provided in this subrule. Effective January 1, 2010, medical assistance that has been paid for Medicare cost sharing or for benefits described in Section 1902(a)(10)(E) of the Social Security Act is not subject to recovery. All assets included in the estate of the member, the surviving spouse, or the surviving child are subject to probate for the purposes of medical assistance estate recovery pursuant to Iowa Code section 249A.5(2)*"d."* The classification of the debt is defined at Iowa Code section 633.425(7).

a. Definition of estate. For the purpose of this subrule, the "estate" of a Medicaid member, a surviving spouse, or a surviving child shall include all real property, personal property, or any other asset in which the member, spouse, or surviving child had any legal title or interest at the time of death, or at the time a child reaches the age of 21, to the extent of that interest. An estate includes, but is not limited to, interest in jointly held property, retained life estates, and interests in trusts.

b. Debt due for member 55 years of age or older. Receipt of medical assistance when a member is 55 years of age or older creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1, 1994.

c. Debt due for member under the age of 55 in a medical institution.

(1) Receipt of medical assistance creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1,1994, when the member:

1. Is under the age of 55; and
2. Is a resident of a nursing facility, an intermediate care facility for the mentally retarded, or a mental health institute; and
3. Cannot reasonably be expected to be discharged and return home.

(2) If the member is discharged from the facility and returns home before staying six consecutive months, no debt will be assessed for medical assistance payments made on the member's behalf for the time in the institution.

(3) If the member remains in the facility for six consecutive months or longer or dies before staying six consecutive months, the department shall presume that the member cannot or could not reasonably be expected to be discharged and return home and a debt due shall be established. The department shall notify the member of the presumption and the establishment of a debt due.

d. Request for a determination of ability to return home. Upon receipt of a notice of the establishment of a debt due based on the presumption that the member cannot return home, the member or someone acting on the member's behalf may request that the department determine whether the member can or could reasonably have been expected to return home.

(1) When a written request is made within 30 days of the notice that a debt due will be established, no debt due shall be established until the department has made a decision on the member's ability to return home. If the determination is that there is or was no ability to return home, a debt due shall be established for all medical assistance as of the date of entry into the institution.

(2) When a written request is made more than 30 days after the notice that a debt due will be established, a debt due will be established for medical assistance provided before the request even if the determination is that the member can or could have returned home.

e. Determination of ability to return home. When the member or someone acting on the member's behalf requests that the department determine if the member can or could have returned home, the determination shall be made by the Iowa Medicaid enterprise (IME) medical services unit.

(1) The IME medical services unit cannot make a determination until the member has been in an institution at least six months or after the death of the member, whichever is earlier. The IME medical services unit will notify the member or the member's representative and the department of the determination.

(2) If the determination is that the member can or could return home, the IME medical services unit shall establish the date the return is expected or could have been expected to occur.

(3) If the determination is that the member cannot or could not return home, a debt due will be established unless the member or the member's representative asks for a reconsideration of the decision. The IME medical services unit will notify the member or the member's representative and the department of the reconsideration decision.

(4) If the reconsideration decision is that the member cannot or could not return home, a debt due will be established against the member unless the decision is appealed pursuant to 441—Chapter 7. The appeal decision will determine the final outcome for the establishment of a debt due and the period when the debt is established.

f. Debt collection.

(1) A nursing facility participating in the medical assistance program shall notify the IME revenue collection unit upon the death of a member residing in the facility by submitting Form 470-4331, Estate Recovery Program Nursing Home Referral.

(2) Upon receipt of Form 470-4331 or a report of a member's death through other means, the IME revenue collection unit will use Form 470-4339, Medical Assistance Debt Response, to request a statement of the member's assets from the member's personal representative. The representative shall sign and return Form 470-4339 indicating whether assets remain and, if so, what the assets are and what higher priority expenses exist. EXCEPTION: The procedures in this subparagraph are not necessary when a probate estate has been opened, because probate procedures provide for an inventory, an accounting, and a final report of the estate.

g. Waiving the collection of the debt.

(1) The department shall waive the collection of the debt created under this subrule from the estate of the member to the extent that collection of the debt would result in either of the following:

1. Reduction in the amount received from the member's estate by a surviving spouse or by a surviving child who is under the age of 21, blind, or permanently and totally disabled at the time of the member's death.

2. Creation of an undue hardship for the person seeking a waiver of estate recovery. Undue hardship exists when total household income is less than 200 percent of the poverty level for a household of the same size, total household resources do not exceed $10,000, and application of estate recovery would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered. For this purpose, "income" and "resources" shall be defined as under the family medical assistance program.

(2) To apply for a waiver of estate recovery due to undue hardship, the person shall provide a written statement and supporting verification to the department within 30 days of the notice of estate recovery pursuant to Iowa Code section 633.425.

(3) The department shall determine whether undue hardship exists on a case-by-case basis. Appeals of adverse decisions regarding an undue hardship determination may be filed in accordance with 441—Chapter 7.

h. Amount waived. If collection of all or part of a debt is waived pursuant to paragraph *"g,"* to the extent that the person received the member's estate, the amount waived shall be a debt due from the following:

(1) The estate of the member's surviving spouse, upon the death of the spouse.

(2) The estate of the member's surviving child who is blind or has a disability, upon the death of the child.

(3) A surviving child who was under 21 years of age at the time of the member's death, when the child reaches the age of 21.

(4) The estate of a surviving child who was under 21 years of age at the time of the member's death, if the child dies before reaching the age of 21.

(5) The hardship waiver recipient, when the hardship no longer exists.

(6) The estate of the recipient of the undue hardship waiver, at the time of death of the hardship waiver recipient.

i. Impact of asset disregard on debt due. The estate of a member who is eligible for medical assistance under 441—subrule 75.5(5) shall not be subject to a claim for medical assistance paid on the member's behalf up to the amount of the assets disregarded by asset disregard. Medical assistance paid on behalf of the member before these conditions shall be recovered from the estate, regardless of the member's having purchased precertified or approved insurance.

j. Interest on debt. Interest shall accrue on a debt due under this subrule at the rate provided pursuant to Iowa Code section 535.3, beginning six months after the death of a Medicaid member, the surviving spouse, or the surviving child, or upon the child's reaching the age of 21.

k. Reimbursement to county. If a county reimburses the department for medical assistance provided under this subrule and the amount of medical assistance is subsequently repaid through a medical assistance income trust or a medical assistance special needs trust as defined in Iowa Code Supplement chapter 633C, the department shall reimburse the county on a proportionate basis.

[**ARC 8343B**, IAB 12/2/09, effective 1/6/10]

441—76.13(249A) Health care data match program. As a condition of doing business in Iowa, health insurers shall provide, upon the request of the state, information with respect to individuals who are eligible for or are provided medical assistance under the state's medical assistance state plan to determine (1) during what period the individual or the individual's spouse or dependents may be or may have been covered by a health insurer and (2) the nature of the coverage that is or was provided by the health insurer. This requirement applies to self-insured plans, group health plans as defined in the federal Employee Retirement Income Security Act of 1974 (Public Law 93-406), service benefit plans, managed care organizations, pharmacy benefits managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

76.13(1) *Agreement required.* The parties shall sign a data use agreement for the purposes of this rule. The agreement shall prescribe the manner in which information shall be provided to the department of human services and the acceptable uses of the information provided.

a. The initial provision of data shall include the data necessary to enable the department to match covered persons and identify third-party payers for the two-year period before the initial provision of the data. The data shall include the name, address, and identifying number of the plan.

b. Ongoing monthly matches may be limited to changes in the data previously provided, including additional covered persons, with the effective dates of the changes.

76.13(2) *Agreement form.*

a. An agreement with the department shall be in substantially the same form as Form 470-4415, Agreement for Use of Data.

b. An agreement with the department's designee shall be in a form approved by the designee, which shall include privacy protections equivalent to those provided in Form 470-4415, Agreement for Use of Data.

76.13(3) *Confidentiality of data.* The exchange of information carried out under this rule shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to:

a. The federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and

b. Regulations promulgated in accordance with that Act and published in 45 CFR Parts 160 through 164.

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CHAPTER 78
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]
[Prior to 2/11/87, Human Services[498]]

441—78.1(249A) Physicians' services. Payment will be approved for all medically necessary services and supplies provided by the physician including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment shall be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid.

b. Routine physical examinations. Rescinded IAB 8/1/07, effective 8/1/07.

c. Treatment of certain foot conditions as specified in 78.5(2*)"a," "b,"* and *"c."*

d. Acupuncture treatments.

e. Rescinded 9/6/78.

f. Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program shall be utilized in determining when a given procedure is unproven or experimental in nature.

g. Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by the Iowa Foundation for Medical Care or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admittance to the hospital. Approval shall be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

78.1(2) Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

a. Drugs are covered as provided by rule 441—78.2(249A).

b. Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. Rescinded IAB 1/30/08, effective 4/1/08.

e. All physicians who administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. Vaccines available through the Vaccines for Children program shall be obtained from the department of public health for Medicaid members. Physicians shall, however, receive reimbursement for the administration of these vaccines to Medicaid members.

f. Nonprescription drugs. Rescinded IAB 1/30/08, effective 4/1/08.

78.1(3) Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug is not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury. When injecting an amphetamine or legend vitamin, prior approval must be obtained as specified in 78.1(2)*"a"*(3).

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment will not be approved for vaccines which are available through the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health.

g. Payment will not be approved for injections of "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

78.1(4) For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

(1) Correction of a congenital anomaly; or

(2) Restoration of body form following an accidental injury; or

(3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

(1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program. This list is for example purposes only and is not considered all inclusive.

(1) Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

78.1(5) The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 78.10(249A).

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 78.15(249A).

78.1(7) No payment shall be made for the services of a private duty nurse.

78.1(8) Payment for mileage shall be the same as that in effect in part B of Medicare.

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

b. When only one patient is seen in a single visit the allowance shall be based on a follow-up home visit. When more than one patient is seen in a single visit, payment shall be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

c. Payment will be approved for mileage in connection with nursing home visits when:

(1) It is necessary for the physician to travel outside the home community, and

(2) There are not physicians in the community in which the nursing home is located.

d. Payment will be approved for tasks related to a resident receiving nursing facility care which are performed by a physician's employee who is a nurse practitioner, clinical nurse specialist, or physician assistant as specified in subrule 81.13(13)*"e."* On-site supervision of the physician is not required for these services.

78.1(10) Payment will be approved in independent laboratory when it has been certified as eligible to participate in Medicare.

78.1(11) Rescinded, effective 8/1/87.

78.1(12) Payment will be made on the same basis as in Medicare for services associated with treatment of chronic renal disease including physician's services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis. Payment will be made for deductibles and coinsurance for those persons eligible for Medicare.

78.1(13) Payment will be made to the physician for services rendered by auxiliary personnel employed by the physician and working under the direct personal supervision of the physician, when such services are performed incident to the physician's professional service.

a. Auxiliary personnel are nurses, physician's assistants, psychologists, social workers, audiologists, occupational therapists and physical therapists.

b. An auxiliary person is considered to be an employee of the physician if the physician:

(1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.

(2) Sets work standards.

(3) Establishes job description.

(4) Withholds taxes from the wages of the auxiliary personnel.

c. Direct personal supervision in the office setting means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

Direct personal supervision outside the office setting, such as the member's home, hospital, emergency room, or nursing facility, means the physician must be present in the same room as the auxiliary person.

Advanced registered nurse practitioners certified under board of nursing rules 655—Chapter 7 performing services within their scope of practice are exempt from the direct personal supervision requirement for the purpose of reimbursement to the employing physicians. In these exempted circumstances, the employing physicians must still provide general supervision and be available to provide immediate needed assistance by telephone. Advanced registered nurse practitioners who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

A physician assistant licensed under board of physician assistants' professional licensure rules in 645—Chapter 325 is exempt from the direct personal supervision requirement but the physician must still provide general supervision and be available to provide immediate needed assistance by telephone.

Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

78.1(14) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a physician for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.1(15) The certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification.

78.1(16) No payment will be made for sterilization of an individual under the age of 21 or who is mentally incompetent or institutionalized. Payment will be made for sterilization performed on an individual who is aged 21 or older at the time the informed consent is obtained and who is mentally competent and not institutionalized when all the conditions in this subrule are met.

a. The following definitions are pertinent to this subrule:

(1) Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing and which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment of an operation on the genital urinary tract. Mental illness or retardation is not considered an illness or injury.

(2) Hysterectomy means a medical procedure or operation to remove the uterus.

(3) Mentally incompetent individual means a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(4) Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

b. The sterilization shall be performed as the result of a voluntary request for the services made by the person on whom the sterilization is performed.

c. The person shall be advised prior to the receipt of consent that no benefits provided under the medical assistance program or other programs administered by the department may be withdrawn or withheld by reason of a decision not to be sterilized.

d. The person shall be informed that the consent can be withheld or withdrawn any time prior to the sterilization without prejudicing future care and without loss of other project or program benefits.

e. The person shall be given a complete explanation of the sterilization. The explanation shall include:

(1) A description of available alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.

(2) A thorough description of the specific sterilization procedure to be performed and benefits expected.

(3) A description of the attendant discomforts and risks including the type and possible effects of any anesthetic to be used.

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs not less than 72 hours after the informed consent was signed. The informed consent shall have

been signed at least 30 days prior to the expected delivery date for premature deliveries. Consent shall be obtained on Form 470-0835 or 470-0835(S), Consent Form, and shall be attached to the claim for payment.

g. The information in paragraphs *"b"* through *"f"* shall be effectively presented to a blind, deaf, or otherwise handicapped individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual's choice present when consent is obtained.

h. Form 470-0835 or 470-0835(S), Consent Form, shall be signed by the individual to be sterilized, the interpreter, when one was necessary, the physician, and the person who provided the required information.

i. Informed consent shall not be obtained while the individual to be sterilized is:

(1) In labor or childbirth, or

(2) Seeking to obtain or obtaining an abortion, or

(3) Under the influence of alcohol or other substance that affects the individual's state of awareness.

j. Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization and only when one or more of the following conditions is met:

(1) The individual or representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing, or

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy and has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

78.1(17) Abortions. Payment for an abortion or related service is made when Form 470-0836 is completed for the applicable circumstances and is attached to each claim for services. Payment for an abortion is made under one of the following circumstances:

a. The physician certifies that the pregnant woman's life would be endangered if the fetus were carried to term.

b. The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition.

c. The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of the rape.

d. The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of incest.

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross-reference 78.28(3))

78.1(19) Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the published criteria established by the IFMC and the department. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

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

78.1(20) Transplants.

a. Payment will be made only for the following organ and tissue transplant services:

(1) Kidney, cornea, skin, and bone transplants.

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

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

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

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

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

(5) Heart transplants. Artificial hearts and ventricular assist devices, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplants, are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants and heart-lung transplants described above require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1)*"f."*) Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

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

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

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.
2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.
- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.
- Consistent failure of insulin-based management to prevent acute complications.

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

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

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

b. Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

c. All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.

d. Payment will not be made for any transplant not specifically listed in paragraph *"a."*

78.1(21) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term "physician" does not include a psychiatrist. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.1(22) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement shall be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

78.1(23) EPSDT care coordination. Rescinded IAB 12/3/08, effective 2/1/09.

78.1(24) Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the Current Dental Terminology, Third Edition (CDT-3), for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

a. Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

b. Separate payment shall be available only for application of topical fluoride varnish, which shall be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening shall not be available, as this service is already part of and paid under the EPSDT screening examination.

c. Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician's supervision that this application is not a substitute for comprehensive dental care.

d. Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

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

441—78.2(249A) Prescribed outpatient drugs. Payment will be made for "covered outpatient drugs" as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) subject to the conditions and limitations specified in this rule.

78.2(1) *Qualified prescriber.* All drugs are covered only if prescribed by a legally qualified practitioner (physician, dentist, podiatrist, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner).

78.2(2) *Prescription required.* As a condition of payment for all drugs, including "nonprescription" or "over-the-counter" drugs that may otherwise be dispensed without a prescription, a prescription shall be transmitted as specified in Iowa Code sections 124.308 and 155A.27, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions shall be available for audit by the department.

78.2(3) *Qualified source.* All drugs are covered only if marketed by manufacturers that have signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990).

78.2(4) *Prescription drugs.* Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act.

(2) Drugs used to cause anorexia, weight gain, or weight loss, except for lipase inhibitor drugs prescribed for weight loss with prior authorization as provided in paragraph *"a."*

(3) Drugs used for cosmetic purposes or hair growth.

(4) Drugs used to promote smoking cessation, except for varenicline with prior authorization as provided in paragraph *"a"* above and generic, sustained-release bupropion products that are indicated for smoking cessation by the U.S. Food and Drug Administration.

(5) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee.

(6) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (drugs identified through the Drug Efficacy Study Implementation (DESI) review)).

(7) "Covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any "Part D eligible individual" as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including a member who is not enrolled in a Medicare Part D plan.

(8) Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility, as defined in subparagraph (1).

(9) Drugs used for the treatment of sexual or erectile dysfunction, except when used to treat a condition other than sexual or erectile dysfunction for which the drug has been approved by the U.S. Food and Drug Administration.

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

78.2(5) *Nonprescription drugs.* The following drugs that may otherwise be dispensed without a prescription are covered subject to the prior authorization requirements stated below and as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

Acetaminophen tablets 325 mg, 500 mg
Acetaminophen elixir 160 mg/5 ml
Acetaminophen solution 100 mg/ml
Acetaminophen suppositories 120 mg
Artificial tears ophthalmic solution
Artificial tears ophthalmic ointment
Aspirin tablets 325 mg, 650 mg, 81 mg (chewable)
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
Aspirin tablets, buffered 325 mg
Bacitracin ointment 500 units/gm
Benzoyl peroxide 5%, gel, lotion
Benzoyl peroxide 10%, gel, lotion
Calcium carbonate chewable tablets 1250 mg (500 mg elemental calcium)
Calcium carbonate suspension 1250 mg/5 ml
Calcium carbonate tablets 600 mg
Calcium carbonate-vitamin D tablets 500 mg-200 units
Calcium carbonate-vitamin D tablets 600 mg-200 units
Calcium citrate tablets 950 mg (200 mg elemental calcium)
Calcium gluconate tablets 650 mg

Calcium lactate tablets 650 mg
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 patch 7 mg/day, 14 mg/day and 21 mg/day
Pediatric oral electrolyte solutions
Permethrin liquid 1%
Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
Pseudoephedrine hydrochloride liquid 30 mg/5 ml
Pseudoephedrine/dextromethorphan 15 mg/7.5 mg/5 mL liquid
Pseudoephedrine/dextromethorphan 20 mg/10 mg/5 mL liquid
Pseudoephedrine/dextromethorphan 30 mg/15 mg/5 mL liquid
Pseudoephedrine/dextromethorphan 20 mg/10 mg/5 mL elixir
Pseudoephedrine/dextromethorphan 15 mg/7.5 mg/5 mL syrup
Pseudoephedrine/dextromethorphan 30 mg/15 mg/5 mL syrup
Pseudoephedrine/dextromethorphan 7.5 mg/2.5 mg/0.8 mL solution
Pyrethrins-piperonyl butoxide liquid 0.33-4%
Pyrethrins-piperonyl butoxide shampoo 0.3-3%
Pyrethrins-piperonyl butoxide shampoo 0.33-4%
Salicylic acid liquid 17%
Senna tablets 187 mg
Sennosides-docusate sodium tablets 8.6 mg-50 mg
Sennosides 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]

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Foundation for Medical Care (IFMC). All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Readmissions to the same facility due to premature discharge shall not be paid a new DRG. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross-reference 78.28(5)) The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

78.3(1) Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

78.3(2) No payment will be approved for private duty nursing.

78.3(3) Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

78.3(4) Services provided for intestinal or gastric bypass surgery for treatment of obesity requires prior approval, which must be obtained by the attending physician before surgery is performed.

78.3(5) Payment will be approved for drugs provided inpatients subject to the same provisions specified in 78.2(1) and 78.2(4)*"b"*(1) to (10) except for 78.2(4)*"b"*(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

a. Payment will be approved for drugs and supplies provided outpatients subject to the same provisions specified in 78.2(1) through 78.2(4) except for 78.2(4)*"b"*(7). The basis of payment for drugs provided outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

b. Hospitals that wish to administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health for Medicaid members.

78.3(6) Payment for nursing care provided by a hospital shall be made to those hospitals which have been certified by the department of inspections and appeals as meeting the standards for a nursing facility.

78.3(7) Payment for inpatient hospital tests for purposes of diagnosis and treatment shall be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient's condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient's diagnosis or treatment.

78.3(8) Rescinded IAB 2/6/91, effective 4/1/91.

78.3(9) Payment will be made for sterilizations in accordance with 78.1(16).

78.3(10) Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

a. Recipient selection and education.

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified.

The team should consist of:

A surgeon director.

A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

Anesthesiology.
Cardiology.
Dialysis.
Gastroenterology.
Hepatology.
Immunology.
Infectious diseases.
Nephrology.
Neurology.
Pathology.
Pediatrics.
Psychiatry.
Pulmonary medicine.
Radiology.
Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include the following:

Persons with expertise in the following areas available at the transplant center:
Anesthesiology.
Blood bank services.
Cardiology.
Cardiovascular surgery.
Dialysis.
Dietary services.
Gastroenterology.
Infection control.

Laboratory services (pathology, microbiology, immunology, tissue typing, and monitoring of immunosuppressive drugs).

Legal counsel familiar with transplantation laws and regulations.

Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.

Respiratory therapy.
Pharmaceutical services.
Physical therapy.
Psychiatry.
Psycho-social.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI). As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. Experience and survival rates.

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year.

For approval of an extrarenal organ transplant program it is highly desirable that the institution: 1. has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or 2. has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level.

To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

d. Organ procurement. The transplant center will participate in a nationwide organ procurement and typing network.

Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria.

The transplant center must be a member of the National Organ Procurement and Transplant Network.

e. Maintenance of data, research, review and evaluation.

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

These data should be maintained in the computer at the transplant center monthly.

The transplant center will submit the above data to the United Network of Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research.

Ongoing research regarding the transplanted organs is required.

The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program.

The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient.

The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program.

The transplant center will provide information to members of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process.

The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

f. Application procedure. A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to the Iowa Medicaid enterprise provider services unit. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to the Iowa Medicaid enterprise provider services unit.

g. Review and approval of facilities. An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes which would affect its approved status. Specifically, a facility must report any significant decrease in its experience level or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

78.3(11) Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

78.3(12) Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16)*"a"* and *"r"* to determine if a medical emergency exists.

Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual's health unless immediate medical treatment is given.

The determination of whether a medical emergency exists will be based on the patient's medical condition including presenting symptoms and medical history prior to treatment or evaluation.

78.3(13) Payment for patients in acute hospital beds who are determined by IFMC to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective *(a)* as of the date of notice by IFMC that the lower level of care is required or *(b)* for the days IFMC determines in an outlier review that the lower level of care was required.

78.3(14) Payment for patients in acute hospital beds who are determined by IFMC to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(1) plus the non-direct

care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective *(a)* as of the date of notice by IFMC that the lower level of care is required or *(b)* for the days IFMC determines in an outlier review that the lower level of care was required.

78.3(15) Payment for inpatient hospital charges associated with surgical procedures on the "Outpatient/Same Day Surgery List" produced by the Iowa Foundation for Medical Care shall be made only when attending physician has secured approval from the hospital's utilization review department prior to admittance to the hospital. Approval shall be granted when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete or modify entries on the "Outpatient/Same Day Surgery List."

78.3(16) Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3) and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3), with the rate component limits being revised July 1, 2001, and every second year thereafter.

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

78.3(18) Preprocedure review by the IFMC is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 78.28(5))

78.3(19) Rescinded IAB 10/8/97, effective 12/1/97.

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

441—78.4(249A) Dentists. Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Payment will also be made for the following dental procedures subject to the exclusions for services to adults 21 years of age and older set forth in subrule 78.4(14):

78.4(1) *Preventive services.* Payment shall be made for the following preventive services:

a. Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six-month period except for persons who, because of physical or mental disability, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

b. Topical application of fluoride is payable once in a six-month period except for people who need more frequent applications because of physical or mental disability. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants are payable for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental disability that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

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

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

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

c. A complete mouth radiograph survey consisting of a minimum of 14 periapical films and bite-wing films is a payable service once in a five-year period, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases. Complete mouth radiograph surveys are not payable under the age of six. A panographic-type radiography with bitewings is considered the same as a complete mouth radiograph survey.

d. Supplemental bitewing films are payable only once in a 12-month period.

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.

i. Temporomandibular joint radiograph.

j. Cephalometric film.

k. Diagnostic casts are payable only for orthodontic cases or when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

78.4(3) *Restorative services.* Payment shall be made for the following restorative services:

a. Treatment of dental caries is payable in those areas which require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials are reimbursable only once for the same restoration in a two-year period.

c. Rescinded IAB 5/1/02, effective 7/1/02.

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

e. Cast post and core, steel post and composite or amalgam in addition to a crown is payable when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

f. Payment as indicated will be made for the following restorative procedures:

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

(2) One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid.

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Rescinded IAB 5/1/02, effective 7/1/02.

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

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, local anesthesia and inhaled anesthesia are included in the restorative fee and may not be billed separately.

(7) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(8) More than four surfaces on an amalgam restoration will be reimbursed as a "four-surface" amalgam.

(9) An amalgam restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

78.4(4) *Periodontal services.* Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is payable once every 24 months. This procedure is not payable on the same date of service when other prophylasix or periodontal services are performed.

b. Periodontal scaling and root planing is payable when prior approval has been received. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (Cross-reference 78.28(2)*"a"*(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.28(2)*"a"*(2))

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

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

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

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

(2) Gingivoplasty will be paid per tooth.

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

78.4(5) *Endodontic services.* Payment shall be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when extensive posttreatment restorative procedures are not necessary and when missing teeth do not jeopardize the integrity or function of the dental arches.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment is payable when prior approval has been received. Payment for an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue will be approved when nonsurgical treatment has been attempted and a reasonable time has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross-reference 78.28(2)*"d"*)

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment shall be granted when the conventional treatment has been completed, a reasonable time has elapsed, and failure has been demonstrated with a radiograph and narrative history.

78.4(6) *Oral surgery—medically necessary.* Payment shall be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy, as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician's reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

a. Extractions, both surgical and nonsurgical.

b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.

c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.

d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.

e. Root recovery (surgical removal of residual root).

f. Oral antral fistula closure (or antral root recovery).

g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.

h. Surgical exposure of impacted or unerupted tooth to aid eruption.

i. General anesthesia, intravenous sedation, and non-intravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants its use.

j. Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

k. Payment may be made for postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

78.4(7) *Prosthetic services.* Payment may be made for the following prosthetic services:

a. An immediate denture and a first-time complete denture including six months' postdelivery care. An immediate denture and a first-time complete denture are payable when the denture is provided to establish masticatory function. An immediate denture or a first-time complete denture is payable only once following the removal of teeth it replaces. A complete denture is payable only once in a five-year period except when the denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of complete dentures due to resorption in less than a five-year period is not payable.

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

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. A removable partial denture replacing posterior teeth shall be approved when the member has fewer than eight posterior teeth in occlusion or the member has a full denture in one arch, and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.28(2)*"c"*(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth shall be approved for members whose medical condition precludes the

use of a removable partial denture. High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2)*"c"*(2))

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

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

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

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

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

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

k. Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

l. Dental implants and related services when prior authorization has been received. Prior authorization shall be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

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

a. When prior approval has been given for orthodontic services to treat the most handicapping malocclusions in a manner consistent with "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J.A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

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

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

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

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

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

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

78.4(10) *Treatment in a nursing facility.* Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

78.4(11) *Office visit.* Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or exams are not billed for that visit.

78.4(12) *Office calls after hours.* Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

78.4(13) *Drugs.* Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist's office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

78.4(14) *Services to members 21 years of age or older.* Orthodontic procedures are not covered for members 21 years of age or older.

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

441—78.5(249A) Podiatrists. Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

a. Durable plantar foot orthotic.

b. Plaster impressions for foot orthotic.

c. Molded digital orthotic.

d. Shoe padding when appliances are not practical.

e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.

f. Rams horn (hypertrophic) nails.

g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

a. Treatment of flatfoot. The term "flatfoot" is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in rule 78.1(2)*"c."* Payment shall be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist's office is located. If eligible to dispense drugs, the podiatrist should

request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

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

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) *Payable professional services are:*

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation.

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

(1) When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.
2. Verification of lenses after fabrication.
3. Adjustment and alignment of completed lens order.

(2) New lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.
2. Up to four times per year for children one through three years of age.
3. Once every 12 months for children four through seven years of age.
4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Protective lenses are allowed for:

1. Children through seven years of age.
2. Members with vision in only one eye.
3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Rescinded IAB 4/3/02, effective 6/1/02.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.
2. Sizing and measurements.
3. Fitting and adjustment.
4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.
2. One frame every 12 months is allowed for children four through six years of age.
3. When there is a prescribed lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.
2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk.

g. Rescinded IAB 4/3/02, effective 6/1/02.

h. Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

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

78.6(2) *Ophthalmic materials.* Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

a. Corrected curve lenses, unless clinically contraindicated, manufactured by reputable American manufacturers.

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

c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

78.6(3) *Reimbursement.* The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice.

a. Materials payable by fee schedule are:

(1) Lenses, single vision and multifocal.
(2) Frames.
(3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

(1) Contact lenses.
(2) Schroeder shield.
(3) Ptosis crutch.
(4) Protective lenses and safety frames.

(5) Subnormal visual aids.

78.6(4) *Prior authorization.* Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

(Cross-reference 78.28(3))

78.6(5) *Noncovered services.* Noncovered services include, but are not limited to, the following services:

a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.

b. Glasses for protective purposes including glasses for eye safety, sunglasses, or glasses with photogray lenses. An exception to this is in 78.6(3)*"b"*(4).

c. A second pair of glasses or spare glasses.

d. Cosmetic surgery and experimental medical and surgical procedures.

e. Contact lenses if vision is correctable with noncontact lenses except as found at paragraph 78.6(1)*"i."*

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

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

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

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross-reference 78.28(3))

78.7(1) to **78.7(3)** Rescinded IAB 4/3/02, effective 6/1/02.

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

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of "pain" is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient's condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

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

ICD-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
		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 date of the signature shall be within the certification period.

78.9(2) *Supervisory visits.* Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician and included in the plan of care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"b."*

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established

by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"c."*

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"d."*

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) *Medical social services.*

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

(1) Are reasonable and necessary to the treatment of a member's illness or injury.

(2) Contribute meaningfully to the treatment of the member's condition.

(3) Are under the direction of a physician.

(4) Are provided by or under the supervision of a qualified medical or psychiatric social worker.

(5) Address social problems that are impeding the member's recovery.

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

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

(1) The potential risk factors,

(2) The medical factor or symptom which verifies the child is at risk,

(3) The reason the member is unable to obtain care outside of the home,

(4) The medically related task of the home health agency,

(5) The member's diagnosis,

(6) Specific services and goals, and

(7) The medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.

(4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.

(5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.

(6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.

(7) Second pregnancy in 12 months.

(8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.

(4) Preexisting mental or physical disabilities such as deaf, blind, hemaplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or mental retardation.

(5) Drug or alcohol abuse.

(6) Symptoms of postpartum psychosis.

(7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.

(8) Demonstrated disturbance in maternal and infant bonding.

(9) Discharge or release from hospital against medical advice before 36 hours postpartum.

(10) Insufficient antepartum care by history.

(11) Multiple births.

(12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

(1) Birth weight of five pounds or under or over ten pounds.

(2) History of severe respiratory distress.

(3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.

(4) Disabling birth injuries.

(5) Extended hospitalization and separation from other family members.

(6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to mental retardation.

(7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.

(8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.

(9) Discharge or release against medical advice before 36 hours of age.

(10) Nutrition or feeding problems.

e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:

(1) Child or sibling victim of child abuse or neglect.

(2) Mental retardation or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.

(3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.

(4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.

(5) Malignancies such as leukemia or carcinoma.

(6) Severe injuries necessitating treatment or rehabilitation.

(7) Disruption in family or peer relationships.

(8) Suspected developmental delay.

(9) Nutritional deficiencies.

78.9(10) *Private duty nursing or personal care services for persons aged 20 and under.* Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.

2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.

3. Services provided to other persons in the member's household.

4. Services requiring prior authorization that are provided without regard to the prior authorization process.

5. Transportation services.

6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.28(9))

78.9(11) *Vaccines.* Home health agencies which wish to administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health for Medicaid members. Home health agencies may provide Vaccines for Children clinics and be reimbursed for vaccine administration to provide Vaccines for Children program vaccines to Medicaid children in other than the home setting.

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

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

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) *General payment requirements.* Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the diagnosis, prognosis, and length of time the item is to be required.

For items requiring prior approval, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior approval is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior approval requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

(1) Physical fitness equipment, e.g., an exercycle, weights.

(2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.

(3) Self-help devices, e.g., safety grab bars, raised toilet seats.

(4) Training equipment, e.g., speech teaching machines, braille training texts.

(5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.

(6) Equipment which basically serves comfort or convenience functions, or is primarily for the convenience of a person caring for the patient, e.g., elevators, stairway elevators and posture chairs.

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

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise, and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 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 the mentally retarded except when a Medicaid-eligible resident of a nursing facility medically needs oxygen for 12 or more hours per day for at least 30 days or more. Medicaid will provide payment to medical equipment and supply dealers to provide oxygen services in a nursing facility when all of the following requirements and conditions have been met:

(1) A physician's, physician assistant's, or advanced registered nurse practitioner's prescription documents that a resident of a nursing facility requires oxygen for 12 hours or more per day and the provider and physician, physician assistant, or advanced registered nurse practitioner jointly submit Certificate of Medical Necessity, Form CMS-484, from Medicare or a reasonable facsimile to the Iowa Medicaid enterprise with the monthly billing. The documentation submitted must contain the following:

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

Oxygen prescribed "PRN" or "as necessary" is not allowed.

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

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

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

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

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

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

Alternating pressure pump.

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

Bedpan.

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

Blood pressure cuffs.

Cane.

Cardiorespiratory monitor (rental and supplies).

Commode.

Commode pail.

Crutches.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(2)*"d"* for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Hospital bed.

Hospital bed accessories.

Inhalation equipment.

Insulin infusion pump. See 78.10(2)*"d"* for prior authorization requirements.

Lymphedema pump.

Neuromuscular stimulator.
Oximeter.
Oxygen, subject to the limitations in 78.10(2)*"a"* and 78.10(2)*"c."*
Patient lift (Hoyer).
Phototherapy bilirubin light.
Pressure unit.
Protective helmet.
Respirator.
Resuscitator bags and pressure gauge.
Seat lift chair.
Suction machine.
Traction equipment.
Urinal (portable).
Vaporizer.
Ventilator.
Vest airway clearance system. See 78.10(2)*"d"* for prior authorization requirements.
Walker.
Wheelchair—standard and adaptive.
Whirlpool bath.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary only for members with significant hypoxemia, as shown by medical documentation. The physician's, physician assistant's, or advanced registered nurse practitioner's prescription shall document that other forms of treatment have been tried and have not been successful, and that oxygen therapy is required.

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

1. A diagnosis of the disease requiring home use of oxygen;
2. The oxygen flow rate and concentration;
3. The type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and
5. The initial reading on the time meter clock on each concentrator, where applicable.

Oxygen prescribed "PRN" or "as necessary" is not allowed.

(2) If the patient's condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician (doctor of medicine or osteopathy), physician assistant, or advanced registered nurse practitioner of the medical necessity for portable oxygen for specific activities.

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

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

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

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

1. The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.
2. The patient's mobility puts the patient at risk for injury.
3. The patient has suffered injuries when getting out of bed.
4. The patient has had a successful trial with an enclosed bed.

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

(3) Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a patient with a diagnosis of a lung disorder if all of the following conditions are met:

1. Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease of lung function.
2. The patient resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.
3. Treatment by flutter device failed or is contraindicated.
4. Treatment by intrapulmonary percussive ventilation failed or is contraindicated.
5. All other less costly alternatives have been tried.

(4) Automated medication dispenser. Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

1. The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.
2. The member is on two or more medications prescribed to be administered more than one time a day.
3. The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.
4. Less costly alternatives, such as medisets or telephone reminders, have failed.

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

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

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

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

78.10(3) *Prosthetic devices.* Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the patient's condition may improve sometime in the future.

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

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

Artificial eyes.

Artificial limbs.

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

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

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

Oral nutritional products. See 78.10(3)*"c"* for prior approval requirements.

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

Ostomy appliances.

Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

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

Tracheotomy tubes.

Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross-reference 78.28(8))

c. Prior approval is required for the following prosthetic devices:

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

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

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

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

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

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

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

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

(3) Oral nutritional products. Payment for oral nutritional products shall be approved as medically necessary only when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition.

A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for oral supplementation pursuant to these standards. The documentation shall include:

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

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

3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member.

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

d. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is photographic evidence supporting moderate to severe nonsynostotic positional plagiocephaly and either:

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

(2) The member is between 6 and 18 months of age and there is documentation of either of the following conditions:

1. Cephalic index at least two standard deviations above the mean for the member's gender and age; or

2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) *Medical supplies.* Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. Medical supplies are not to be dispensed at any one time for quantities exceeding a three-month supply. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member's caregiver for each refill.

a. Only the following types of medical supplies and supplies necessary for the effective use of a payable item can be purchased through the medical assistance program:

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

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

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

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

Dialysis supplies.

Diapers (for members aged four and above).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

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

Disposable underpads.

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Respirator supplies.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for the mentally retarded when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

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

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

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

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

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

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

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

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

a. The individual is admitted as a hospital inpatient or in an emergency situation.

b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

One patient - normal allowance

Two patients - 3/4 normal allowance per patient

Three patients - 2/3 normal allowance per patient

Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the

hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 79.1(5)*"j."*

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

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

441—78.12(249A) Remedial services. Payment will be made for remedial services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a psychological disorder, subject to the limitations in this rule.

78.12(1) *Covered services.* Medicaid covers the following remedial services:

a. Community psychiatric supportive treatment, which offers intensive interventions to modify psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning when less intensive remedial services do not meet the member's needs.

(1) Interventions must focus on the member's remedial needs to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Interventions may assist the member in skills such as conflict resolution, problem solving, social skills, interpersonal relationship skills, and communication.

(3) Community psychiatric supportive treatment is covered only for Medicaid members who are aged 20 or under.

(4) Community psychiatric supportive treatment is not intended for members in congregate care.

(5) Community psychiatric supportive treatment is not intended to be provided in a group.

b. Crisis intervention to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

c. Health or behavior intervention, used to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community: conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and communication skills.

(2) The purpose of intervention shall be to minimize or eliminate psychological barriers to the member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.

(3) Health or behavior intervention is covered only for Medicaid members aged 20 or under.

d. Rehabilitation program, which consists of interventions to enhance a member's independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and to maximize the member's ability to live and participate in the community.

(1) Interventions may address the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.

(2) Rehabilitation program services are covered only for Medicaid members who are aged 18 or over.

e. Skills training and development, which consists of interventions to enhance independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and to maximize a member's ability to live and participate in the community.

(1) Interventions may include the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.

(2) Skills training and development services are covered only for Medicaid members aged 18 or over.

78.12(2) *Excluded services.* Services that are habilitative in nature are not covered as remedial services. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

78.12(3) *Coverage requirements.* Medicaid covers remedial services only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder. For example, licensed practitioners of the healing arts include physicians (M.D. or D.O.), advanced registered nurse practitioners (ARNP), psychologists (Ph.D. or Psy.D.), independent social workers (LISW), marital and family therapists (LMFT), and mental health counselors (LMHC). For purposes of this rule, the licensed practitioner of the healing arts must be:

(1) Enrolled in the Iowa Plan pursuant to 441—Chapter 88, Division IV; and

(2) Qualified to provide clinical assessment services under the Iowa Plan pursuant to 441—Chapter 88, Division IV (Current Procedural Terminology code 90801).

b. The licensed practitioner of the healing arts has recommended the remedial services as part of a plan of treatment designed to treat the member's psychological disorder. Diagnosis and treatment plan development provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441— Chapter 88, Division IV.

c. The remedial services provider has prepared a written remedial services implementation plan that has been approved by:

(1) The member or the member's parent or guardian; and

(2) The medical services unit of the Iowa Medicaid enterprise.

78.12(4) *Approval of plan.* The remedial services provider shall submit the treatment plan and the remedial services implementation plan to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

a. Initial plan. The IME medical services unit shall approve the provider's initial remedial services implementation plan if:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(3);

(2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;

(3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

(4) The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan, as required in rule 441—77.12(249A);

(5) The plan does not exceed six months' duration; and

(6) The plan requires that written progress notes be submitted no less often than every six weeks to the IME medical services unit.

b. Subsequent plans. The IME medical services unit may approve a subsequent remedial services implementation plan according to the conditions in paragraph *"a"* if the services are recommended by a licensed practitioner of the healing arts who has:

(1) Reexamined the member;

(2) Reviewed the original diagnosis and treatment plan; and

(3) Evaluated the member's progress.

c. Quality review. The IME medical services unit will establish a quality review process. Reviews will evaluate:

(1) The time elapsed from referral to remedial plan development;

(2) The continuity of treatment;

(3) The affiliation of the licensed practitioner of the healing arts with the remedial services provider;
(4) Gaps in service;
(5) The results achieved; and
(6) Member satisfaction.

78.12(5) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of remedial services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
(2) The professional literature regarding best practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2006 Iowa Acts, House File 2734, section 10, subsection 11.

441—78.13(249A) Transportation to receive medical care. Payment will be approved for transportation to receive services covered under the program, including transportation to obtain prescribed drugs, when all of the following conditions are met.

78.13(1) Transportation costs are reimbursable only when:

a. The source of the care is located outside the city limits of the community in which the member resides; or

b. The member resides in a rural area and must travel to a city to receive necessary care.

78.13(2) Transportation costs are reimbursable only when:

a. The type of care is not available in the community in which the member resides; or

b. The member has been referred by the attending physician to a specialist in another community.

78.13(3) Transportation costs are reimbursable only when there is no resource available to the member through which necessary transportation might be secured free of charge. EXCEPTION: Costs of transportation to obtain prescribed drugs may be reimbursed irrespective of whether free delivery is offered when the prescription drug is needed immediately.

78.13(4) Transportation is reimbursable only to the nearest institution or practitioner having appropriate facilities for the care of the member.

78.13(5) Transportation may be of any type and may be provided from any source.

a. When transportation is by car, the maximum payment that may be made will be the actual charge made by the provider for transportation to and from the source of medical care, but not in excess of 30 cents per mile.

b. When public transportation is utilized, the basis of payment will be the actual charge made by the provider of transportation, not to exceed $1.40 per mile.

c. In all cases where public transportation is reasonably available to or from the source of care and the member's condition does not preclude its use, public transportation must be utilized. When the member's condition precludes the use of public transportation, a statement to the effect shall be included in the case record.

78.13(6) In the case of a child too young to travel alone, or an adult or child who because of physical or mental incapacity is unable to travel alone, payment subject to the above conditions shall be made for the transportation costs of an escort. The worker is responsible for making a decision concerning the necessity of an escort and recording the basis for the decision in the case record.

78.13(7) When meals and lodging or other travel expenses are required in connection with transportation, payment will be subject to the same conditions as for a state employee and the maximum

amount payable shall not exceed the maximum payable to a state employee for the same expenses in connection with official travel within the state of Iowa.

78.13(8) When the services of an escort are required subject to the conditions in subrule 78.13(6), payment may be made for the escort's meals and lodging, when required, on the same basis as for the member.

78.13(9) Payment will not be made in advance to a member or a provider of medical transportation.

78.13(10) Payment for transportation to receive medical care is made to the member with the following exceptions:

a. Payment may be made to the agency that provided transportation if the agency is certified by the department of transportation and requests direct payment. Reimbursement for transportation shall be based on a fee schedule by mile or by trip.

b. In cases where the local office has established that the member has persistently failed to reimburse a provider of medical transportation, payment may be made directly to the provider.

c. In all situations where one of the department's volunteers is the provider of transportation.

78.13(11) Form 470-0386, Medical Transportation Claim, shall be completed by the member and the medical provider and submitted to the local office for each trip for which payment is requested. All trips to the same provider in a calendar month may, at the member's option, be submitted on the same form.

78.13(12) No claim shall be paid if presented after the lapse of 365 days from its accrual unless it is to correct payment on a claim originally submitted within the required period.

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

[**ARC 8344B**, IAB 12/2/09, effective 12/1/09]

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.

a. Assignment of payment slot. The number of persons who may be approved for home- and community-based habilitation services is subject to a yearly total to be served. The total is set by the department based on available funds and is contained in the Medicaid state plan approved by the federal Centers for Medicare and Medicaid Services. The limit is maintained through the awarding of payment slots to members applying for services.

(1) The case manager shall contact the Iowa Medicaid enterprise through ISIS to determine if a payment slot is available for each member applying for home- and community-based habilitation services.

(2) When a payment slot is assigned, the case manager shall give written notice to the member.

(3) The department shall hold the assigned payment slot for the member as long as reasonable efforts are being made to arrange services and the member has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next applicant on the waiting list, if applicable. The member must reapply for a new slot.

b. Waiting list for payment slots. When the number of applications exceeds the number of members specified in the state plan and there are no available payment slots to be assigned, the member's application for habilitation services shall be denied. The department shall issue a notice of decision stating that the member's name will be maintained on a waiting list.

(1) The Iowa Medicaid enterprise shall enter the member on a waiting list based on the date and time when the member's request for habilitation services was entered into ISIS. In the event that more than one application is received at the same time, members shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(2) When a payment slot becomes available, the Iowa Medicaid enterprise shall notify the member's case manager, based on the member's order on the waiting list. The case manager shall give written notice to the member within five working days.

(3) The department shall hold the payment slot for 20 calendar days to allow the case manager to reapply for habilitation services by entering a program request through ISIS. If a request for habilitation services has not been entered within 20 calendar days, the slot shall revert for use by the next member on the waiting list, if applicable. The member assigned the slot must reapply for a new slot.

(4) The case manager shall notify the Iowa Medicaid enterprise within five working days of the withdrawal of an application.

c. Notice of decision. The department shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the service plan have been completed.

78.27(4) *Comprehensive service plan.* Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager shall establish an interdisciplinary team for the member. The team shall include the case manager and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved.

(2) With the interdisciplinary team, the case manager shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

b. Service goals and activities. The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;
2. The funding source for the service; and
3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;
2. The number of hours per day of on-site staff supervision needed by the member; and
3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan shall include documentation of:

(1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;

(2) The need for the restriction; and

(3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. Emergency plan. The comprehensive service plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

(1) The member's interdisciplinary team shall identify in the comprehensive service plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

(2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

(3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval. Services shall be entered into ISIS based on the comprehensive service plan. A service plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2)*"e."*

78.27(5) *Requirements for services.* Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member's needs as identified in the member's comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) *Case management.* Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Exclusion. Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) *Home-based habilitation.* "Home-based habilitation" means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

(1) Adaptive skill development;
(2) Assistance with activities of daily living;
(3) Community inclusion;
(4) Transportation;
(5) Adult educational supports;
(6) Social and leisure skill development;
(7) Personal care; and
(8) Protective oversight and supervision.

b. Exclusions. Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) *Day habilitation.* "Day habilitation" means assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member's maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member's:

(1) Intellectual functioning;
(2) Physical and emotional health and development;
(3) Language and communication development;
(4) Cognitive functioning;
(5) Socialization and community integration;
(6) Functional skill development;
(7) Behavior management;
(8) Responsibility and self-direction;
(9) Daily living activities;
(10) Self-advocacy skills; or
(11) Mobility.

b. Setting. Day habilitation shall take place in a nonresidential setting separate from the member's residence. Services shall not be provided in the member's home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member's home if the services are provided in an area apart from the member's sleeping accommodations.

c. Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

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

(1) Vocational or prevocational services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in day habilitation services.

78.27(9) *Prevocational habilitation.* "Prevocational habilitation" means services that prepare a member for paid or unpaid employment.

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

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

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

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available for the service under these programs shall be maintained in the file of each member receiving prevocational habilitation services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in prevocational services.

78.27(10) *Supported employment habilitation.* "Supported employment habilitation" means services associated with maintaining competitive paid employment.

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

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

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

2. Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in subrule 78.27(4). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include: developing relationships with employers and

providing leads for individual members when appropriate; job analysis for a specific job; development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities; identifying and arranging reasonable accommodations with the employer; providing disability awareness and training to the employer when it is deemed necessary; and providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available under these programs shall be maintained in the file of each member receiving supported employment services.

(2) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing or maintaining members in day activity programs, work activity programs, or sheltered workshop programs.

(6) Supports for volunteer work or unpaid internships.

(7) Tuition for education or vocational training.

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

78.27(11) *Adverse service actions.*

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

(1) A payment slot is not available to the member pursuant to paragraph 78.27(3)*"a."*

(2) The member is not eligible for or in need of home- and community-based habilitation services.

(3) The service is not identified in the member's comprehensive service plan.

(4) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(5) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(6) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 consecutive days, the department will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

78.27(12) *County reimbursement.* The county board of supervisors of the member's county of legal settlement shall reimburse the department for all of the nonfederal share of the cost of home- and community-based habilitation services provided to an adult member with a chronic mental illness as defined in 441—Chapter 90. The department shall notify the county's central point of coordination administrator through ISIS of the approval of the member's service plan.

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter)]

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

78.28(1) Services, procedures, and medications prescribed by a physician (M.D. or D.O.) which are subject to prior approval or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code Supplement section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Automated medication dispenser. (Cross-reference 78.10(2)*"b"*) Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

(2) The member is on two or more medications prescribed to be administered more than one time a day.

(3) The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

(4) Less costly alternatives, such as medisets or telephone reminders, have failed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) The patient has had a successful trial with an enclosed bed.

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross-reference 78.10(2)*"c"*)

i. Prior authorization is required for oral nutritional products. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for oral nutritional products when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition.

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

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

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

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

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

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

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

(2) The patient resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

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

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

a. The following periodontal services:

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

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

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

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

b. Surgical endodontic treatment which includes an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue will be approved when nonsurgical treatment has been attempted and a reasonable time has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross-reference 78.4(5)*"c"*)

c. The following prosthetic services:

(1) A removable partial denture replacing posterior teeth will be approved when the member has fewer than eight posterior teeth in occlusion or the member has a full denture in one arch, and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial

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

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

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

(4) Dental implants and related services will be authorized when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

d. Orthodontic services will be approved when it is determined that a patient has the most handicapping malocclusion. This determination is made in a manner consistent with the "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J. A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

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

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

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

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

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

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

78.28(3) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross-references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(4) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross-reference 78.14(7)*"d"*(1))

b. A hearing aid costing more than $650. The department shall approve payment for either of the following purposes (Cross-reference 78.14(7)*"d"*(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(5) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross-reference 441—78.1(249A))

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

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

78.28(6) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

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

78.28(7) Rescinded IAB 6/4/08, effective 5/15/08.

78.28(8) Rescinded IAB 1/3/96, effective 3/1/96.

78.28(9) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.9(10))

78.28(10) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross-reference 78.10(3)*"b"*)

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

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

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, or master social worker within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) *Limitations.*

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) *Exclusions.* Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) *Payment.*

a. Payment shall be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

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

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) *Vaccines.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as birth center services. Birth centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Birth centers shall receive reimbursement for the administration of vaccines to Medicaid members.

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

441—78.31(249A) Hospital outpatient services.

78.31(1) *Covered hospital outpatient services.* Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs *"g"* to *"m"* are subject to a random sample retrospective review for medical necessity by the Iowa Foundation for Medical Care. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs *"a"* to *"f"* shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs *"g"* to *"m"* shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

a. Emergency service.
b. Outpatient surgery.
c. Laboratory, X-ray and other diagnostic services.
d. General or family medicine.
e. Follow-up or after-care specialty clinics.
f. Physical medicine and rehabilitation.
g. Alcoholism and substance abuse.
h. Eating disorders.
i. Cardiac rehabilitation.
j. Mental health.
k. Pain management.
l. Diabetic education.
m. Pulmonary rehabilitation.
n. Nutritional counseling for persons aged 20 and under.

78.31(2) *Requirements for all outpatient services.*

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs *"d"* and *"f"* and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. Hospital outpatient programs that wish to administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health for Medicaid members. Hospital outpatient programs receive payment via the APC reimbursement for the administration of vaccines to Medicaid members.

78.31(3) *Application for certification.* Hospital outpatient programs listed in subrule 78.31(1), paragraphs *"g"* to *"m,"* must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff's relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) *Requirements for specific types of service.*

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

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

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

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

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

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa, bulimia, or bulimarexia. Compulsive overeaters are not acceptable for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia as established by the DSM III R (Diagnostic and Statistical Manual, Third Edition, Revised).

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

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

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

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

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

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

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

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

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

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

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

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

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

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

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

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

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

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

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

c. Cardiac rehabilitation.

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

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

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

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

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

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

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

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

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.

Physician's orders.

Laboratory reports.

Electrocardiogram reports.

History and physical examination.

Angiogram report, if applicable.

Operative report, if applicable.

Preadmission interview.

Exercise prescription.

Rehabilitation plan, including participant's goals.

Documentation for exercise sessions and progress notes.

Nurse's progress reports.

Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, disrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

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

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

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

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

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

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

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

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

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

441—78.33(249A) Case management services. Payment on a monthly payment per enrollee basis will be approved for the case management functions required in 441—Chapter 90.

78.33(1) Payment will be approved for MR/CMI/DD case management services pursuant to 441—Chapter 90 to:

a. Recipients 18 years of age or over with a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

b. Rescinded IAB 1/8/03, effective 1/1/03.

c. Recipients under 18 years of age receiving HCBS MR waiver or HCBS children's mental health waiver services.

78.33(2) Payment for services pursuant to 441—Chapter 90 to recipients under age 18 who have a primary diagnosis of mental retardation or developmental disabilities as defined in rule 441—90.1(249A) and are residing in a child welfare decategorization county shall be made when the following conditions are met:

a. The child welfare decategorization county has entered into an agreement with the department certifying that the state match for case management is available within funds allocated for the purpose of decategorization.

b. The child welfare decategorization county has executed an agreement to remit the nonfederal share of the cost of case management services to the enhanced mental health, mental retardation and developmental disabilities services fund administered by the department.

c. The child welfare decategorization county has certified that the funds remitted for the nonfederal share of the cost of case management services are not federal funds.

78.33(3) Rescinded IAB 10/12/05, effective 10/1/05.

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

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to clients eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.34(1) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and include:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the client, and dishes.

c. Rescinded IAB 9/30/92, effective 12/1/92.

d. Meal preparation planning and preparing balanced meals.

78.34(2) *Home health services.* Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

a. Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

(8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service are as set forth in rule 441—171.6(234) or the department of elder affairs rule 321—24.7(231).

78.34(4) *Nursing care services.* Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) *Respite care services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

e. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite, or group respite as defined in rule 441—83.1(249A).

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

78.34(9) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The service worker shall encumber up to $505 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response system.* A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency when the consumer is alone.

a. The required components of the system are:

(1) An in-home medical communications transmitter and receiver.

(2) A remote, portable activator.

(3) A central monitoring station with backup systems staffed by trained attendants at all times.

(4) Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each consumer.

b. The service shall be identified in the consumer's service plan.

c. A unit of service is a one-time installation fee or one month of service.

d. Maximum units per state fiscal year shall be the initial installation and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard. When a restaurant provides the home-delivered meal, the recipient is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and what constitutes the minimum one-third daily dietary allowance.

A maximum of 14 meals is allowed per week. A unit of service is a meal.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be set for each consumer. The consumer's department service worker or case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a consumer in the HCBS ill and handicapped waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) The department shall determine an average unit cost for each service selected under subparagraph (1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the consumer's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS ill and handicapped waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services with the exception of the independent support broker and the financial management service. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The consumer may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the following services:

(1) Assist the consumer with developing the consumer's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the consumer for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the consumer.

(5) Assist the consumer with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the consumer with obtaining a signed consent from a potential employee to conduct background checks if requested by the consumer.

(7) Assist the consumer with negotiating with entities providing services and supports if requested by the consumer.

(8) Assist the consumer with contracts and payment methods for services and supports if requested by the consumer.

(9) Assist the consumer with developing an emergency backup plan. The emergency backup plan shall also address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the consumer. Contact documentation shall include information on the extent to which the consumer's individual budget has addressed the consumer's needs and the satisfaction of the consumer.

k. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the consumer, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees, if requested.

(6) Verify for the consumer an employee's citizenship or alien status.

(7) Assist the consumer with fiscal and payroll-related responsibilities. Key employer-related tasks include:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Purchase from the individual budget workers' compensation or other forms of insurance, as applicable or if requested by the consumer.

(9) Assist the consumer in completing required federal, state, and local tax and insurance forms.

(10) Establish and manage documents and files for the consumer and the consumer's employees.

(11) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each consumer for a total of five years.

(12) Provide monthly and quarterly status reports for the department, the independent support broker, and the consumer that include a summary of expenditures paid and amount of budget unused.

(13) Establish an accessible customer service system and a method of communication for the consumer and the individual support broker that includes alternative communication formats.

(14) Establish a customer services complaint reporting system.

(15) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(16) Develop a business continuity plan in the case of emergencies and natural disasters.

(17) Provide to the department an annual independent audit of the financial management service.

(18) Assist in implementing the state's quality management strategy related to the financial management service.

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

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.36(249A) Hospice services.

78.36(1) *General characteristics.* A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

(1) Nursing care.

(2) Medical social services.

(3) Physician services.

(4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.

(5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.

(6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

(7) Homemaker and home health aide services.

(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.

(9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of

care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.

4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

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

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to consumers eligible for the HCBS elderly waiver services as established in 441—Chapter 83. The consumer shall have a billable waiver service each calendar quarter. Services must be billed in whole units.

78.37(1) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service are set forth in rule 441—171.6(234) or as indicated in the Iowa department of elder affairs Annual Service and Fiscal Reporting Manual.

78.37(2) *Emergency response system.* The emergency response system allows a person experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

a. An in-home medical communications transceiver.
b. A remote, portable activator.
c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.
d. Current data files at the central monitoring station containing preestablished response protocols and personal, medical, and emergency information for each client.

78.37(3) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.
b. Helping a client with bath, shampoo, or oral hygiene.
c. Helping a client with toileting.
d. Helping a client in and out of bed and with ambulation.
e. Helping a client reestablish activities of daily living.
f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client is incapacitated or occupied providing direct care to the client. A unit of service is one hour. Components of the service include:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, and washing and mending clothes.

c. Accompaniment to medical or psychiatric services.

d. Meal preparation: planning and preparing balanced meals.

e. Bathing and dressing for self-directing recipients.

78.37(5) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) *Respite care services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.21(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

78.37(7) *Chore services.* Chore services include the following services: window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows; minor repairs to walls, floors, stairs, railings and handles; heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal; and yard work such as mowing lawns, raking leaves and shoveling walks. A unit of service is one-half hour.

78.37(8) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and

Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard. When a restaurant provides the home-delivered meal, the recipient is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and explain what constitutes the minimum one-third daily dietary allowance.

A maximum of 14 meals is allowed per week. A unit of service is a meal.

78.37(9) *Home and vehicle modification.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for recipients to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation, and to reduce social isolation. A unit of service is per mile, per trip, or rate established by area agency on aging.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is one hour.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service provided by an individual or an agency, other than an assisted living program, is 1 hour, or one 8- to 24-hour day. When provided by an assisted living program, a unit of service is one calendar month. If services are provided by an assisted living program for less than one full calendar month, the monthly reimbursement rate shall be prorated based on the number of days service is provided. Except for services provided by an assisted living program, each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service

provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.37(16) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a consumer in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph (1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the consumer's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS elderly waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services with the exception of the independent support broker and the financial management service. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The consumer may perform the following functions:

(1) Recruit employees.
(2) Select employees from a worker registry.
(3) Verify employee qualifications.
(4) Specify additional employee qualifications.
(5) Determine employee duties.
(6) Determine employee wages and benefits.
(7) Schedule employees.
(8) Train and supervise employees.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

78.37(17) *Case management services.* Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

This rule is intended to implement Iowa Code section 249A.4.
[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to clients eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.38(1) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

a. Observation and reporting of physical or emotional needs.
b. Helping a client with bath, shampoo, or oral hygiene.
c. Helping a client with toileting.
d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and are:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the client, and dishes.

c. Accompaniment to medical or psychiatric services or for children aged 18 and under to school.

d. Meal preparation: planning and preparing balanced meals.

78.38(4) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) *Respite care services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is otherwise reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.41(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

78.38(6) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard. A maximum of 14 meals is allowed per week. A unit of service is a meal.

78.38(7) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full

day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service are as set forth in rule 441—171.6(234) or the department of elder affairs rule 321—24.7(231).

78.38(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.38(9) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a consumer in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph (1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the consumer's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS AIDS/HIV waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services with the exception of the independent support broker and the financial management service. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The consumer may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) *Vaccines.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Federally qualified health centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and

obtain the vaccines from the department of public health. However, vaccine administration is a covered service.

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

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) *Direct payment.* Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) *Location of service.* Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) *Vaccine administration.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Advanced registered nurse practitioners who wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Advanced registered nurse practitioners shall receive reimbursement for the administration of vaccines to Medicaid members.

78.40(5) *Prenatal risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

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

441—78.41(249A) HCBS MR waiver services. Payment will be approved for the following services to consumers eligible for the HCBS MR waiver services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services include the applicable and necessary instruction, supervision, assistance and support as required by the consumer in achieving the consumer's life goals. The services, amount and supports provided under the HCBS MR waiver shall be delivered in the least restrictive environment and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through the Medicaid state plan.

All services shall be billed in whole units.

78.41(1) *Supported community living services.* Supported community living services are provided by the provider within the consumer's home and community, according to the individualized consumer need as identified in the service plan pursuant to rule 441—83.67(249A).

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are those activities which assist a consumer to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) "Individual advocacy services" means the act or process of representing the individual's rights and interests in order to realize the rights to which the individual is entitled and to remove barriers to meeting the individual's needs.

(3) "Community skills training services" means activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget; plan and prepare nutritional meals; ability to use community resources such as public transportation, libraries, etc., and ability to select foods at the grocery store.

2. Socialization skills training services are those activities which assist a consumer to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a person to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) "Personal and environmental support services" means activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

(5) "Transportation services" means activities and expenditures designed to assist the person to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work.

(6) "Treatment services" means activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.

2. Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the consumer and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to consumers living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified time periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to consumers for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of three consumers receiving community-supported alternative living arrangements or HCBS MR services may reside in a living unit except providers meeting requirements set forth in 441—paragraph 77.37(14)*"e."*

(1) Consumers may live within the home of their family or legal representative or within other types of typical community living arrangements.

(2) Consumers of services living with families or legal representatives are not subject to the maximum of three consumers in a living unit.

(3) Consumers may not live in licensed medical or health care facilities or in settings required to be licensed as medical or health care facilities.

(4) Consumers aged 17 or under living within the home of their family, legal representative, or foster families shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age appropriateness and individual attention span.

d. Rescinded IAB 2/5/03, effective 2/1/03.

e. Transportation to and from a day program is not a reimbursable service. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect all staff-to-consumer ratios and shall reflect costs associated with consumers' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per consumer per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 14 or more hours per day as an average over a 7-day week and the consumer's individual comprehensive plan or case plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

g. The maximum number of units available per consumer is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 5,110 hourly units are available per state fiscal year except a leap year when 5,124 hourly units are available.

h. The service shall be identified in the consumer's individual comprehensive plan.

i. Services shall not be simultaneously reimbursed with other residential services, HCBS MR respite, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

78.41(2) *Respite services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where the respite is provided is reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Payment for respite services shall not exceed $7,050 per the consumer's waiver year.

e. The service shall be identified in the consumer's individual comprehensive plan.

f. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS MR waiver supported community living services, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

g. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

h. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.60(249A).

i. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

j. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.41(3) *Personal emergency response system.* The personal emergency response system is an electronic component that transmits a coded signal via digital equipment to a central monitoring station. The electronic device allows a person to access assistance in the event of an emergency when alone.

a. The necessary components of the system are:

(1) An in-home medical communications transceiver.

(2) A remote, portable activator.

(3) A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

(4) Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

b. The service shall be identified in the consumer's individual comprehensive plan.

c. A unit is a one-time installation fee or one month of service.

d. Maximum units per state fiscal year are the initial installation and 12 months of service.

78.41(4) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the consumer which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS MR supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the consumer's individual comprehensive plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs *"a"* and *"b"* that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in 441—subrule 83.67(1) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.

2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.

3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in 441—subrule 83.67(1). Employer development

services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

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

1. Job opening identification with the consumer.
2. Assistance with applying for a job, including completion of applications or interviews.
3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Consumer-directed attendant care services as defined in subrule 78.41(8).
6. Assistance with time management.
7. Assistance with appropriate grooming.
8. Employment-related supportive contacts.
9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
10. On-site vocational assessment after employment.
11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

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

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.

(6) All services shall be identified in the consumer's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;
3. Tuition for education or vocational training; or
4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.41(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker or case manager prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)*"d."*

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS MR waiver supported community living service.

78.41(12) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis. A unit of service is a full day (4 to 8 hours) or a half-day (1 to 4 hours) or an extended day (8 to 12 hours).

78.41(13) *Prevocational services.* Prevocational services are services that are aimed at preparing a consumer eligible for the HCBS MR waiver for paid or unpaid employment, but are not job-task oriented. These services include teaching the consumer concepts necessary as job readiness skills, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but at more generalized habilitative goals, and are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) that are otherwise available to the consumer through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the consumer through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

78.41(14) *Day habilitation services.*

a. Scope. Day habilitation services are services that assist or support the consumer in developing or maintaining life skills and community integration. Services must enable or enhance the consumer's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the consumer's home. The unit of service is an hour. The units of services payable are limited to a maximum of 10 hours per month.

c. Unit of service. Except as provided in paragraph *"b,"* the unit of service may be an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

d. Exclusions.

(1) Services shall not be provided in the consumer's home, except as provided in paragraph *"b."* For this purpose, services provided in a residential care facility where the consumer lives are not considered to be provided in the consumer's home.

(2) Services shall not include vocational or prevocational services and shall not involve paid work.

(3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(4) Services shall not be provided simultaneously with other Medicaid-funded services.

78.41(15) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a consumer in the HCBS mental retardation waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph (1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the consumer's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS mental retardation waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services with the exception of the independent support broker and the financial management service. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer

has the right to direct and control the performance of the services. The consumer may perform the following functions:

(1) Recruit employees.
(2) Select employees from a worker registry.
(3) Verify employee qualifications.
(4) Specify additional employee qualifications.
(5) Determine employee duties.
(6) Determine employee wages and benefits.
(7) Schedule employees.
(8) Train and supervise employees.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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

441—78.42(249A) Rehabilitative treatment services. Rescinded IAB 8/1/07, effective 9/5/07.

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to consumers eligible for the HCBS brain injury services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan. The services, amount and supports provided under the HCBS brain injury waiver shall be delivered in the least restrictive environment and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid.

All services shall be billed in whole units.

78.43(1) *Case management services.* Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are at the ICF/MR level of care whose county has voluntarily chosen to participate in the HCBS brain injury waiver are eligible for targeted case management and, therefore, are not eligible for case management as a waiver service.

78.43(2) *Supported community living services.* Supported community living services are provided by the provider within the consumer's home and community, according to the individualized consumer need as identified in the individual comprehensive plan (ICP) or department case plan. Intermittent service shall be provided as defined in rule 441—83.81(249A).

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are those activities which assist a consumer to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the individual's rights and interests in order to realize the rights to which the individual is entitled and to remove barriers to meeting the individual's needs.

(3) Community skills training services are those activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are those activities which assist a consumer to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a person to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

(5) Transportation services are those activities and expenditures designed to assist the consumer to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work or day programs.

(6) Treatment services are those activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.

Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the consumer and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to consumers living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified time periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to consumers for whom a daily rate is not established.

(3) Intermittent service shall be provided as defined in rule 441—83.81(249A).

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of three consumers may reside in a living unit, except when the provider meets the requirements set forth in 441—paragraph 77.39(13)*"e."*

(1) Consumers may live in the home of their family or legal representative or in other types of typical community living arrangements.

(2) Consumers of services living with families or legal representatives are not subject to the maximum of three consumers in a living unit.

(3) Consumers may not live in licensed medical or health care facilities or in settings required to be licensed as medical or health care facilities.

(4) Consumers aged 17 or under living in the home of their family, legal representative, or foster families shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age appropriateness and individual attention span.

d. Rescinded IAB 2/5/03, effective 2/1/03.

e. Provider budgets shall reflect all staff-to-consumer ratios and shall reflect costs associated with consumers' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per consumer per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 19 or more hours during a 24-hour calendar day and the consumer's individual comprehensive plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

f. The maximum numbers of units available per consumer are as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 8,395 hourly units are available per state fiscal year except a leap year, when 8,418 hourly units are available.

g. The service shall be identified in the consumer's individual comprehensive plan.

h. Services shall not be simultaneously reimbursed with other residential services, HCBS brain injury waiver respite, transportation or personal assistance services, Medicaid nursing, or Medicaid home health aide services.

78.43(3) *Respite services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

e. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS brain injury waiver supported community living services, Medicaid nursing, or Medicaid home health aide services.

f. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.81(249A).

g. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

h. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.43(4) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs *"a"* and *"b"* that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in rule 441—83.87(249A) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet the consumer's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.
2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.
3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in rule 441—83.87(249A). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the consumer for a minimum of 30 days or with assisting the consumer in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the consumer's

employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the consumer.
2. Assistance with applying for a job, including completion of applications or interviews.
3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Consumer-directed attendant care services as defined in subrule 78.43(13).
6. Assistance with time management.
7. Assistance with appropriate grooming.
8. Employment-related supportive contacts.
9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
10. On-site vocational assessment after employment.
11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

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

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.

(6) All services shall be identified in the consumer's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;

3. Tuition for education or vocational training; or

4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.43(5) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle

modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The service worker shall encumber up to $505 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response system.* The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

d. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

e. The service shall be identified in the consumer's individual and comprehensive plan.

f. A unit is a one-time installation fee or one month of service.

g. Maximum units per state fiscal year are the initial installation and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service.

78.43(8) *Specialized medical equipment.* Specialized medical equipment shall include medically necessary items for personal use by consumers with a brain injury which provide for health and safety of the consumer which are not ordinarily covered by Medicaid, and are not funded by educational or vocational rehabilitation programs, and are not provided by voluntary means. This includes, but is not limited to: electronic aids and organizers, medicine dispensing devices, communication devices, bath aids, and noncovered environmental control units. This includes repair and maintenance of items purchased through the waiver in addition to the initial purchase cost.

a. Consumers may receive specialized medical equipment once per month until a maximum yearly usage of $6,060 has been reached.

b. The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and identified in the consumer's individual comprehensive plan.

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a full day (4 to 8 hours) or a half day (1 to 4 hours) or an extended day (8 to 12 hours). Components of the service are set forth in rule 441—171.6(234).

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are services aimed at preparing a consumer eligible for the HCBS brain injury waiver for paid or unpaid employment, but which are not job task oriented. These services include teaching the consumer concepts necessary as job readiness skills, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

Prevocational services do not include services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) which are otherwise available to the individual through a state or local education agency or vocational rehabilitation services which are otherwise available to the individual through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

a. A complete assessment of both appropriate and maladaptive behaviors.

b. Development of a structured behavioral intervention plan which should be identified in the ITP.

c. Implementation of the behavioral intervention plan.

d. Ongoing training and supervision to caregivers and behavioral aides.

e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding of performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker or case manager prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

78.43(15) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a consumer in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Specialized medical equipment.
7. Supported community living.

8. Supported employment.

9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph (1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the consumer's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS brain injury waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services with the exception of the independent support broker and the financial management service. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The consumer may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

441—78.45(249A) Teleconsultive services. Rescinded IAB 9/6/00, effective 11/1/00.

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to consumers eligible for the HCBS physical disability waiver established in 441—Chapter 83 when identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving

the goals written specifically in the service plan and those delineated in Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. The service shall be delivered in the least restrictive environment consistent with the consumer's needs and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid or from any other funding source.

All services shall be billed in whole units as specified in the following subrules.

78.46(1) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities listed below performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able. The services must be cost-effective and necessary to prevent institutionalization.

Providers must demonstrate proficiency in delivery of the services in the consumer's plan of care. Proficiency must be demonstrated through documentation of prior training or experience or a certificate of formal training. All training or experience will be detailed on Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, which must be reviewed and approved by the service worker for appropriateness of training or experience prior to the provision of services. Form 470-3372 becomes an attachment to and part of the case plan. Consumers shall give direction and training for activities which are not medical in nature to maintain independence. Licensed registered nurses and therapists must provide on-the-job training and supervision to the provider for skilled activities listed below and described on Form 470-3372. The training and experience must be sufficient to protect the health, welfare and safety of the consumer.

a. Nonskilled service activities covered are:

(1) Help with dressing.

(2) Help with bath, shampoo, hygiene, and grooming.

(3) Help with access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance which includes emptying the catheter bag, collecting a specimen and cleaning the external area around the catheter. Certification of training which includes demonstration of competence for catheter assistance is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding assistance but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Help with medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. Certification of training in a medication aide course is available through the area community colleges.

(8) Minor wound care which does not require skilled nursing care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistance in use of assistive devices for communication.

(12) Assisting and accompanying a consumer in using transportation essential to the health and welfare of the consumer, but not the cost of the transportation.

b. Skilled service activities covered are the following performed under the supervision of a licensed nurse or licensed therapist working under the direction of a licensed physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall not be included in the reimbursement for consumer-directed attendant care services.

(1) Tube feedings of consumers unable to eat solid foods.

(2) Assistance with intravenous therapy which is administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions such as brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nurse-delegated activities under the supervision of the registered nurse.

(11) Monitoring medication reactions requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood altering or psychotropic drugs or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour for up to 7 hours per day or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.46(2) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for

the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The service worker shall encumber up to $505 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response system.* The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The service shall

be identified in the consumer's service plan. A unit is a one-time installation fee or one month of service. Maximum units per state fiscal year are the initial installation and 12 months of service. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days a week.

d. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each consumer.

78.46(4) *Specialized medical equipment.* Specialized medical equipment shall include medically necessary items for personal use by consumers with a physical disability which provide for the health and safety of the consumer that are not covered by Medicaid, are not funded by vocational rehabilitation programs, and are not provided by voluntary means. This includes, but is not limited to: electronic aids and organizers, medicine-dispensing devices, communication devices, bath aids and noncovered environmental control units. This includes repair and maintenance of items purchased through the waiver in addition to the initial costs.

a. Consumers may receive specialized medical equipment once a month until a maximum yearly usage of $6,060 has been reached.

b. The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and shall be identified in the consumer's service plan.

78.46(5) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through Medicaid as medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging.

78.46(6) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a consumer in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph (1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the consumer's service plan when calculating the value of that service to be included in the individual budget.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no

lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS physical disability waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services with the exception of the independent support broker and the financial management service. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The consumer may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) *Medicaid recipient eligibility.* Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) *Provider eligibility.* Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) *Services.* Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. Initial assessment. The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;
2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
3. Assessment for the presence of untreated illness; and
4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Rehabilitation services for adults with chronic mental illness. Rescinded IAB 8/1/07, effective 9/5/07.

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) *Covered services.* Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) *Case management services.* Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. "Case management" means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services.— However, noninstitutional case management services may be provided during the last 14 days before the child's planned discharge if the child's stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child's planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child's service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

(1) Taking the child's history;

(2) Identifying the needs of the child;

(3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;

(4) Completing documentation of the information gathered and the assessment results; and

(5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

(1) Include the child's strengths and preferences;

(2) Consider the child's physical and social environment;

(3) Specify goals of providing services to the child; and

(4) Specify actions to address the child's medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which

there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.
2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.
3. Making referrals to providers for needed services.
4. Scheduling appointments for the child.
5. Facilitating the timely delivery of services.
6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.
2. Whether the services in the plan of care are adequate to meet the needs of the child.
3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

(1) The name of the child;
(2) The dates of case management services;
(3) The agency chosen by the family to provide the case management services;
(4) The nature, content, and units of case management services received;
(5) Whether the goals specified in the care plan have been achieved;
(6) Whether the family has declined services in the care plan;
(7) Time lines for providing services and reassessment; and
(8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

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

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) *Covered services.* Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as local education agency services. Agencies that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, the administration of vaccines is a covered service.

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) *Coordination services.* Rescinded IAB 12/3/08, effective 2/1/09.

78.50(3) *Delivery of services.* Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

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

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to consumers eligible for the HCBS children's mental health waiver as established in 441—Chapter 83. All services shall be provided in accordance with the general standards in subrule 78.52(1), as well as standards provided specific to each waiver service in subrules 78.52(2) through 78.52(5).

78.52(1) *General service standards.* All children's mental health waiver services shall be provided in accordance with the following standards:

a. Services must be based on the consumer's needs as identified in the consumer's service plan developed pursuant to 441—83.127(249A).

(1) Services must be delivered in the least restrictive environment consistent with the consumer's needs.

(2) Services must include the applicable and necessary instruction, supervision, assistance and support as required by the consumer to achieve the consumer's goals.

b. Payment for services shall be made only upon departmental approval of the services. Waiver services provided before approval of the consumer's eligibility for the waiver shall not be paid.

c. Services or service components must not be duplicative.

(1) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through the Iowa Medicaid program outside of the waiver.

(2) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through natural supports or community resources.

(3) Services may not be simultaneously reimbursed for the same period as nonwaiver Medicaid services or other Medicaid waiver services.

(4) Costs for waiver services are not reimbursable while the consumer is in a medical institution.

78.52(2) *Environmental modifications and adaptive devices.*

a. Environmental modifications and adaptive devices include items installed or used within the consumer's home that address specific, documented health, mental health, or safety concerns.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the consumer's case file a signed statement from a mental health professional on the consumer's interdisciplinary team that the service has a direct relationship to the consumer's diagnosis of serious emotional disturbance.

78.52(3) *Family and community support services.* Family and community support services shall support the consumer and the consumer's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the consumer's and the family's social and emotional strength.

a. Dependent on the needs of the consumer and the consumer's family members individually or collectively, family and community support services may be provided to the consumer, to the consumer's family members, or to the consumer and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the consumer's interdisciplinary team pursuant to 441—83.127(249A).

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

(1) Developing and maintaining a crisis support network for the consumer and for the consumer's family.

(2) Modeling and coaching effective coping strategies for the consumer's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the consumer and the family.

(4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.

(5) Modeling and coaching the strategies and interventions identified in the consumer's crisis intervention plan as defined in 441—24.1(225C) for life situations with the consumer's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the consumer's positive self-image.

(8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed $1500 per consumer per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must identify the transportation or therapeutic resource as a support need.

(2) The annual amount available for transportation and therapeutic resources must be listed in the consumer's service plan.

(3) The consumer's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the consumer or the consumer's family or legal guardian.

(4) The consumer's Medicaid targeted case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

(6) Family and community support services providers shall maintain records to:

1. Ensure that the transportation and therapeutic resources provided to not exceed the maximum amount authorized; and

2. Support the annual reporting requirements in 441—subparagraph 79.1(15)*"a"*(1).

e. The following components are specifically excluded from family and community support services:

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

(5) Academic services.

(6) General supervision and consumer care.

f. A unit of family and community support services is one hour.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the consumer and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the consumer to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is one hour. Any period less than one hour shall be prorated.

78.52(5) *Respite care services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The "usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

a. Respite care shall not be provided to consumers during the hours in which the usual caregiver is employed, except when the consumer is attending a camp.

b. The usual caregiver cannot be absent from the home for more than 14 consecutive days during respite provision.

c. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team. The team shall determine the type of respite care to be provided according to these definitions:

(1) Basic individual respite is provided on a ratio of one staff to one consumer. The consumer does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(2) Specialized respite is provided on a ratio of one or more nursing staff to one consumer. The consumer has specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(3) Group respite is provided on a ratio of one staff to two or more consumers receiving respite. These consumers do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

d. Respite services provided for a period exceeding 24 consecutive hours to three or more consumers who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.

e. Respite services provided outside the consumer's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

f. A unit of service is one hour.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

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1 Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

3 Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

4 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

5 At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

6 Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

7 July 1, 2009, effective date of amendments to 78.27(2)*"d"* delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Payments to health care providers that are owned or operated by Iowa state or non-state government entities shall not exceed the provider's cost of providing services to Medicaid members. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

79.1(1) *Types of reimbursement.*

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Fee for service with cost settlement. Effective July 1, 2009, providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical

Report. The cost settlement represents the difference between the amount received by the provider during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:

1. The indirect administrative costs shall be limited to 20 percent of other costs.
2. Mileage shall be reimbursed at a rate no greater than the state employee rate.
3. The rates a provider may charge are subject to limits established at 79.1(2).
4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation, subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on actual, current costs of operation so as not to exceed reasonable and proper costs by more than 2.5 percent.

The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs. The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation. The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 2.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5)*"aa"* and 79.1(16)*"h."*

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

Provider category	Basis of reimbursement	Upper limit
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/08 plus 1%. Air ambulance: Fee schedule in effect 6/30/08 plus 1%.
Ambulatory surgical centers	Fee schedule. See 79.1(3)	Fee schedule in effect 6/30/08 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Audiologists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Behavioral health services	Fee schedule	Fee schedule.
Birth centers	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/08 plus 1%.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Federally qualified health centers	Retrospective cost-related See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.

Provider category	Basis of reimbursement	Upper limit
1. Adult day care	Fee schedule	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Veterans Administration contract rate or $22.12 per half-day, $44.03 per full day, or $66.03 per extended day if no Veterans Administration contract. For mental retardation waiver: County contract rate or, in the absence of a contract rate, $29.47 per half-day, $58.83 per full day, or $75.00 per extended day.
2. Emergency response system	Fee schedule	Initial one-time fee $49.53. Ongoing monthly fee $38.52.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers: Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%. For mental retardation waiver: Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
4. Homemakers	Fee schedule	Maximum of $19.81 per hour.
5. Nursing care	For elderly and mental retardation waivers: Fee schedule as determined by Medicare.	For elderly waiver: $82.92 per visit. For mental retardation waiver: Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers: Cannot exceed $82.92 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate, not to exceed $296.94 per day.

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate, not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$33.75 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$18.01 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$33.75 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	18.01 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	$13.12 per hour not to exceed daily per diem for skilled nursing facility level of care.
Nursing facility	Fee schedule	$13.12 per hour not to exceed daily per diem for nursing facility level of care.
Camps	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Adult day care	Fee schedule	$13.12 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	$13.12 per hour not to exceed daily per diem for ICF/MR level of care.
Residential care facilities for persons with mental retardation	Fee schedule	$13.12 per hour not to exceed contractual daily per diem.
Foster group care	Fee schedule	$13.12 per hour not to exceed daily per diem rate for child welfare services.
Child care facilities	Fee schedule	$13.12 per hour not to exceed contractual daily per diem.
7. Chore service	Fee schedule	$7.71 per half hour.
8. Home-delivered meals	Fee schedule	$7.71 per meal. Maximum of 14 meals per week.

Provider category	Basis of reimbursement	Upper limit
9. Home and vehicle modification	Fee schedule	For elderly waiver: $1010 lifetime maximum. For mental retardation waiver: $5050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: $6060 per year.
10. Mental health outreach providers	Fee schedule	On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	County contract rate or, in the absence of a contract rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	$8.25 per unit.
13. Assistive devices	Fee schedule	$110.05 per unit.
14. Senior companion	Fee schedule	$6.59 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by consumer and provider	$20.20 per hour not to exceed the daily rate of $116.72 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by consumer and provider	For elderly waiver only: $1,117 per calendar month. Rate must be prorated per day for a partial month, at a rate not to exceed $36.71 per day.
Individual	Fee agreed upon by consumer and provider	$13.47 per hour not to exceed the daily rate of $78.56 per day.
16. Counseling		
Individual:	Fee schedule	$10.79 per unit.
Group:	Fee schedule	$43.14 per hour.
17. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	For brain injury waiver: Retrospective cost-settled rate. For elderly waiver: Quarterly revision of reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted under the appropriations made for the medical assistance program for the fiscal year.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	$34.98 per hour, $78.88 per day not to exceed the maximum daily ICF/MR per diem.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.

Provider category	Basis of reimbursement	Upper limit
Employer development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $34.98 per hour for all activities other than personal care and services in an enclave setting. Maximum of $19.81 per hour for personal care. Maximum of $6.19 per hour for services in an enclave setting. Total not to exceed $2,883.71 per month. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule	$6060 per year.
21. Behavioral programming	Fee schedule	$10.79 per 15 minutes.
22. Family counseling and training	Fee schedule	$43.14 per hour.
23. Prevocational services	Fee schedule	For the brain injury waiver: $37.44 per day. For the mental retardation waiver: County contract rate or, in absence of a contract rate, $48.22 per day.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
Child development home or center	Fee schedule	$13.12 per hour.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	The maximum daily per diem for ICF/MR.
26. Day habilitation	Fee schedule	County contract rate or, in the absence of a contract rate, $13.21 per hour, $32.15 per half-day, or $64.29 per day.
27. Environmental modifications and adaptive devices	Fee schedule	$6060 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	$34.98 per hour.
29. In-home family therapy	Fee schedule	$93.63 per hour.
30. Financial management services	Fee schedule	$65.65 per enrolled consumer per month.
31. Independent support broker	Rate negotiated by consumer	$15.15 per hour.

Provider category	Basis of reimbursement	Upper limit
32. Self-directed personal care	Rate negotiated by consumer	Determined by consumer's individual budget.
33. Self-directed community supports and employment	Rate negotiated by consumer	Determined by consumer's individual budget.
34. Individual-directed goods and services	Rate negotiated by consumer	Determined by consumer's individual budget.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/08 plus 1%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	$46.70 per hour or $105.97 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	$13.21 per hour, $32.15 per half-day, or $64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	$9.91 per hour, $24.11 per half-day, or $48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of $34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	$6.19 per hour for services in an enclave setting; $19.81 per hour for personal care; and $34.98 per hour for all other services. Total not to exceed $2,883.71 per month. Maximum of 40 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost settlement	Medicaid rate in effect 6/30/08 plus 1%.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)*"d"*)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.

Provider category	Basis of reimbursement	Upper limit
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/08 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)*"c"*	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 7/01/08.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate.
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/08 plus 1%.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"1" and (2)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"2" and (2)"2" is 96% of the patient-day-weighted median.	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	Medicare fee schedule.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/08 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/08 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Physical therapists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 6/30/08 plus 1%.
Anesthesia services	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.

Provider category	Basis of reimbursement	Upper limit
Podiatrists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Prescribed drugs	See 79.1(8)	$4.57 dispensing fee. (See 79.1(8)*"a," "b,"* and *"e."*)
Psychiatric medical institutions for children		
1. Inpatient	Prospective reimbursement	Rate based on actual costs on 6/30/07, not to exceed a maximum of $167.19 per day.
2. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Psychologists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule; refer to 79.1(21).
Remedial services	Retrospective cost-related plus 1%. See 79.1(23)	110% of average cost.
Rural health clinics	Retrospective cost-related See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
Screening centers	Fee schedule	Reimbursement rate for center in effect 6/30/08 plus 1%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.

79.1(3) *Ambulatory surgical centers.*

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," for rates effective October 1, 2005, shall mean the hospital's cost report with fiscal year end on or after January 1, 2004, and before January 1, 2005, except as noted in 79.1(5)*"x."* Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base amount" shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Blended capital costs" shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" shall mean an add-on to the blended base amount, which shall compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children's Hospitals and Related Institutions.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5)*"f,"* so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Disproportionate share percentage" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5)*"y"*(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"Graduate medical education and disproportionate share fund" shall mean a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

"Indirect medical education rate" shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Inlier" shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

"Long stay outlier" shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)*"f."*

"Low-income utilization rate" shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Medicaid inpatient utilization rate" shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" shall mean a designated level II or level III neonatal unit.

"Net discharges" shall mean total discharges minus transfers and short stay outliers.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rate table listing" shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

"Rebasing" shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Recalibration" shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*"f."*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)*"r."* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)*"r."* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. Using all applicable claims for the period January 1, 2003, through December 31, 2004, and paid through March 31, 2005, the recalibration for rates effective October 1, 2005, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated from Medicaid charge data on discharge dates occurring from January 1, 2003, to December 31, 2004, and paid through March 31, 2005. Medicaid charge data

for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.
4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's 2004 fiscal year and paid through March 31, 2005, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using claims and associated DRG weights only for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $16,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by

submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)*"r,"* and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)*"r,"* which are paid per diem, as specified in paragraph 79.1(5)*"i."*

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)*"r"* and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's base-year cost report pursuant to paragraph 79.1(5)*"a."* No recognition will

be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)*"j."*

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)*"y"*(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid

client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph *"y."*

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph *"y."*

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph *"f."*

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically

necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)*"b"*(1), a neonatal intensive care unit under subparagraph 79.1(5)*"b"*(2), a psychiatric unit under paragraph 79.1(5)*"i,"* or a physical rehabilitation hospital or unit under paragraph 79.1(5)*"i"* shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if the unit's program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit's certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)*"i"* if it is excluded from the Medicare prospective payment

system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5)*"i"* if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

t. Limitations and application of limitations on payment. Diagnosis related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

Payment limits as stated in subparagraphs (1) and (2) below are applied in the aggregate during the cost settlement process at the completion of the hospital's fiscal year end. The payment limit stated in subparagraph (3) is applied to aggregate Medicaid payments at the end of the state's fiscal year.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services.

(2) Payments to a hospital that is owned or operated by state or non-state government shall not exceed the hospital's actual medical assistance program costs. The department shall perform a cost settlement annually after the desk review or audit of the hospital's cost report. The department shall determine the aggregate payments made to the hospital under the diagnosis-related group methodology and compare this amount to the hospital's actual medical assistance program costs as determined from the audit or desk review of the hospital's cost report. For purposes of this determination, payments shall include amounts received from the Medicaid program, including graduate medical education payments and outlier payments, as well as patient and third-party payments up to the Medicaid-allowed amount. If the payments exceed the hospital's actual medical assistance program costs, the amount by which payments exceed actual costs shall be requested and collected from the hospital.

(3) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.

u. Determination of payment amounts for outpatient hospitalization. Rescinded IAB 7/6/94, effective 7/1/94.

v. Reimbursement of malpractice costs. Rescinded IAB 5/30/01, effective 8/1/01.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

(1) Advertising.
(2) Promotional items.
(3) Feasibility studies.
(4) Administrative travel and entertainment.
(5) Dues, subscriptions, or membership costs.
(6) Contributions made to other organizations.
(7) Home office costs.
(8) Public relations items.

(9) Any patient convenience items.

(10) Management fees for administrative services.

(11) Luxury employee benefits (i.e., country club dues).

(12) Motor vehicles for other than patient care.

(13) Reorganization costs.

y. Graduate medical education and disproportionate share fund. Payment shall be made to all hospitals qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

(2) Allocation to fund for direct medical education. Except as reduced pursuant to subparagraph 79.1(5)*"y"*(3), the total amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services for July 1, 2008, through June 30, 2009, is $8,642,112.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from July 1, 2005, through June 30, 2006, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year.

If a hospital fails to qualify for direct medical education payments from the fund because it does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(4) Qualifying for indirect medical education. Hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size.

(5) Allocation to fund for indirect medical education. Except as reduced pursuant to subparagraph 79.1(5)*"y"*(6), the total amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services for July 1, 2008, through June 30, 2009, is $15,174,101.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from July 1, 2005, through June 30, 2006, for each hospital reporting direct medical education costs that qualify for payment as medical

education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year.

If a hospital fails to qualify for indirect medical education payments from the fund because it does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10).

For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

Information contained in the hospital's available 2004 submitted Medicare cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments for July 1, 2008, through June 30, 2009, is $7,253,641.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid July 1, 2005, through June 30, 2006, for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year. In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the fund and supplemental disproportionate share payments pursuant to paragraph 79.1(5)*"ab"* cannot exceed the amount of the federal cap under Public Law 102-234. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age, is a voting member of the National Association of Children's Hospitals and Related Institutions, and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audits and rate-setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Adjustments to the graduate medical education and disproportionate share fund for changes in utilization. Rescinded IAB 10/31/01, effective 1/1/02.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)*"a"* to *"z"* are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)*"a"* to *"z."* Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)*"k."*

ab. Enhanced disproportionate-share payments. In addition to payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5)*"y,"* payment shall be made to all Iowa hospitals qualifying for enhanced disproportionate-share payments. Interim payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph. Final payments under this paragraph will be determined as follows:

(1) Qualifying criteria for enhanced disproportionate-share payments. A hospital qualifies for enhanced disproportionate-share payments if it qualifies for payments for disproportionate share from the graduate medical education and disproportionate-share fund pursuant to paragraph 79.1(5)*"y"* and meets one of the following conditions:

1. Is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

2. Is a non-state government-owned acute-care teaching hospital located in a county with a population over 350,000.

3. Is an Iowa state-owned hospital for persons with mental illness.

(2) Amount of payment. The total amount of disproportionate-share payments from the graduate medical education and disproportionate share fund and enhanced disproportionate share shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of disproportionate-share payments from the graduate medical education and disproportionate share fund and enhanced disproportionate-share payments shall not exceed the hospital-specific disproportionate-share caps under Public Law 103-666.

The amount available for enhanced disproportionate-share payments shall be the federal allotment less disproportionate-share payments from the graduate medical education and disproportionate share fund. In the event that the disproportionate-share allotment for enhanced payments is insufficient to pay 100 percent of the cost that is eligible for disproportionate-share payments, the allotment shall be allocated among qualifying hospitals using their eligible cost as an allocation basis.

(3) Final disproportionate-share adjustment. The department's total year-end disproportionate-share obligation to a qualifying hospital shall be calculated following completion of the desk review or audit of the hospital's Form CMS 2552, Hospital and Hospital Health Care Complex Cost Report.

ac. Enhanced graduate medical education payments. In addition to payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5)*"y,"* payment shall be made to all Iowa hospitals qualifying for enhanced graduate medical education payments. Interim payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph. Final payments under this paragraph will be determined as follows:

(1) Qualifying for enhanced graduate medical education payments. A hospital shall qualify for enhanced graduate medical education payments if it qualifies to receive both direct and indirect medical education payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5)*"y"* and meets one of the following conditions:

1. Is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education; or

2. Is a non-state government-owned acute-care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of graduate medical education payments from the graduate medical education and disproportionate share fund and enhanced graduate medical education shall not exceed each hospital's actual medical assistance program graduate medical education costs. The amount paid to each qualifying hospital for enhanced graduate medical education payments shall be the hospital's actual medical assistance program graduate medical education costs less the graduate medical education payments from the graduate medical education and disproportionate share fund.

(3) Final graduate medical education adjustment. The department's total year-end graduate medical education obligation to a qualifying hospital shall be calculated following completion of the desk review or audit of the hospital's Form CMS 2552, Hospital and Hospital Health Care Complex Cost Report.

79.1(6) *Independent laboratories.* The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician's Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) *Physicians.*

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)*"e"* for the guidelines for immunization replacement.

b. Supplemental payments. Rescinded IAB 7/6/05, effective 7/1/05.

79.1(8) *Drugs.* The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to October 7, 2008. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. 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 lowest 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. The professional dispensing fee is $4.57 or the pharmacy's usual and customary fee, whichever is lower, except for the period from December 1, 2009, to June 30, 2010, during which the professional dispensing fee shall be $4.34.

h. For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

i. Pharmacies and providers that are enrolled in the Iowa Medicaid program shall make available drug acquisition cost information, product availability information, and other information deemed necessary by the department to assist the department in monitoring and revising reimbursement rates subject to 79.1(8)*"a"*(3) and 79.1(8)*"c"* and for the efficient operation of the pharmacy benefit.

(1) Pharmacies and providers shall produce and submit the requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

(2) Pharmacies and providers shall submit information to the department or its designee within 30 days following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy or provider.

j. Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

79.1(9) *HCBS consumer choices financial management.*

a. Monthly allocation. A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer's individual budget amount as determined under 441—paragraph 78.34(13)*"b,"*78.37(16)*"b,"*78.38(9)*"b,"*78.41(15)*"b,"*78.43(15)*"b,"* or 78.46(6)*"b."*

b. Cost settlement. The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

c. Start-up grants. A qualifying financial management service provider may be reimbursed up to $10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) *Copayment by member.* A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than $25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is $25.01 to $50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is $50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

b. The member shall pay $1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay $2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay $3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay $1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

79.1(14) *Reimbursement for hospice services.*

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.
2. Multiplying excess inpatient care days by the routine home care rate.
3. Adding together the amounts calculated in "1" and "2."
4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency; HCBS respite when provided by nonfacility providers, camps, home care agencies, or providers of residential-based supported community living; and HCBS group respite provided by home health agencies.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate-Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed $1,570 per consumer per year for supported community living services.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed $1,500 per child per year for family and community support services.

c. Prospective rates for new providers other than respite.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph *"e."*

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph *"d."*

d. Prospective rates for established providers other than respite.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph *"f."*

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph *"f."*

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective adjustment.

(3) Providers who do not reimburse revenues exceeding 2.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 2.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site

or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) *Outpatient reimbursement for hospitals.*

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or *"APC"* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or *"APC relative weight"* means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base-year cost report," for rates effective July 1, 2008, shall mean the hospital's cost report with fiscal year end on or after January 1, 2006, and before January 1, 2007. Cost reports shall be reviewed using Medicare's cost-reporting and cost reimbursement principles for those cost-reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph *"g"* and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

"Discount factor" means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

"Graduate medical education and disproportionate share fund" shall mean a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the

direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

"Healthcare common procedures coding system" or *"HCPCS"* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

"Hospital-based clinic" means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

"International classifications of diseases—fourth edition, ninth revision (ICD-9)" is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person's injury or illness.

"Modifier" means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

"Multiple significant procedure discounting" means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

"Observation services" means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

"Outpatient hospital services" means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

"Outpatient prospective payment system" or *"OPPS"* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

"Outpatient visit" shall mean those hospital-based outpatient services which are billed on a single claim form.

"Packaged service" means a service that is secondary to other services but is considered an integral part of another service.

"Pass-through" means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rebasing" shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

"Significant procedure" shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

"Status indicator" or *"SI"* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)*"c."*

(2) Except as provided in paragraph 79.1(16)*"h,"* outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. For dates of services beginning on or after July 1, 2008, the department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights shall be updated pursuant to paragraph 79.1(16)*"j."*

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)*"e."*
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital.	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid under the specific rate or methodology established by other rules (other than outpatient hospital).
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. ● May be paid when submitted on a bill type other than outpatient hospital. ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	Items, codes, and services: ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.

G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Blood and blood products Brachytherapy sources Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.

P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q	Packaged services subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC in a separate APC payment based on Medicare OPPS payment criteria. If criteria are not met, payment, including outliers, is packaged into payment for other services; therefore, no separate APC payment is made.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using all applicable claims with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital's base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007, to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n."*

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital during the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n,"* for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services for the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus $2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)*"a"* shall be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible

fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)*"j."*

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16)*"v"*(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except that APC payment amounts for out-of-state hospitals may be based on either the Iowa statewide base APC rate or the Iowa blended base APC rate for the out-of-state hospital.

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) If an out-of-state hospital qualifies for reimbursement for direct medical education under Medicare guidelines, it shall qualify for such reimbursement from the Iowa Medicaid program for services to Iowa Medicaid members.

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Hospital billing. Rescinded IAB 07/02/08, effective 07/01/08.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—78.31(4)*"d"*(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Payment for outpatient services delivered in the emergency room. Rescinded IAB 07/02/08, effective 07/01/08.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Payments to a hospital that is owned or operated by state or non-state government shall not exceed the hospital's actual medical assistance program costs.

(1) The department shall perform a cost settlement annually after the desk review or audit of the hospital's cost report.

(2) The department shall determine the aggregate payments made to the hospital under the APC methodology and shall compare this amount to the hospital's actual medical assistance program costs as determined from the audit or desk review of the hospital's cost report. For purposes of this determination, aggregate payments shall include amounts received from the Medicaid program, including graduate medical education payments and outlier payments, as well as patient and third-party payments up to the Medicaid-allowed amount.

(3) If the aggregate payments exceed the hospital's actual medical assistance program costs, the amount by which payments exceed actual costs shall be requested and collected from the hospital.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO

contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to all hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

(2) Allocation to fund for direct medical education. Except as reduced pursuant to subparagraph 79.1(16)*"v"*(3), the total amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services for July 1, 2008, through June 30, 2009, is $2,922,460.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from July 1, 2005, through June 30, 2006, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of the count of outpatient visits shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of the count of outpatient visits shall be updated by a three-year period effective for payments from the fund for July of every third year.

If a hospital fails to qualify for direct medical education payments from the fund because it does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

w. Adjustments to the graduate medical education and disproportionate share fund for changes in utilization. Rescinded IAB 10/29/03, effective 1/1/04.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification.* Payment is made for home and vehicle modifications at the amount of payment to the subcontractor provided in the contract between the supported community living provider and subcontractor. All contracts shall be awarded through competitive bidding, shall be approved by the department, and shall be justified by the consumer's service plan. Payment for completed work shall be made to the supported community living provider.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

Service	Payment amount	Number of payments
Initial assessment	$75	One per patient
New problem assessment	$40	Two per patient per 12 months
Problem follow-up assessment	$40	Four per patient per 12 months
Preventative follow-up assessment	$25	One per patient per 6 months

79.1(19) *Reimbursement for translation and interpretation services.* Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. 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 shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1). The unit of service may be a quarter-hour, a half-hour, an hour, a half-day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

(5) If a provider fails to submit a cost report that meets the requirement of this paragraph, the department shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

(6) A projected cost report shall be submitted when a new remedial services provider enters the program or an existing remedial services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the

provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) *Reimbursement for home- and community-based habilitation services.* Reimbursement for case management, job development, and employer development is based on a fee schedule developed using the methodology described in paragraph 79.1(1)*"d."* Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment is based on a retrospective cost-related rate calculated using the methodology in this subrule. All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) Effective July 1, 2009, a unit of case management is 15 minutes.

(2) A unit of home-based habilitation is one hour. EXCEPTIONS:

1. A unit of service is one day when a member receives direct supervision for 14 or more hours per day, averaged over a calendar month. The member's comprehensive service plan must identify and reflect the need for this amount of supervision. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

2. When cost-effective, a daily rate may be developed for members needing fewer than 14 hours of direct supervision per day. The provider must obtain approval from the Iowa Medicaid enterprise for a daily rate for fewer than 14 hours of service per day.

(3) A unit of day habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(4) A unit of prevocational habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(5) A unit of supported employment habilitation for activities to obtain a job is:

1. One job placement for job development and employer development.

2. One hour for enhanced job search.

(6) A unit of supported employment habilitation supports to maintain employment is one hour.

b. Submission of cost reports. The department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed $1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report that meets the requirement of paragraph 79.1(24)*"b,"* the department shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. Reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(25) *Reimbursement for community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).*

a. Reimbursement methodology. Effective for services rendered on or after October 1, 2006, community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles. Rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report.

(1) Until a provider that was enrolled int he Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

b. Reporting requirements. All providers shall submit cost reports using Form 470-4419, Financial and Statistical Report. A hospital-based provider shall also submit the Medicare cost report, CMS Form 2552-96.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

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

[**ARC 7835B**, IAB 6/3/09, effective 7/8/09; **ARC 7937B**, IAB 7/1/09, effective 7/1/09; **ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **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]

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 surveillance and utilization review services unit requests providers to submit records for review. (See paragraph 79.4(2)*"b."*)

(1) Physician (MD and DO) services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(2) Pharmacy services:
1. Prescriptions.
2. Nursing facility physician order.
3. Telephone order.
4. Pharmacy notes.
5. Prior authorization documentation.

(3) Dentist services:

1. Treatment notes.
2. Anesthesia notes and records.
3. Prescriptions.

(4) Podiatrist services:

1. Service or office notes or narratives.
2. Certifying physician statement.
3. Prescription or order form.

(5) Certified registered nurse anesthetist services:

1. Service notes or narratives.
2. Preanesthesia physical examination report.
3. Operative report.
4. Anesthesia record.
5. Prescriptions.

(6) Other advanced registered nurse practitioner services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(7) Optometrist and optician services:

1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
3. Prior authorization documentation.

(8) Psychologist services:

1. Service or office psychotherapy notes or narratives.
2. Psychological examination report and notes.

(9) Clinic services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Prescriptions.
5. Medication administration records.

(10) Services provided by rural health clinics or federally qualified health centers:

1. Service or office notes or narratives.
2. Form 470-2942, Prenatal Risk Assessment.
3. Procedure, laboratory, or test orders and results.
4. Immunization records.

(11) Services provided by community mental health centers:

1. Service referral documentation.
2. Initial evaluation.
3. Individual treatment plan.
4. Service or office notes or narratives.
5. Narratives related to the peer review process and peer review activities related to a member's treatment.
6. Written plan for accessing emergency services.

(12) Screening center services:

1. Service or office notes or narratives.
2. Immunization records.
3. Laboratory reports.
4. Results of health, vision, or hearing screenings.

(13) Family planning services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Immunization records.

5. Consent forms.
6. Prescriptions.
7. Medication administration records.

(14) Maternal health center services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Form 470-2942, Prenatal Risk Assessment.

(15) Birthing center services:

1. Service or office notes or narratives.
2. Form 470-2942, Prenatal Risk Assessment.

(16) Ambulatory surgical center services:

1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
2. Physician orders.
3. Consent forms.
4. Anesthesia records.
5. Pathology reports.
6. Laboratory and X-ray reports.

(17) Hospital services:

1. Physician orders.
2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
3. Progress or status notes.
4. Diagnostic procedures, including laboratory and X-ray reports.
5. Pathology reports.
6. Anesthesia records.
7. Medication administration records.

(18) State mental hospital services:

1. Service referral documentation.
2. Resident assessment and initial evaluation.
3. Individual comprehensive treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.

(19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:

1. Physician orders.
2. Progress or status notes.
3. Service notes or narratives.
4. Procedure, laboratory, or test orders and results.
5. Nurses' notes.
6. Physical therapy, occupational therapy, and speech therapy notes.
7. Medication administration records.
8. Form 470-0042, Case Activity Report.

(20) Services provided by intermediate care facilities for persons with mental retardation:

1. Physician orders.
2. Progress or status notes.
3. Preliminary evaluation.
4. Comprehensive functional assessment.
5. Individual program plan.
6. Form 470-0374, Resident Care Agreement.
7. Program documentation.

8. Medication administration records.
9. Nurses' notes.
10. Form 470-0042, Case Activity Report.

(21) Services provided by psychiatric medical institutions for children:
1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.

(22) Hospice services:
1. Physician certifications for hospice care.
2. Form 470-2618, Election of Medicaid Hospice Benefit.
3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
4. Plan of care.
5. Physician orders.
6. Progress or status notes.
7. Service notes or narratives.
8. Medication administration records.
9. Prescriptions.

(23) Services provided by rehabilitation agencies:
1. Physician orders.
2. Initial certification, recertifications, and treatment plans.
3. Narratives from treatment sessions.
4. Treatment and daily progress or status notes and forms.

(24) Home- and community-based habilitation services:
1. Notice of decision for service authorization.
2. Service plan (initial and subsequent).
3. Service notes or narratives.

(25) Remedial services and rehabilitation services for adults with a chronic mental illness:
1. Order for services.
2. Comprehensive treatment or service plan (initial and subsequent).
3. Service notes or narratives.

(26) Services provided by area education agencies and local education agencies:
1. Service notes or narratives.
2. Individualized education program (IEP).
3. Individual health plan (IHP).
4. Behavioral intervention plan.

(27) Home health agency services:
1. Plan of care or plan of treatment.
2. Certifications and recertifications.
3. Service notes or narratives.
4. Physician orders or medical orders.

(28) Services provided by independent laboratories:
1. Laboratory reports.
2. Physician order for each laboratory test.

(29) Ambulance services:
1. Documentation on the claim or run report supporting medical necessity of the transport.
2. Documentation supporting mileage billed.

(30) Services of lead investigation agencies:
1. Service notes or narratives.
2. Child's lead level logs (including laboratory results).

3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.

4. Health education notes, including follow-up notes.

(31) Medical supplies:

1. Prescriptions.

2. Certificate of medical necessity.

3. Prior authorization documentation.

4. Medical equipment invoice or receipt.

(32) Orthopedic shoe dealer services:

1. Service notes or narratives.

2. Prescriptions.

3. Certifying physician's statement.

(33) Case management services, including HCBS case management services:

1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.

2. Notice of decision for service authorization.

3. Service notes or narratives.

4. Social history.

5. Comprehensive service plan.

6. Reassessment of member needs.

7. Incident reports in accordance with 441—subrule 24.4(5).

(34) Early access service coordinator services:

1. Individualized family service plan (IFSP).

2. Service notes or narratives.

(35) Home- and community-based waiver services, other than case management:

1. Notice of decision for service authorization.

2. Service plan.

3. Service logs, notes, or narratives.

4. Mileage and transportation logs.

5. Log of meal delivery.

6. Invoices or receipts.

7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.

(36) Physical therapist services:

1. Physician order for physical therapy.

2. Initial physical therapy certification, recertifications, and treatment plans.

3. Treatment notes and forms.

4. Progress or status notes.

(37) Chiropractor services:

1. Service or office notes or narratives.

2. X-ray results.

(38) Hearing aid dealer and audiologist services:

1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).

2. Documentation of hearing aid evaluation and selection (Form 470-0828).

3. Waiver of informed consent.

4. Prior authorization documentation.

5. Service or office notes or narratives.

(39) Behavioral health services:

1. Assessment.

2. Individual treatment plan.

3. Service or office notes or narratives.

e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) *Maintenance requirement.* The provider shall maintain records as required by this rule:

a. During the time the member is receiving services from the provider.

b. For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.

c. As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

79.3(4) *Availability.* Rescinded IAB 1/30/08, effective 4/1/08.

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 8262B**, IAB 11/4/09, effective 12/9/09]

441—79.4(249A) Reviews and audits.

79.4(1) *Definitions.*

"Authorized representative," within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

"Claim" means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

"Clinical record" means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

"Confidence level" means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

"Customary and prevailing fee" means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

"Extrapolation" means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

"Fiscal record" means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

"Overpayment" means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

"Procedure code" means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

"Random sample" means a statistically valid random sample for which the probability of selection for every item in the universe is known.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

"Universe" means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records of the provider to determine whether:

(1) The department has correctly paid claims for goods or services.

(2) The provider has furnished the services to Medicaid members.

(3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise surveillance and utilization review services unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)*"d"* to document the basis for services or activities provided, in the following format:

Iowa Department of Human Services

Iowa Medicaid Enterprise Surveillance and Utilization Review Services

Documentation Checklist

Date of Request: _____

Reviewer Name & Phone Number: _____

Provider Name: _____

Provider Number: _____

Provider Type: _____

Please sign this form and return it with the information requested.

Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.

Please send copies. Do not send original records.

If you have any questions about this request or checklist, please contact the reviewer listed above.

	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[Note: number of specific documents required varies by provider type]
	Any additional documentation that demonstrates the medical necessity of the service provided or otherwise required for Medicaid payment. List additional documentation below if needed.

The person signing this form is certifying that all documentation that supports the Medicaid billed rates, units, and services is enclosed.

Signature	Title	Telephone Number

470-4479 (4/08)

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph *"b."*

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) Under exceptional circumstances, a provider may request one additional 15-calendar-day extension. The provider or the provider's designee shall submit a written request that:

1. Establishes exceptional circumstances for the delay in submitting records; and
2. Is received by the department before the expiration of the initial 15-day extension period.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

79.4(4) *Preliminary report of audit or review findings.* If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) *Disagreement with audit or review findings.* If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph *"a"* of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph *"c"* of this subrule.

c. Disagreement with sampling results. When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:

(1) Be arranged and paid for by the provider.

(2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.

(3) Be conducted by a certified public accountant if the issues relate to fiscal records.

(4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.

(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) *Finding and order for repayment.* Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) *Appeal by provider of care.* A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment.

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

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

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

441—79.7(249A) Medical assistance advisory council.

79.7(1) *Officers.* Officers shall be a chairperson and a vice-chairperson.

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) *Membership.* The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2 and 3.

79.7(3) *Expenses, staff support, and technical assistance.* Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

79.7(4) *Meetings.* The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting. Each notice shall include an agenda for the meeting.

79.7(5) *Procedures.*

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.

d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) *Duties.*

a. Executive committee. Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

(1) Recommendations on the reimbursement for medical services rendered by providers of services.

(2) Identification of unmet medical needs and maintenance needs which affect health.

(3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

(4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

(5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. Council. The medical assistance advisory council shall:

(1) Advise the professional groups and business entities represented and act as liaison between them and the department.

(2) Report at least annually to the professional groups and business entities represented.

(3) Perform other functions as may be provided by state or federal law or regulation.

(4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) *Responsibilities.*

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

(1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and

(2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members on the council and executive committee.

[**ARC 8263B**, IAB 11/4/09, effective 12/9/09]

441—79.8(249A) Requests for prior authorization. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) *Making the request.*

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

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

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

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

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may

request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.12(249A) Advance directives. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

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

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

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

441—79.14(249A) Provider enrollment.

79.14(1) Application request. A provider of medical or remedial services that wishes to enroll as an Iowa Medicaid provider shall begin the enrollment process by contacting the provider services unit at the Iowa Medicaid enterprise to request an application form.

a. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

b. An intermediate care facility for persons with mental retardation shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the Iowa Medicaid enterprise provider services unit at P.O. Box 36450, Des Moines, Iowa 50315.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

c. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

79.14(3) Notification. Providers shall be notified of the decision on their application by the Iowa Medicaid enterprise provider services unit within 30 calendar days.

79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.

79.14(5) Effective date of approval. Applications shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application forms by the Iowa Medicaid enterprise provider services unit.

79.14(6) Providers approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(7) No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.

79.14(8) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(9) Amendments to application forms shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(10) Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(11) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 60 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, and telephone number.

a. When a provider fails to provide current information within the 60-day period, the department may terminate the provider's Medicaid enrollment upon 30 days' notice. The termination may be appealed under 441—Chapter 7.

b. When the department incurs an informational tax-reporting fine because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine shall be the responsibility of the individual provider to the extent that the fine relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine may be appealed under 441—Chapter 7.

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

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least $5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) *Policy requirements.* Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1)*"a"*;

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) *Reporting requirements.*

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

(1) Mailing the information to the IME Surveillance and Utilization Review Services Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

79.15(3) *Enforcement.* Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

441—79.16(249A) Payment reductions pursuant to executive order. The following payment provisions shall apply to services rendered during the period from December 1, 2009, to June 30, 2010, notwithstanding any contrary provision in this chapter.

79.16(1) Notwithstanding any provision of subrule 79.1(2), payment for covered services rendered by the following providers shall be reduced by 5 percent from the rates in effect November 30, 2009:

a. Ambulance services.

b. Ambulatory surgical centers.

c. Advanced registered nurse practitioners, including certified nurse-midwives.

d. Audiologists and hearing aid dealers.

e. Behavioral health providers.

f. Birth centers.

g. Chiropractors.

h. Clinics.

i. Durable medical equipment, medical supply, orthopedic shoe, and prosthetic device dealers.

j. Family planning clinics.

k. Hospitals, not including services rendered by critical access hospitals or services billed under the IowaCare program, but including:

(1) Inpatient hospital care, including Medicaid-certified psychiatric and rehabilitation units.

(2) Outpatient hospital care.

(3) Indirect medical education payments.

(4) Direct medical education payments.

(5) Disproportionate-share payments (except for payments to the Iowa state-owned teaching hospital).

l. Independent laboratories and X-ray providers.

m. Independently practicing occupational therapists, physical therapists, and psychologists.

n. Lead inspection agencies.

o. Maternal health centers.

p. Optometrists and opticians.

q. Physicians, excluding services billed to the IowaCare program except for preventative examinations.

r. Podiatrists.

s. Rehabilitation agencies.

t. Screening centers.

79.16(2) Notwithstanding any provision of subrule 79.1(2), the basis of reimbursement for skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services, and home health care for maternity patients and children provided by home health agencies shall be retrospective cost-related with cost settlement based on the lesser of the following:

a. The maximum Medicare rate in effect November 30, 2009, less 5 percent,

b. The maximum Medicaid rate in effect November 30, 2009, less 5 percent, or

c. 95 percent of the reasonable and allowable Medicaid cost.

79.16(3) Notwithstanding any provision of subrule 79.1(2), the basis of reimbursement for private duty nursing and personal care for persons aged 20 or under provided by home health agencies shall be retrospective cost-related with cost settlement based on the lesser of the following:

a. The maximum Medicaid rate in effect November 30, 2009, less 5 percent, or

b. 95 percent of the reasonable and allowable Medicaid cost.

79.16(4) Notwithstanding any provision of subrule 79.1(2) or 79.1(23), the basis of reimbursement for remedial services providers shall be consistent with the methodology described in subrule 79.1(23) except that the reasonable and proper cost of operation is equal to the actual and allowable cost less 5 percent subject to the established rate maximum less 5 percent.

79.16(5) Notwithstanding any provision of subrule 79.1(2) or rule 441—81.6(249A), the patient-day-weighted medians used in rate setting for nursing facilities shall be calculated and the rates adjusted to provide a 5 percent decrease in nursing facility rates (except for state-owned facilities).

79.16(6) Notwithstanding any provision of subrule 79.1(2) or rule 441—85.25(249A), the basis of reimbursement for non-state-owned psychiatric medical institutions for children shall be consistent with the methodology described in 441—subrule 85.25(1) except that the per diem rate shall be based on the facility's cost for the service less 5 percent, not to exceed the upper limit as provided in subrule 79.1(2) less 5 percent.

79.16(7) Notwithstanding any provision of subrule 79.1(2), payment for covered services rendered by dentists shall be reduced by 2.5 percent from the rates in effect November 30, 2009.

79.16(8) Notwithstanding any provision of subrule 79.1(2) or 79.1(25), the basis of reimbursement for community mental health centers shall be retrospective and cost-related with cost settlement limited to 97.5 percent of the provider's reasonable and allowable Medicaid cost.

79.16(9) Notwithstanding any provision of subrule 79.1(2), the basis of reimbursement for targeted case management shall be fee for service with cost settlement limited to 97.5 percent of the provider's reasonable and allowable Medicaid cost.

79.16(10) Notwithstanding any provision of subrule 79.1(2), payment for covered services rendered by home- and community-based waiver service providers shall be reduced by 2.5 percent from the rates in effect November 30, 2009.

a. Rates based on a submitted financial and statistical report shall be consistent with the methodology described in subparagraph 79.1(15)*"d"*(1) except that the inflation adjustment applied to actual, historical costs and the prior period base cost shall be reduced by 2.5 percent.

b. The retrospective adjustment of prospective rates shall be made based on revenues exceeding 100 percent of adjusted actual costs. Adjusted actual costs shall not exceed the upper limits as specified in subrule 79.1(2).

This rule is intended to implement Executive Order 19 and Iowa Code chapter 249A.

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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 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 Foundation for Medical Care (IFMC)" is the peer review organization on contract with the department to provide level of care determinations. The address of IFMC is 6000 Westown Parkway, West Des Moines, Iowa 50266.

"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.

"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).

"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.

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. Initial decisions on level of care shall be made for the department by the Iowa Foundation for Medical Care (IFMC) within two working days of receipt of medical information. After notice of an adverse decision by IFMC, the Medicaid applicant or recipient, the applicant's or recipient's representative, the attending physician, or the nursing facility may request reconsideration by IFMC by sending a letter requesting a review to IFMC not more than 60 days after the date of the notice of adverse decision. On initial and reconsideration decisions, IFMC 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). Adverse decisions by IFMC on reconsiderations may be appealed to the department pursuant to 441—Chapter 7.

a. If a timely request for reconsideration of an initial denial determination is made, IFMC will complete its reconsidered determination and send written notice including appeal rights to the Medicaid applicant or recipient, the applicant's or recipient's representative, the attending physician or the facility provider within the following time limits:

(1) Within three working days after IFMC receives the request for reconsideration and a copy of the medical record, if the initial determination was made before the Medicaid applicant or recipient was admitted to the nursing facility.

(2) Within ten working days after IFMC receives the request for reconsideration and a copy of the medical record, if the Medicaid applicant or recipient was admitted to the nursing facility when the initial determination was made and is still in the nursing facility when the request for reconsideration is received.

(3) Within 30 working days after IFMC receives the request for reconsideration and a copy of the medical record, if the Medicaid applicant or recipient was admitted to the nursing facility when the initial determination was made but is no longer in the nursing facility when the request for reconsideration is received.

b. If a copy of the medical record is not submitted with the reconsideration request, IFMC shall request a copy from the facility within two working days.

c. Written notice of the IFMC reconsidered determination shall contain the following:

(1) The basis for the reconsidered determination.

(2) A detailed rationale for the reconsidered determination.

(3) A statement explaining the Medicaid payment consequences of the reconsidered determination.

(4) A statement informing the parties of their appeal rights, including the information that must be included in the request for an administrative hearing, the locations for submitting a request for an administrative hearing, and the time period for filing a request.

d. If the request for reconsideration is mailed or delivered to IFMC within ten days of the date of the initial determination, any medical assistance payments previously approved will not be terminated

until the decision on reconsideration. If the initial decision is upheld on reconsideration, medical assistance benefits continued pursuant to this subrule will be treated as an overpayment to be repaid to the department.

81.3(2) *Skilled nursing care level of need.* Rescinded IAB 7/11/01, effective 7/1/01.

81.3(3) *Screening.* All persons, regardless of the source of payment, seeking admission to a nursing facility shall also be screened by the Iowa Foundation for Medical Care to determine if mental illness, mental retardation, or a related condition is present. The Iowa Medicaid program will cover the cost of this screening through the managed mental health contractor.

Final approval for initial admissions and continued stay of persons with mental illness, mental retardation, or a related condition is determined by the department of human services, division of mental health, mental retardation and developmental disabilities.

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, mental retardation and developmental disabilities 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.

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) Aggregate payments to a nursing facility that is owned or operated by state or non-state government shall not exceed the facility's actual medical assistance program costs. Aggregate payments shall include amounts received from the Medicaid program, as well as receipts from patient and other third-party payments up to the Medicaid-allowed amount.

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. 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 90 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. Accountability measures. Additional reimbursement for non-state-owned facilities, based on accountability measures, is available beginning July 1, 2008, as provided in this paragraph. Accountability measures are nursing facility characteristics that indicate the quality of care, efficiency, or commitment to care for certain resident populations. These characteristics are objective, measurable, and, when considered in combination with each other, 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.

Additional reimbursement for accountability measures 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 amount of additional reimbursement based on accountability measures.

To qualify for additional Medicaid reimbursement for accountability measures, a facility must achieve a minimum score of 3 points. The maximum available points are 11.

The Iowa Medicaid enterprise shall award points based on the measures described in subparagraphs (1) through (10).

(1) Deficiency-free survey.

1. Standard. Facilities shall be deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations. If a nursing 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, for purposes of this measure, be deemed to have a deficiency-free survey. Surveys are considered complete when all appeal rights have been exhausted.

2. Measurement period. The measurement period shall be the latest annual survey completed on or before December 31 of each year and any subsequent surveys, complaint investigations, or revisit investigations completed between the annual survey date and December 31.

3. Value. 2 points.

4. Source. The department shall request that the department of inspections and appeals furnish by May 1 of each year a listing of nursing facilities that have met the standard.

(2) Regulatory compliance with survey.

1. Standard. Facilities shall be considered to be in regulatory compliance if no on-site revisit is required for recertification surveys or for any substantiated complaint investigations during the measurement period.

2. Measurement period. The measurement period shall include any recertification survey or complaint investigations completed on or before December 31 of each year.

3. Value. 1 point. (A nursing facility that achieves a deficiency-free survey according to subparagraph (1) cannot also receive a point value for this standard.)

4. Source. The department shall request that the department of inspections and appeals furnish by May 1 of each year a listing of nursing facilities that have met the standard.

(3) Nursing hours provided.

1. Standard. A nursing facility's per resident day nursing hours are at or above the fiftieth percentile of per resident day nursing hours. Nursing hours include those of registered nurses, licensed practical nurses, certified nursing assistants, 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. The case-mix index used to normalize nursing hours shall be the facility cost report period case-mix index.

2. Measurement period. The measurement period shall be calculated using the latest financial and statistical report with a fiscal year end of December 31 or earlier.

3. Value. 1 point for a nursing facility that falls between the fiftieth and seventy-fifth percentiles. 2 points for a nursing facility at or above the seventy-fifth percentile.

4. Source. The fiscal consultant shall calculate whether the nursing facility has met this measure from Form 470-0030, Financial and Statistical Report.

(4) Resident satisfaction.

1. Standard. A nursing facility shall be at or above the fiftieth percentile of resident satisfaction. Resident satisfaction shall be measured using Form 470-3890, Resident Opinion Survey. To be considered for this measure, a nursing facility must have a minimum survey response rate of 35 percent from its residents or their responsible parties.

2. Measurement period. For purposes of determining the July 1, 2002, rate, Form 470-3890, Resident Opinion Survey, must be completed by April 1, 2002, and Form 470-3891, Resident Opinion Survey Transmittal Report, must be submitted to the department by May 1, 2002. For purposes of determining rates for years on or after July 1, 2003, Form 470-3890, Resident Opinion Survey, may be completed anytime during the period September through December of the preceding year and the transmittal report submitted to the department by April 1 of the following year.

3. Value. 1 point.

4. Source. The nursing facility shall distribute Form 470-3890, Resident Opinion Survey, and instructions to all residents or their responsible parties. The nursing facility shall have an independent party collect and compile the results of the survey and communicate the results to the department by May 1 of 2002 and April 1 of each year thereafter on Form 470-3891, Resident Opinion Survey Transmittal Report. The department or its contractor shall calculate whether the nursing facility has met this measure.

(5) Resident advocate committee resolution rate.

1. Standard. A nursing facility shall have a resident advocate committee resolution rate of issues and grievances pursuant to 321—Chapter 9 at or above 60 percent.

2. Measurement period. For the purpose of determining the July 1, 2002, rates, the resolution rate shall be computed for the period October 1, 2001, through March 31, 2002. For the purpose of determining rates for July 1, 2003, and thereafter, the resident advocate committee resolution rate shall be computed using data from the immediately preceding calendar year.

3. Value. 1 point.

4. Source. The department shall request that the office of the long-term care ombudsman furnish by May 1 of each year a listing of nursing facilities that have met the standard.

(6) High employee retention rate.

1. Standard. A nursing facility shall have an employee retention rate at or above the fiftieth percentile.

2. Measurement period. The high employee retention rate shall be calculated using Schedule I of the latest Form 470-0030, Financial and Statistical Report, with a fiscal year end of December 31 or earlier.

3. Value. 1 point.

4. Source. The department's fiscal consultant shall calculate whether the nursing facility has met this measure from Form 470-0030, Financial and Statistical Report, Schedule I.

(7) High occupancy rate.

1. Standard. A nursing facility shall have an occupancy rate at or above 95 percent. "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.

2. Measurement period. The high occupancy rate shall be calculated using the latest Form 470-0030, Financial and Statistical Report, with a fiscal year end of December 31 or earlier.

3. Value. 1 point.

4. Source. The department's fiscal consultant shall calculate whether the nursing facility has met this measure from Form 470-0030, Financial and Statistical Report.

(8) Low administrative costs.

1. Standard. A nursing facility's percentage of administrative costs to total costs shall be at or below the fiftieth percentile.

2. Measurement period. The low administrative costs shall be calculated using the latest Form 470-0030, Financial and Statistical Report, with a fiscal year end of December 31 or earlier.

3. Value. 1 point.

4. Source. The department's fiscal consultant shall calculate whether the nursing facility has met this measure from Form 470-0030, Financial and Statistical Report.

(9) Special licensure classification.

1. Standard. Nursing facility units shall be licensed for the care of residents with chronic confusion or a dementing illness (CCDI units).

2. Measurement period. The measurement period shall be the facility's status on December 31 of each year.

3. Value. 1 point.

4. Source. The department shall request that the department of inspections and appeals furnish the department by May 1 of each year a listing of nursing facilities that were licensed as CCDI units as of December 31.

(10) High Medicaid utilization.

1. Standard. A nursing facility shall have Medicaid utilization at or above the fiftieth percentile. Medicaid utilization is determined by dividing total nursing facility Medicaid days by total nursing facility patient days.

2. Measurement period. The Medicaid utilization rate shall be calculated using the latest Form 470-0030, Financial and Statistical Report, with a fiscal year end of December 31 or earlier.

3. Value. 1 point.

4. Source. The department's fiscal consultant shall calculate whether the nursing facility has met this measure from Form 470-0030, Financial and Statistical Report.

(11) Calculation of potential reimbursement. The number of points awarded shall be determined annually on the first day of the state fiscal year and shall be used to calculate the amount of the additional reimbursement for accountability measures as follows:

0 - 2 points	No additional reimbursement
3 - 4 points	1 percent of the direct care plus non-direct care cost component patient-day-weighted medians multiplied by 80 percent, subject to reduction as provided in subparagraph (12)
5 - 6 points	2 percent of the direct care plus non-direct care cost component patient-day-weighted medians multiplied by 80 percent, subject to reduction as provided in subparagraph (12)
7 or more points	3 percent of the direct care plus non-direct care cost component patient-day-weighted medians multiplied by 80 percent, subject to reduction as provided in subparagraph (12)

(12) Reduction of additional reimbursement. The additional reimbursement for accountability measures calculated according to subparagraph (11) shall be subject to reduction as follows:

1. A facility's additional reimbursement 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.

2. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections and appeals, the additional reimbursement shall be forfeited and the facility shall not receive any accountability measure payment for the year.

3. If a facility receives a citation for a deficiency resulting in actual harm or immediate jeopardy at a scope and severity level of H or higher pursuant to the federal certification guidelines, regardless of

the amount of any fines assessed, the additional reimbursement shall be forfeited and the facility shall not receive any accountability measure payment for the year.

(13) Report of deficiencies. The department shall request that the department of inspections and appeals furnish by September 1, December 1, March 1 and August 1 of each year a list of nursing facilities subject to a reduction of the additional reimbursement for accountability measures pursuant to the criteria in subparagraph (12).

(14) Application of additional payments. The additional reimbursement for accountability measures 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 to the first day of the state fiscal year to include the amount of additional reimbursement for accountability measures calculated according to 81.6(16)*"g"*; and

2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for accountability measures is effective to reflect the adjusted reimbursement rate.

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. 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 90 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. 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 90 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.2(7), 249A.3(2)*"c,"* 249A.4, and 249A.16, chapter 249K, and 2009 Iowa Acts, Senate File 476.

[**ARC 8258B**, IAB 11/4/09, effective 1/1/10; **ARC 8344B**, IAB 12/2/09, effective 12/1/09]

441—81.7(249A) Continued review. The Iowa Foundation for Medical Care shall review Medicaid recipients' need of continued care in nursing facilities, pursuant to the standards and subject to the reconsideration and appeals processes in subrule 81.3(1).

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)*"a."*

441—81.8(249A) Quality of care review. Rescinded IAB 8/8/90, effective 10/1/90.

441—81.9(249A) Records.

81.9(1) *Content.* The facility shall as a minimum maintain the following records:

a. All records required by the department of public health and the department of inspections and appeals.

b. Records of all treatments, drugs, and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

c. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.

d. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

e. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

f. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for all residents of the facility.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.

g. Resident accounts.

h. In-service education program records.

i. Inspection reports pertaining to conformity with federal, state and local laws.

j. Residents' personal records.

k. Residents' medical records.

l. Disaster preparedness reports.

81.9(2) *Retention.* Records identified in subrule 81.9(1) shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

81.9(3) *Change of owner.* All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)*"a."*

441—81.10(249A) Payment procedures.

81.10(1) *Method of payment.* Except for Medicaid accountability measures payment established in paragraph 81.6(16)*"g,"* facilities shall be reimbursed under a modified price-based vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—81.6(249A). Effective July 1, 2002, the per diem rate shall include an amount for Medicaid accountability measures.

81.10(2) *Authorization of payment.* The department shall authorize payment for care in a facility. The authorization shall be obtained prior to admission of the resident, whenever possible. For a nursing facility to be eligible for Medicaid payment for a resident, the facility must, when applicable, exhaust all Medicare benefits.

81.10(3) Rescinded IAB 8/9/89, effective 10/1/89.

81.10(4) *Periods authorized for payment.*

a. Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in a nursing facility.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent overnight for purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 18 days in any calendar year. Additional days shall be based upon a recommendation by the resident's physician in the plan of care that additional days would be rehabilitative.

e. Payment will be approved for a period not to exceed 10 days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for a visit shall be made at 42 percent of the nursing facility's rate. Payment for periods when residents are absent for hospitalization shall:

(1) Be made at 25 percent of the nursing facility's rate if the facility occupancy percentage is 95 percent or greater.

(2) Not be made if a facility's occupancy percentage is less than 95 percent.

(3) Be made at 42 percent of the nursing facility's rate for special population facilities.

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 transportation to receive necessary medical services outside the facility. 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.

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 outside the community subject to limitations specified in rule 441—78.13(249A).

(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 spends over 18 days per year on visits (or longer under 81.10(4)*"d"*) or spends over 10 days per calendar month on a hospital stay. These supplementation payments shall not exceed the amount the department would pay to hold the bed under paragraph 81.10(4)*"f."*

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.

[**ARC 8344B**, IAB 12/2/09, effective 12/1/09]

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.

(1) A nursing facility shall not admit a new resident with mental illness or mental retardation unless the division of mental health, mental retardation, and developmental disabilities has approved the admission, based on an independent physical and mental health evaluation. This evaluation shall be reviewed by the Iowa Foundation for Medical Care prior to admission to determine whether the individual requires the level of services provided by the facility because of the physical and mental condition of the individual. If the individual requires nursing facility level of services, the individual shall receive specialized services for mental illness or mental retardation.

(2) Definition. For purposes of this rule:

1. An individual is considered to have "mental illness" if the individual has a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

2. An individual is considered to be "mentally retarded" if the individual is mentally retarded or a person with a related condition as described in 42 CFR 435.1009.

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 rehabilitative services.*

a. Provision of services. If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, 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. Qualifications. Specialized rehabilitative services shall be provided under the written order of a physician by qualified personnel.

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.

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) Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at 75 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.

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.

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.*

a. 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, such as:

(1) Payment for the cost of relocating residents to other facilities;

(2) State costs related to the operation of a facility pending correction of deficiencies or closure; and

(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.

b. Reserved.

441—81.53(249A) Civil money penalties—settlement of penalties. The department of inspections and appeals has the authority to settle cases at any time prior to the evidentiary hearing decision.

441—81.54(249A) Continuation of payments to a facility with deficiencies.

81.54(1) *Criteria.*

a. The department may continue payments to a facility that is not in substantial compliance for the periods specified in subrule 81.54(3) if the following criteria are met:

(1) The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility;

(2) The department of inspections and appeals has submitted a plan and timetable for corrective action approved by CMS; and

(3) The facility agrees to repay the department for all payments received under this provision if corrective action is not taken in accordance with the approved plan and timetable for corrective action and posts a bond acceptable to the department to guarantee agreement to repay.

b. The facility provider agreement may be terminated before the end of the correction period if the criteria in 81.54(1)*"a"* are not met.

81.54(2) *Cessation of payments.* If termination is not sought, either by itself or along with another remedy or remedies, or any of the criteria in 81.54(1)*"a"* are not met or agreed to by either the facility or the department, the facility shall receive no payments, as applicable, from the last day of the survey.

81.54(3) *Period of continued payments.* If the conditions in 81.54(1)*"a"* are met, the department may continue payments to a facility with noncompliance that does not constitute immediate jeopardy for up to six months from the last day of the survey.

81.54(4) *Failure to achieve substantial compliance.* If the facility does not achieve substantial compliance by the end of the period specified in subrule 81.54(3), the provider agreement for the facility may be terminated.

441—81.55(249A) State and federal disagreements involving findings not in agreement when there is no immediate jeopardy. This rule applies when CMS and the department of inspections and appeals disagree over findings of noncompliance or application of remedies.

81.55(1) *Disagreement over whether facility has met requirements.*

a. The department of inspections and appeals' finding of noncompliance takes precedence when:

(1) CMS finds the facility is in substantial compliance with the participation requirements; and

(2) The department of inspections and appeals finds the facility has not achieved substantial compliance.

b. CMS's findings of noncompliance take precedence when:

(1) CMS finds that a facility has not achieved substantial compliance; and

(2) The department of inspections and appeals finds the facility is in substantial compliance with the participation requirements.

c. When CMS's survey findings take precedence, CMS may:

(1) Impose any of the alternative remedies specified in rule 441—81.34(249A);

(2) Terminate the provider agreement subject to the applicable conditions of rule 441—81.54(249A); and

(3) Stop federal financial participation to the department for a nursing facility.

81.55(2) *Disagreement over decision to terminate.*

a. CMS's decision to terminate the participation of a facility takes precedence when:

(1) Both CMS and the department of inspections and appeals find that the facility has not achieved substantial compliance; and

(2) CMS, but not the department of inspections and appeals, finds that the facility's participation should be terminated. CMS will permit continuation of payment during the period prior to the effective date of termination, not to exceed six months, if the applicable conditions of rule 441—81.54(249A) are met.

b. The department of inspections and appeals' decision to terminate a facility's participation and the procedures for appealing the termination take precedence when:

(1) The department of inspections and appeals, but not CMS, finds that a facility's participation should be terminated; and

(2) The department of inspections and appeals' effective date for the termination of the nursing facility's provider agreement is no later than six months after the last day of survey.

81.55(3) *Disagreement over timing of termination of facility.* The department of inspections and appeals' timing of termination takes precedence if it does not occur later than six months after the last day of the survey when both CMS and the department of inspections and appeals find that:

a. A facility is not in substantial compliance; and

b. The facility's participation should be terminated.

81.55(4) *Disagreement over remedies.*

a. When CMS or the department of inspections and appeals, but not both, establishes one or more remedies, in addition to or as an alternative to termination, the additional or alternative remedies will also apply when:

(1) Both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance; and

(2) Both CMS and the department of inspections and appeals find that no immediate jeopardy exists.

b. When CMS and the department of inspections and appeals establish one or more remedies, in addition to or as an alternative to termination, only the CMS remedies apply when both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance.

81.55(5) *One decision.* Regardless of whether CMS's or the department of inspections and appeals' decision controls, only one noncompliance and enforcement decision is applied to the Medicaid agreement, and for a dually participating facility, that same decision will apply to the Medicare agreement.

441—81.56(249A) Duration of remedies.

81.56(1) *Remedies continue.* Except as specified in subrule 81.56(2), alternative remedies continue until:

a. The facility has achieved substantial compliance as determined by the department of inspections and appeals based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit; or

b. The provider agreement is terminated.

81.56(2) *State monitoring.* In the cases of state monitoring and denial of payment imposed for repeated substandard quality of care, remedies continue until:

a. The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance; or

b. The provider agreement is terminated.

81.56(3) *Temporary management.* In the case of temporary management, the remedy continues until:

a. The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance;

b. The provider agreement is terminated; or

c. The facility which has not achieved substantial compliance reassumes management control. In this case, the department of inspections and appeals initiates termination of the provider agreement and may impose additional remedies.

81.56(4) *Facility in compliance.* If the facility can supply documentation acceptable to the department of inspections and appeals that it was in substantial compliance, and was capable of remaining in substantial compliance, if necessary, on a date preceding that of the revisit, the remedies terminate on the date that the department of inspections and appeals can verify as the date that substantial compliance was achieved.

441—81.57(249A) Termination of provider agreement.

81.57(1) *Effect of termination.* Termination of the provider agreement ends payment to the facility and any alternative remedy.

81.57(2) *Basis of termination.*

a. A facility's provider agreement may be terminated if a facility:

(1) Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present; or

(2) Fails to submit an acceptable plan of correction within the time frame specified by the department of inspections and appeals.

b. A facility's provider agreement shall be terminated if a facility:

(1) Fails to relinquish control to the temporary manager, if that remedy is imposed by the department of inspections and appeals; or

(2) Does not meet the eligibility criteria for continuation of payment as set forth in 81.37(1)*"a."*

81.57(3) *Notice of termination.* Before a provider agreement is terminated, the department of inspections and appeals shall notify the facility and the public:

a. At least two calendar days before the effective date of termination for a facility with immediate jeopardy deficiencies; and

b. At least 15 calendar days before the effective date of termination for a facility with nonimmediate jeopardy deficiencies that constitute noncompliance.

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

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[1] Effective date of 81.16(4) delayed 30 days by the Administrative Rules Review Committee at its September 12, 1990, meeting; at the October 9, 1990, meeting the delay was extended to 70 days. Amendment effective 12/1/90 superseded the 70-day delay.

[2] Effective date of 81.10(5) delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its November 13, 1990, meeting.

[3] Effective date of 81.13(7)*"c"*(1) delayed 70 days by the Administrative Rules Review Committee at its meeting held July 14, 1992; delay lifted by the Committee at its meeting held August 11, 1992, effective August 12, 1992.

[4] Effective date of 81.6(3), first unnumbered paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held April 5, 1993.

[5] At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

OBJECTION

At its meeting held August 11, 1992, the Administrative Rules Review Committee voted to object to the amendments published in **ARC 3069A** on the grounds the amendments are unreasonable. This filing is published in IAB Vol. XIV No. 253 (06-10-92). It is codified as an amendment to paragraph 441 IAC 81.13(7)*"c"*(1).

In brief, this filing provides that care facilities shall not employ persons who have been found guilty in a court of law of abusing, neglecting or mistreating facility residents, or who have had a "finding" entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. Additionally, the filing eliminates a previous provision which allowed the Department of Inspections and Appeals some discretion in deciding whether the lifetime ban on employment should be applied.

This language originated in the federal government which mandated that the department adopt these provisions or possibly face sanctions. The Committee does not believe these amendments are an improvement to Iowa's system and has the following objection. The Committee believes that the amendments published in **ARC 3069A** are unreasonable because of the inconsistency in the burdens of proof and the levels of procedural safeguards in the two proceedings. A facility employee may either be found guilty in a court of law or have an administrative finding entered into the registry. In either case the result is the same, the employee is permanently banned from further employment in a care facility; however, the two paths to the result are significantly different. The first proceeding is a criminal tribunal in which the burden of proof is "beyond a reasonable doubt." The second proceeding is a simple administrative hearing in which the burden is "preponderance of the evidence." The two proceedings also differ in the level of many other due process protections accorded to the individual. A criminal proceeding provides the accused with the opportunity for a trial by jury, competent legal counsel, strict rules of evidence and many procedural protections not present in administrative hearings. It should also be noted that the penalty in this situation—a lifetime ban on employment—is more serious than is usually imposed in contested cases. In licensee discipline cases, a license can be revoked, but the possibility of reinstatement exists; under this new rule no reinstatement is allowed, the facility employee is banned from employment no matter how serious or minor the offense or how far in the past it occurred. Because of the magnitude of this penalty, the Committee believes that the accused should be provided with greater procedural protections than are generally found in administrative hearings.

The Committee also believes this filing is unreasonable because it eliminates the discretion accorded to the Department of Inspections and Appeals to not apply the lifetime ban on employment. Under the previous rule, the department's discretion in applying the employment ban acted as a safeguard against unjust results. It recognized that a person would make amends for past offenses and earn a second chance. The provision was a genuine improvement in the process; it recognized that flexibility was needed in government decision making and that some decisions should be made on a case-by-case basis. There does not appear to be any rational basis to justify the elimination of this safeguard and, therefore, the Committee believes this action to be unreasonable.

NOTE: The Committee voted to retain this objection at their meeting held February 8, 1993.

TITLE IX
WORK INCENTIVE DEMONSTRATION

CHAPTER 93
PROMISE JOBS PROGRAM

[Prior to 7/1/89, see 441—Chapters 55, 59 and 90]

PREAMBLE

This chapter implements the promoting independence and self-sufficiency through employment, job opportunities, and basic skills (PROMISE JOBS) program. The PROMISE JOBS program is designed to assist family investment program (FIP) recipients to become self-sufficient. Unless exempt, each FIP applicant must develop a family investment agreement (FIA) that outlines steps the applicant will take to leave public assistance and must cooperate with the terms of the agreement as a condition for receiving FIP as directed in Iowa Code chapter 239B. Rules regarding FIP eligibility requirements, including participation in the PROMISE JOBS program, are found in 441—Chapter 41.

The PROMISE JOBS program also implements the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Title I, "Block Grants for Temporary Assistance for Needy Families (TANF)," which was reauthorized on February 8, 2006, through the Deficit Reduction Act of 2005, Public Law 109-171.

441—93.1(239B) Definitions.

"Applicant" means a child for whom assistance is being requested under the family investment program, any parent living in the home with the child, and any nonparental relative as defined in 441—subrule 41.22(3) who is requesting assistance for the child.

"FaDSS" means the family development and self-sufficiency program operated under 441—Chapter 165, which provides services to families at risk of long-term welfare dependency.

"Family investment agreement" or *"FIA"* means the agreement developed with a participant in accordance with Iowa Code section 239B.8.

"FIA-responsible person" means any member of the FIP applicant family unless exempt as described at 441—subrule 41.24(2). See subrule 93.4(2) for more information.

"FIP" means the family investment program authorized in Iowa Code chapter 239B.

"Limited benefit plan" or *"LBP"* means a period of time in which a participant or member of a participant's family is either ineligible for any assistance under the family investment program or eligible for reduced assistance only in accordance with Iowa Code section 239B.9.

"Needy specified relative" means a nonparental specified relative as defined in 441—subrule 41.22(3) who meets all the eligibility requirements to be included in the family investment program.

"Participant" for purposes of the PROMISE JOBS program means a person who has signed an FIA and is approved to receive FIP benefits, a parent or relative living in the home of a child approved to receive FIP benefits, or a person reconsidering a subsequent limited benefit plan.

"PROMISE JOBS program" means the promoting independence and self-sufficiency through employment, job opportunities, and basic skills program created in Iowa Code section 239B.17.

441—93.2(239B) Program administration. The department of human services shall administer an employment and training program known as PROMISE JOBS. To the extent compatible with resources available, the department's bureau of refugee services shall provide PROMISE JOBS services to persons who entered the United States with refugee status until those persons obtain United States citizenship.

93.2(1) *Availability of service.* PROMISE JOBS services shall include, but are not limited to, those listed in paragraph 93.4(4)*"b."*

a. The program shall be available statewide. If the department of human services determines that sufficient funds are not available to offer services on location in each county, the department shall prioritize the availability of services to those counties having the largest FIP populations.

b. Because of state and federal budgetary limitations, federal mandatory work requirements, requirements for minimum participation rates, and other TANF requirements imposed on the PROMISE JOBS program, the department of human services shall have the administrative authority to:

(1) Determine agency and geographical breakdowns for service;

(2) Designate specific groups for priority services; and

(3) Designate specific PROMISE JOBS components or supportive service levels for a waiting list.

93.2(2) *Contracts with provider agencies.* The department of human services may contract with the department of workforce development, the department of economic development, or other appropriate entity to provide PROMISE JOBS services and case management of those services.

a. Reimbursement for services. The provider agency shall receive financial reimbursement as specified in contracts negotiated with each agency. Contracts shall also specify in detail the expenses that are not eligible for reimbursement.

b. Record keeping. All PROMISE JOBS agencies shall maintain PROMISE JOBS participant case files and records for at least five years, in either paper or electronic format. Records shall be maintained for longer than five years if any litigation, audit, or claim is started and not resolved during that period. In these instances, the records must be retained for five years after the litigation, audit, or claim is resolved. Case files must be disposed of in accordance with applicable federal requirements pertaining to confidentiality.

c. Confidentiality. The departments of education, workforce development, economic development, and human rights, local education agencies, and all subcontractor provider agencies shall safeguard participant information in conformance with Iowa Code section 217.30. The department of human services and the PROMISE JOBS provider agencies may disclose participant information to other state agencies or to any other entity when that agency or entity must have that information in order to provide services to PROMISE JOBS participants that have been determined to be necessary for successful participation in PROMISE JOBS.

441—93.3(239B) Registration and referral.

93.3(1) *Registration for PROMISE JOBS.* Unless the department of human services determines a person is exempt as specified in 441—subrule 41.24(2), an application for FIP assistance constitutes a registration for the PROMISE JOBS program and acceptance of the requirement to enter into an FIA for all members of the FIP case and all other persons responsible for the FIA as specified at rule 441—41.24(239B).

93.3(2) *Referral.* The department of human services shall refer all FIA-responsible persons from FIP applicant and recipient households to PROMISE JOBS pursuant to 441—subrule 41.24(1).

93.3(3) *Initial appointment.*

a. FIP applicants. FIP applicants, including those who are in a limited benefit plan, shall be offered an appointment for assessment and FIA development at the earliest available time. The appointment shall be no later than ten calendar days after the date of the notice that FIA responsibility has begun, as required by rule 441—93.4(239B) and 441—paragraphs 41.24(1)*"c,"* 41.24(1)*"d,"* and 41.24(10)*"g."*

(1) At the time of referral, applicants shall be notified verbally and hand-issued the notice of a scheduled appointment for FIA development.

(2) If the notice of appointment cannot be hand-issued, at least five working days shall be allowed from the date notice is mailed for an applicant to appear for the scheduled appointment for orientation and FIA development unless the applicant agrees to an appointment that is scheduled to take place in less than five working days.

b. Exempt status change. Persons from FIP participant households who are referred to PROMISE JOBS shall initiate PROMISE JOBS assessment and FIA development by contacting the appropriate PROMISE JOBS office to schedule an appointment within ten calendar days of the mailing date of the notice that exempt status has been lost and FIA responsibility has begun, as required by 441—subrule 41.24(5).

93.3(4) *Orientation.* Every person referred to PROMISE JOBS shall receive orientation services. PROMISE JOBS workers shall provide FIA orientation if not previously provided by the department of human services.

a. During orientation, each applicant shall receive a full explanation of:

(1) The advantages of employment under the family investment program (FIP), including information on earned income tax credits;

(2) Services available under PROMISE JOBS;

(3) Participant rights and responsibilities under the FIA and PROMISE JOBS;

(4) The limited benefit plan as described at 441—subrule 41.24(8);

(5) The benefits of cooperation with the child support recovery unit;

(6) Other programs available through the department of human services, specifically the transitional Medicaid and child care assistance programs; and

(7) The availability of family planning counseling services in the area and the financial implications of newly born children on the participant's family.

b. Each applicant shall sign Form 470-3104, Your FIA Rights and Responsibilities, acknowledging that information described in paragraph *"a"* of this subrule has been provided.

93.3(5) *Initial meeting.* The PROMISE JOBS worker shall meet with each referred person, or with the family if another parent or a child is also referred to PROMISE JOBS, to:

a. Determine participation activities,

b. Establish expenses and a schedule for supportive payments, and

c. Discuss child care needs.

93.3(6) *Workforce development registration.* Each applicant is required to complete a current workforce development registration form as described at 877—subrule 8.2(3) when requested by the PROMISE JOBS worker.

441—93.4(239B) The family investment agreement (FIA). The family investment agreement (FIA) is the condition of and basis for PROMISE JOBS services and is an eligibility requirement for the family investment program as specified in rule 441—41.24(239B).

93.4(1) *Development.* An initial FIA shall be developed during the orientation and assessment process through discussion between the FIA-responsible person and the PROMISE JOBS worker. For the FIA to be considered completed, Form 470-3095, Family Investment Agreement, and Form 470-3096, FIA Steps to Achieve Self-Sufficiency, shall be signed by all of the following:

a. The FIA-responsible person or persons.

b. Other family members who are referred to PROMISE JOBS.

c. The PROMISE JOBS worker.

d. The PROMISE JOBS supervisor.

93.4(2) *FIA-responsible persons.* All members of the FIP applicant family shall develop and sign an FIA, unless exempt as described at 441—subrule 41.24(2). When an FIA-responsible person is incompetent or incapacitated, someone acting responsibly on that person's behalf may participate in the interview. Responsibility for carrying out the steps of the FIA ends at the point that FIP assistance is not provided to the participant or when a participant becomes exempt.

a. Parents. All parents who are not exempt from PROMISE JOBS shall be responsible for signing and carrying out the activities of the FIA. Parents of any age are exempt only if they are receiving Supplemental Security Income (SSI) or they do not meet citizenship requirements. When the FIP eligible group includes a minor parent living with one or both parents or a needy specified relative who receives FIP, as described at 441—subparagraph 41.28(2)*"b"*(2), and none is exempt from PROMISE JOBS participation, each parent or needy specified relative is responsible for a separate FIA.

b. Teens. Persons aged 16 to 19 shall be responsible for signing and carrying out the activities of the FIA unless they are receiving Supplemental Security Income (SSI) or they attend school full-time.

(1) When the FIP-eligible group includes one or both parents or a needy specified relative and a child or children and none is exempt from PROMISE JOBS participation, all shall be asked to sign one FIA with the family and to carry out the activities of that FIA rather than signing separate FIAs. Copies of the FIA shall be placed in each individual case file.

(2) When the FIP-eligible group includes one or both parents or a needy specified relative who is exempt from PROMISE JOBS participation and a child or children who are not exempt, each child is responsible for completing a separate FIA.

(3) A minor nonparental specified relative who is not exempt and whose needs are included in the FIP grant shall be responsible for signing and carrying out the activities of the FIA.

c. Other adults. All other adults who are not exempt and whose needs are included in the FIP grant shall be responsible for signing and carrying out the activities of the FIA.

93.4(3) *FIA content.* The FIA shall include the goals of the family for achieving self-sufficiency and shall establish a time frame with a specific ending date, during which the family expects to become self-sufficient and after which FIP benefits will be terminated. For individuals and families with acknowledged barriers, one or more incremental FIAs may be written.

a. All FIAs shall:

(1) Outline the expectations of the PROMISE JOBS program and of the family;

(2) Clearly establish interim goals and FIA activities necessary to reach long-term goals and self-sufficiency;

(3) Identify barriers to participation so that the FIA may include a plan, appropriate referrals, and supportive services necessary to eliminate or manage the barriers;

(4) Stipulate specific services to be provided by the PROMISE JOBS program, including child care assistance, transportation assistance, family development services, and other supportive services;

(5) Include the participant's responsibility to provide verification of hours of participation, and how and when the verification shall be submitted;

(6) Record a participant's response to the option of referral for family planning counseling as described at subrule 93.9(3).

b. Plans from other agencies. The FIA may incorporate a self-sufficiency plan that the family has developed with another agency or person, such as, but not limited to, Head Start, public housing authorities, child welfare workers, vocational rehabilitation, and FaDSS grantees, subject to the following requirements:

(1) The participant shall authorize PROMISE JOBS to obtain the self-sufficiency plan and to arrange coordination with the manager of the self-sufficiency plan by signing Form 470-0429, Consent to Obtain and Release Information.

(2) The self-sufficiency plan may be included in the participant's FIA if the self-sufficiency plan meets the requirements of this chapter and is deemed by the PROMISE JOBS worker to be appropriate to the family circumstances.

93.4(4) *Participation requirements.* The FIA shall require the FIA-responsible persons and family members who are referred to PROMISE JOBS to choose participation in one or more activities as described in this subrule.

a. Goals. It is expected that employment leading to economic self-sufficiency is the eventual goal of the FIA.

(1) To the maximum extent possible, the FIA shall reflect the goals of the family, subject to program rules; funding; the capability, experience, and aptitudes of family members; and the potential market for the job skills currently possessed or to be developed.

(2) The program goal for all participants is to be involved in PROMISE JOBS activities on a full-time basis unless barriers prohibit this level of involvement. "Full-time" is considered as an average of at least 30 hours per week. Exceptions to full-time involvement are identified in rule 441—93.14(239B) and subrule 93.4(5).

b. Activities. Except as specified in paragraph 93.4(4)*"c,"* PROMISE JOBS activities may include, but are not limited to, any combination of the following activities:

(1) Orientation as described in subrule 93.3(4).

(2) Assessment as described in rule 441—93.5(239B).

(3) Job readiness activities, including job club, individual job search, workplace essentials training, mental health treatment, substance abuse treatment, or other rehabilitative activities, as described in rule 441—93.6(239B).

(4) Work activities, including part-time or full-time employment, self-employment, on-the-job training, work experience, or unpaid community service as described in rule 441—93.7(239B).

(5) Educational activities, including high school completion, general education development (GED) certification, adult basic education (ABE), English as a second language (ESL) training, vocational training, or postsecondary training up to and including a baccalaureate degree, as described in rule 441—93.8(239B).

(6) Parenting skills training as described in subrule 93.9(1).

(7) Participation in the family development and self-sufficiency program (FaDSS) or other family development programs as described in subrule 93.9(2).

(8) Referral for family planning counseling as described in subrule 93.9(3).

(9) Services provided by other agencies.

c. FIA activities for participants aged 16 to 19. Development of FIA activities shall follow these guidelines for participants aged 16 to 19.

(1) Participants aged 16 to 19 who are not parents and who have not completed high school shall be strongly encouraged to participate in educational activities to obtain a high school diploma or the equivalent. A high school education is recognized as important to achieving self-sufficiency. Participants shall be given information on the earning power of people with a high school education compared to those who do not so that participants are able to make an informed choice. If high school or GED completion is not included in a teenager's FIA, other FIA activities shall be required. High school or GED completion shall be proposed and reconsidered at the next FIA review.

(2) Parents under the age of 18 who are not married and who have not completed high school shall be expected to use enrollment or continued attendance in high school or involvement in a high school equivalency program as a first step in the FIA, except when the parent is deemed incapable of participating in these activities by the local education agency.

(3) Parents aged 19 and younger shall include parenting skills training as described at subrule 93.9(1) in their FIA or the case file shall include documentation that this requirement has been fulfilled.

(4) Unmarried parents aged 17 and younger who do not live with a parent or legal guardian shall include FaDSS, as described at 441—Chapter 165, or other family development services, as described in subrule 93.9(2), in the FIA. The FaDSS or other family development services shall continue after the parent reaches the age of 18 only when the participant and the family development worker believe that the services are needed for the family to reach self-sufficiency.

d. Waiting lists. The department of human services reserves the authority to prioritize services to FIP applicants and participants in the order that best fits the needs of FIP applicants and recipients and of the PROMISE JOBS program. Participants who are placed on a waiting list for a PROMISE JOBS component shall include other appropriate activities in the FIA while waiting unless family circumstances indicate otherwise.

(1) Persons shall be removed from these waiting lists and placed in components at the discretion of state-level PROMISE JOBS administrators in order to help participants achieve self-sufficiency in the shortest possible time, meet budgetary limitations, enable participants to make maximum use of other programs, fulfill the federal minimum participation rate requirements, and meet other TANF requirements.

(2) Persons who were enrolled in approved postsecondary training at the time of FIP cancellation shall not be placed on a postsecondary training waiting list if the participant is still satisfactorily participating in approvable training at the time that FIP eligibility is regained.

e. Unavailability of funding. If funding for the PROMISE JOBS activities included in a participant's FIA or required supportive payments are not available, the participant's FIA shall be renegotiated to include different activities.

93.4(5) *Barriers to participation.* Problems with participation of a permanent or long-term nature shall be considered barriers to participation and shall be identified in the FIA as issues to be resolved or managed so that maximum participation can result.

a. Barriers defined. Barriers to participation shall include, but not be limited to, the following:

(1) Child or adult care needed before a person can participate or take a job is not available. Participants are not required to do any activity unless suitable child or adult care has been arranged.

(2) Lack of transportation.

(3) Substance addiction.

(4) Sexual or domestic abuse history.

(5) Overwhelming family stress.

(6) Physical or cognitive disability or mental illness.

b. Inclusion in FIA.

(1) When barriers are identified during assessment, removal or management of the barrier shall be part of the FIA from the beginning.

(2) When barriers are revealed by the applicant or participant during the FIA development or are identified by problems that develop after the FIA is signed, the FIA shall be renegotiated and amended to provide for removal or management of the barriers.

(3) In limited instances where special-needs care for a child or adult is not available, it may be most practical for the participant to develop the FIA to identify providing the care as part of the FIA.

c. Cooperation with removing or managing barriers.

(1) Applicants. An FIA-responsible applicant who chooses not to cooperate in removing or managing barriers to participation identified during FIA development shall be denied FIP.

(2) Participants. A participant who chooses not to cooperate in removing or managing identified barriers to participation shall be considered to have chosen the limited benefit plan. If the participant claims a cognitive or physical disability or mental illness that is expected to last for more than 12 consecutive months, the participant is required to apply for Social Security Disability and Supplemental Security Income benefits. When the participant refuses to apply for those benefits, the FIP household is ineligible for FIP as described at 441—subrule 41.27(1), and the limited benefit plan does not apply.

93.4(6) *Failure to complete an FIA.*

a. FIP applicants. An applicant's failure to develop or sign an FIA shall result in denial of the family's application for FIP assistance, as described at 441—paragraph 41.24(4)*"c."*

b. FIP participants. FIP participants who choose not to enter into an FIA or who choose not to continue its activities after signing an FIA shall enter into the limited benefit plan (LBP) as described at 441—subrule 41.24(8).

93.4(7) *Progress reviews.* The PROMISE JOBS worker shall review all FIAs at least once every six months. Progress reviews do not have to be face-to-face interviews but must include verbal contact with and input from at least one family member. FIA goals, Form 470-3096, FIA Steps for Achieving Self-Sufficiency, and, if appropriate, the needs for child care, transportation, and other supports shall be reviewed for continued appropriateness.

93.4(8) *Renegotiation.*

a. The FIA shall be renegotiated to reflect a new plan for self-sufficiency if:

(1) The participant has participated satisfactorily in the current FIA activities but is not self-sufficient by the end date specified in the FIA; or

(2) The participant demonstrates effort in carrying out the steps of the FIA but is unable to participate satisfactorily in the current FIA activities due to a barrier as described at subrule 93.4(5); or

(3) The participant's circumstances change to such an extent that the current FIA activities are no longer appropriate.

b. Participants who choose not to cooperate in the renegotiation process when requested by PROMISE JOBS shall be considered to have chosen the limited benefit plan.

93.4(9) *Reinstatement.* When a participant who has signed an FIA loses FIP eligibility and has not become exempt from PROMISE JOBS at the time of FIP reapplication, the contents of the original FIA and the participant's responsibility for carrying out the steps of that FIA may be reinstated when the steps of the FIA fit the family's current circumstances. The FIA shall be renegotiated and amended if needed to accommodate changed family circumstances.

441—93.5(239B) Assessment. The purpose of assessment is to provide an evaluation of the FIP applicant or participant family that furnishes a basis for the PROMISE JOBS worker to determine: (1) family members' employability and educational potential, so that participants can make well-informed

choices; and (2) the services that will be needed for the family to achieve self-sufficiency, so that the worker can provide appropriate guidance.

93.5(1) *Initial assessment.* All persons referred to PROMISE JOBS shall complete an initial assessment, which shall be used to develop the initial FIA. The PROMISE JOBS worker shall meet individually with FIA-responsible persons who are referred to PROMISE JOBS to develop the FIA.

a. Self-assessment. The participant may either fill out Form 470-0806, Self-Assessment, before the meeting or fill the form out during the meeting with assistance from the PROMISE JOBS worker. The results from self-assessment shall be used to assist in identifying the applicant's needs.

b. Scope of initial assessment. The initial assessment meeting, at a minimum, shall review the family's financial situation, family profile and goals, employment background, educational background, housing needs, child care needs, transportation needs, health care needs, family-size assessment and the participant's wishes regarding referral to family planning counseling, and other barriers which may require referral to entities other than PROMISE JOBS for services.

93.5(2) *Additional assessments.* Additional assessments may include, but are not limited to, literacy and aptitude testing, educational level and basic skills assessment, evaluation of job interests or job skills, occupation-specific assessment or testing, or an evaluation of past pertinent information. An additional assessment may be used by mutual agreement between the PROMISE JOBS worker and the participant as a tool and to help explore possible FIA development. For a specific additional assessment to be required, completion of the assessment must be specified in the FIA.

a. Additional information on applicants. If information identified during the initial assessment indicates that further information is needed to help the participant and PROMISE JOBS worker identify appropriate FIA activities and level of involvement, the applicant shall complete additional assessments as determined by the PROMISE JOBS worker. Completion of this assessment may be the first step in the initial FIA.

b. Medical examination. The PROMISE JOBS worker may require a person to complete a medical examination before including a particular PROMISE JOBS activity in the FIA when a participant specifies or exhibits any condition that might jeopardize successful participation in the program. The worker shall ask the health practitioner to indicate to the best of the practitioner's knowledge whether the person is capable of completing the FIA activity or continuing with appropriate employment.

c. Rehabilitation assessments. At any time during the assessment process or as more information is revealed, a referral may be made for professional assessments in physical health, mental health, substance abuse, or other rehabilitative services.

d. Additional information on participants. Assessments may be completed or redone at any time throughout the development and duration of the FIA if the information is needed to help the participant and the PROMISE JOBS worker make decisions concerning the type or level of the participant's involvement in PROMISE JOBS activities.

93.5(3) *Postsecondary educational evaluation.* Participants who wish to include postsecondary education in their FIA shall complete an educational evaluation to determine the likelihood of success.

a. Request for education resulting in a vocational certificate or certificate of completion. Vocational certificate or certification of completion training programs offer short-term training in a specific vocational area. Examples include, but are not limited to: nurse aid certification, training to receive a commercial driver's license, training in information technology, health care services, and child care services. The PROMISE JOBS worker shall determine the likelihood of success using the following types of tools or information:

(1) A review of information from past training situations,
(2) Past job performance in comparable positions,
(3) Basic skills tests,
(4) Career-specific assessments,
(5) A specific standardized test, or
(6) Other key historical information.

b. Request for education resulting in an associate or baccalaureate degree. The PROMISE JOBS worker shall determine the likelihood of academic success through an educational evaluation. The evaluation may include use of the following types of tools or information:

(1) Standardized assessments in reading comprehension, math, and writing skills, such as GATB (General Aptitude Test Battery), Kuder Skills Assessment, or CASA (Comprehensive Adult Student Assessment) system;

(2) Occupation-specific skills assessments;

(3) Interest inventories;

(4) Current or past grades; and

(5) Other pertinent historical information.

c. Documenting educational evaluation results. When a participant has requested education to be included in the FIA, the PROMISE JOBS worker shall document:

(1) What formal assessments were completed, if any, and what the results were;

(2) What other information was reviewed;

(3) How the evaluation information was used by the PROMISE JOBS worker in either approving or denying the inclusion of education in the participant's FIA; and

(4) Whether the request is approved or denied. If the request is denied, PROMISE JOBS shall issue Form 470-0602, Notice of Decision: Services, to the participant as required in paragraph 93.10(1)*"b."*

93.5(4) *Substituting or supplementing an assessment.*

a. Substituting assessment information. If the FIA-responsible person's mental status, physical status, and life situation have not changed significantly, comparable assessment information completed with another agency or person within the past two years may be used instead of performing new assessments.

(1) Examples of agencies or persons that may complete comparable assessment information include, but are not limited to, the department of workforce development, Head Start, public housing authorities, child welfare workers, vocational rehabilitation services, an educational institution or testing service, or family development services.

(2) The FIA-responsible person may authorize PROMISE JOBS to obtain these assessment results by signing Form 470-0429, Consent to Obtain and Release Information.

b. Supplementing assessment information. In order to ensure that the family investment agreement activities do not conflict with any case plans that have already been established for the family, the FIA-responsible person may:

(1) Supplement assessment information, and

(2) Establish communication between the PROMISE JOBS worker and other agencies or persons.

c. Use of key historical information. When key historical information, such as a review of the participant's job history or past training outcomes, relays a clear picture of the participant's skills and abilities, a formal, standardized educational assessment may not be needed.

(1) If a participant is currently enrolled in or has been enrolled in comparable training or an academic program in the past two years, the evaluation of the participant's performance, including grades received, may be substituted for a formal, standardized educational assessment.

(2) When using historical information as an indicator of future success, changes in the participant's mental status, physical status, life circumstances, and motivation shall be given consideration.

93.5(5) *Assessment after FIP cancellation or limited benefit plan.* FIP participants who previously participated in either a basic or additional assessment and then were canceled from FIP or entered a limited benefit plan may be required to complete an assessment again when the PROMISE JOBS worker determines that updated information is needed for development or amendment of the FIA.

93.5(6) *Participants with FaDSS services only.* For participants with FaDSS services as the only activity in their FIA, the PROMISE JOBS worker shall use information provided by the FaDSS worker to help assess when a participant is ready to participate in other PROMISE JOBS activities. The PROMISE JOBS worker may require additional assessments to be completed if more information is needed to decide the type or level of the participant's involvement in other PROMISE JOBS activities.

93.5(7) *Documenting participation.* The participant shall provide documentation of participation in assessments as described at subrule 93.10(2). Persons who miss any portion of a scheduled assessment may be required to make up the missed portion, based on worker judgment and participant needs.

93.5(8) *Supportive payments allowed.* Except for assessment activities that occur on the same day as orientation, persons participating in assessment activities are eligible for payments for transportation and child care needed to allow the scheduled participation as described at rule 441—93.11(239B). When make-up sessions are required, the participant shall not receive an additional transportation payment, but necessary child care shall be paid.

93.5(9) *Failure to complete assessment.* Participants who do not complete assessments that are written into their FIA shall be considered to have chosen the limited benefit plan unless they have good cause. Procedures at 441—93.14(239B) shall apply.

441—93.6(239B) Job readiness and job search activities. Job readiness and job search activities include job club, job search, workplace essentials training, substance abuse treatment, mental health treatment, and other rehabilitation activities. The participant and the PROMISE JOBS worker shall incorporate into the FIA the job readiness and job search activities that are appropriate for the goals, work history, skill level, and life circumstances of the participant.

93.6(1) *Job club.* Job club prepares participants to search for work. Job club consists of training in job-seeking skills and structured job search.

a. Delivery of services. Job club is provided over a consecutive three-week period. Each week consists of 30 hours of structured activity.

(1) Generally, the first week of job club consists of job-seeking skills training and the next two weeks consist of structured group job search.

(2) Based on local office need and resources, the 30 hours of job-seeking skills training may be completed over the first two weeks when the hours not spent in job-seeking skills training are spent in structured job search. The total time spent in each of the two weeks must meet the 30-hour requirement. The third week of job club is 30 hours of structured group job search.

b. Job-seeking skills training. Job-seeking skills training may include but is not limited to:

(1) Résumé development;
(2) Writing application and follow-up letters;
(3) Completing job applications and interest and skills assessments;
(4) Job retention skills;
(5) Motivational exercises;
(6) Identifying and eliminating employment barriers;
(7) Self-marketing;
(8) Finding job leads;
(9) Obtaining interviews;
(10) Use of telephones for job seeking;
(11) Interviewing skills; and
(12) Financial education.

c. Structured job search. A written plan shall be developed with each participant using Form 470-4481, Job Search Plan Agreement, indicating the number of job search hours required depending on family circumstances and other component activities listed on the participant's FIA. Structured job search includes daily reporting to the job search site to access resources for job leads.

d. Attendance. Daily attendance is required during both the job-seeking skills training and structured job search. Participants who miss any portion of the job-seeking skills training or structured job search may be required to either make up the missed portion of the sessions or to retake the entire week of training based on practical worker judgment and participant need.

(1) Participants who obtain employment are required to continue the job-seeking skills training unless the scheduled job club hours conflict with the scheduled hours of employment.

(2) Participants who obtain employment averaging 30 hours or more per week may discontinue the structured job search portion of job club.

(3) Participants who obtain employment averaging 20 hours per week or more but less than 30 hours per week may discontinue the structured job search portion of job club if part-time employment was the FIA goal or the scheduled job club hours conflict with the scheduled hours of employment. The participant may be required to participate in other FIA activities during the hours that do not conflict with work hours.

(4) Participants who obtain employment averaging less than 20 hours per week shall continue the structured job search portion of job club unless the scheduled job club hours conflict with the scheduled hours of employment. The participant may be required to participate in other FIA activities during the hours that do not conflict with work hours.

e. Supportive payments allowed. Child care and transportation payments shall be provided as described at rule 441—93.11(239B) when needed to participate in job club. The transportation payment shall be paid in full at the start of participation.

(1) Participants who must repeat the job-seeking skills training or structured job search because of absence due to reasons as described at rule 441—93.14(239B) shall receive an additional transportation payment as described at subrule 93.11(3) for each day that must be repeated and a child care payment for needed child care. This rule applies only when the participant will have transportation costs that exceed the participant's original payment because of repeating a portion of job club.

(2) Participants who must repeat job-seeking skills training or structured job search as a result of absences due to reasons other than those described at rule 441—93.14(239B) shall not receive an additional transportation payment.

f. Documenting job club participation. Participants shall provide documentation of job search activities as described at subrule 93.10(2).

g. Failure to participate in job club activities. Participants who without good cause do not appear for scheduled job club activities or who fail to complete or document and submit job search contacts according to their written plan shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.6(2) *Individual job search.* Individual job search shall be available to participants for whom job club is not appropriate or not available, such as, but not limited to, participants who have completed training or have recent ties with the workforce. The total period for each episode of individual job search shall not exceed 12 weeks or three calendar months.

a. Job search plan. In consultation with the PROMISE JOBS worker, the participant shall design and provide a written plan of the individual job search activities on Form 470-4481, Job Search Plan Agreement. The plan shall:

(1) Contain a designated period for job search not to exceed five weeks ending on a Friday and the specific methods for finding job openings.

(2) Specify the number of hours to be committed for each week of the designated period so as to provide the most effective use of transportation funds.

(3) Specify due dates for providing documentation of job search activities.

(4) Contain information as specific as possible about areas of employment interest, employers to be contacted, and other pertinent factors.

b. Supportive payments allowed. Child care and transportation payments shall be provided as described at rule 441—93.11(239B) when needed for participation in individual job search. The transportation payment shall be paid in full at the start of each designated period of the individual job search. Transportation payments for any missed days of job search activity shall be subject to transportation overpayment policies as described at subrule 93.11(3).

c. Documenting job search participation. The participant shall document the actual hours spent on job contacts and other job search activities. Participant documentation shall be provided as described at subrule 93.10(2).

d. Failure to participate in individual job search. Participants who without good cause do not complete the steps of the written plan of the individual job search shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.6(3) *Unplanned job opportunity.* PROMISE JOBS participants who have an unplanned opportunity to interview or apply for a job shall be encouraged to take advantage of the opportunity.

a. Supportive payments allowed. Child care and transportation payments needed to make an unplanned job contact shall be provided as described at rule 441—93.11(239B) when the following conditions are met:

(1) The participant has a signed FIA,

(2) The job contact is an in-person contact to complete an application or to attend an interview, and

(3) The participant provides documentation as described in paragraph *"b"* of this subrule. Payment shall be issued after documentation is received.

b. Documenting participation. The participant shall provide documentation of the actual time spent making the specific job contact. Documentation shall be provided as described at subrule 93.10(2).

c. Limited benefit plan. A limited benefit plan does not apply when a participant fails to complete a job contact that is not part of a structured or individual job search plan.

93.6(4) *Workplace essentials.* The workplace essentials component consists of soft skills and life-skills training.

a. Delivery of services. Workplace essentials training is one 30-hour week in duration. Based on local office need and resources, the 30 hours may be completed over a two-week period. For the remainder of the 30 participation hours required in each week, participants must engage in other PROMISE JOBS activities.

b. Content. Workplace essentials training may include but is not limited to:

(1) Identifying and setting goals.

(2) Self-esteem building.

(3) Emotional awareness.

(4) Relationship management.

(5) Conflict-resolution skills.

(6) Problem-solving skills.

(7) Decision-making skills.

(8) Time-management skills.

(9) Team-building skills.

(10) Networking skills.

(11) Listening skills.

(12) Positive thinking.

(13) Priority setting.

(14) Appropriate workplace behaviors.

(15) Cultural sensitivity.

(16) Workplace expectations.

(17) Stress management.

c. Supportive payments allowed. Child care and transportation payments shall be provided as described at rule 441—93.11(239B) when needed to participate in workplace essentials.

d. Documenting participation. The PROMISE JOBS worker shall verify and document each participant's monthly hours of actual participation in workplace essentials. Participant documentation shall be provided as described at subrule 93.10(2).

e. Failure to participate in workplace essentials. Participants who without good cause do not complete workplace essentials as identified in their FIA shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.6(5) *Substance abuse treatment, mental health treatment, and other rehabilitative activities.* Substance abuse or mental health treatment or other rehabilitative activities are available when needed for a participant to be successful in participating in other FIA activities.

a. Treatment determination. The need for treatment or rehabilitative activities must be determined by a qualified medical professional, substance abuse professional, or mental health professional. The qualified professional must document that treatment or rehabilitative activities are needed for the participant to obtain or retain employment.

b. Supportive payments allowed. Transportation and child care payments as described at rule 441—93.11(239B) are available for participating in substance abuse treatment, mental health treatment, or other rehabilitative activities when specified in the FIA.

c. Documenting participation. The service provider shall verify actual hours of participation in treatment. Documentation of participation shall be provided as described at subrule 93.10(2).

d. Failure to participate in treatment or other rehabilitative activities. Participants who without good cause do not participate in substance abuse treatment, mental health treatment, or other rehabilitative activities as specified in their FIA shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

441—93.7(239B) Work activities. Work activities include full-time employment, part-time employment, self-employment, on-the-job training, work experience placement, and unpaid community service. The participant and the PROMISE JOBS worker shall incorporate into the FIA employment activities that are appropriate for the work history, skill level, and life circumstances of the participant. If the FIA activity is so hazardous that safety glasses, hard hats, or other safety equipment is needed, participation shall not be arranged or approved unless these safety precautions are available.

93.7(1) *Full-time or part-time employment.* FIAs may include full-time employment or part-time employment. Employment that does not lead to economic self-sufficiency may be included in the FIA only if the employment situation leads to better employment opportunities through building work skills and work history. See subrule 93.7(2) for additional policies applicable to self-employment.

a. Full-time employment. The goal for all participants is to participate in full-time employment. "Full-time employment" is defined as being employed an average of 30 or more hours per week.

(1) Persons who have not achieved self-sufficiency through full-time employment before the end date of the FIA may have the FIA extended.

(2) Persons who choose not to enter into the renegotiation process to extend the FIA shall be considered to have chosen the limited benefit plan.

b. Part-time employment. Part-time employment is defined as being employed an average of less than 30 hours per week. An FIA that includes part-time employment shall also include participation in other PROMISE JOBS activities, including additional part-time employment, unless barriers to participation exist as defined in rule 441—93.14(239B) and subrule 93.4(5).

c. Supportive payments allowed. Transportation expenses are not paid through PROMISE JOBS but are covered by FIP earned income deductions. Child care payments shall be provided when needed as described at rule 441—93.11(239B).

d. Verification of employment hours. Participants must provide verification of employment hours as described at subrule 93.10(2).

e. Failure to provide verification. Failure to provide verification of work hours after receiving a written reminder will result in a limited benefit plan. PROMISE JOBS can void the limited benefit plan if the participant provides verification of work hours by the tenth day following the effective date of the limited benefit plan.

f. Failure to maintain employment. A participant who without good cause does not maintain employment as identified in the FIA shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.7(2) *Self-employment.*

a. Calculation of hours. Hours of participation for persons who are self-employed shall be calculated using actual gross income less business expenses divided by the federal minimum wage. PROMISE JOBS shall use the same income as used for FIP eligibility and benefits.

(1) Participants with self-employment income that equates to 30 or more hours per week are considered to be working full-time.

(2) Participants with self-employment income that equates to less than 30 hours per week are considered to be working part-time.

b. Review of participation. The PROMISE JOBS worker shall review calculated hours:

(1) When income changes, or

(2) At least once every six months.

c. Progress toward self-sufficiency. At the participant's FIA review, the participant's progress is determined by noting incremental increases in income and calculated work hours. In order to maintain self-employment as the only FIA activity, participants must:

(1) Reach full-time employment as defined in subparagraph 93.7(2)*"a"*(1), or

(2) Show progress toward self-sufficiency.

d. Requiring other FIA activities. When a participant has been self-employed for more than 12 months and has not shown progress toward self-sufficiency, the FIA shall include the part-time self-employment in combination with participation in other PROMISE JOBS activities, unless barriers to participation exist as described in subrule 93.4(5).

(1) The other activities could include additional part-time employment.

(2) When the determination that a participant has not shown progress toward self-sufficiency is made after the initial FIA is developed, the FIA shall be renegotiated to include the other PROMISE JOBS activities. Participants who choose not to enter into the FIA renegotiation process shall enter into a limited benefit plan as described in 441—subrule 41.24(8).

e. Supportive payments allowed. Transportation expenses are not paid through PROMISE JOBS but are covered by FIP earned income deductions. Child care payments shall be provided when needed as described at subrule 93.11(2).

f. Documenting participation. Hours of participation in self-employment shall be calculated as specified in paragraph 93.7(2)*"a"* and documented in the case file. Participant documentation shall be provided as described at subrule 93.10(2).

g. Failure to maintain employment. Participants who without good cause do not maintain employment as identified in their FIA shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.7(3) *On-the-job training.*

a. Definition. "On-the-job training" is defined as training in the public or private sector that:

(1) Is given to a paid employee while the employee is engaged in productive work, and

(2) Provides knowledge and skills essential to the full and adequate performance of the job.

b. Supportive payments. Transportation for on-the-job training is treated in the same manner as transportation for employment. Expenses are not paid through PROMISE JOBS but are covered by FIP earned income deductions. Child care payments shall be provided when needed as described at subrule 93.11(2).

c. Documenting participation. Documentation of participation shall be provided as described at subrule 93.10(2).

d. Failure to participate in on-the-job training. Participants who without good cause do not participate in on-the-job training as identified in their FIA shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.7(4) *Work experience program.* Work experience sites shall provide participants with work experience and on-the-job training opportunities.

a. Sponsors. Employers who participate in the work experience program are referred to as sponsors. Work experience sponsors may be public sector, private sector, community-based, faith-based, or nonprofit employers.

(1) Participants may be placed at work sites with religious institutions only when the work performed is nonsectarian and not in support of sectarian activities.

(2) Participants may not be used to replace regular employees in the performance of nonsectarian work for the purpose of enabling regular employees to engage in sectarian activities.

(3) Each work experience program sponsor shall provide to the PROMISE JOBS service provider a copy of the sponsor's safety rules before participants are referred for work site placement.

b. Positions. To request a work experience placement, the sponsor shall complete Form 470-0809, Sponsor's Request for Work Experience (WEP) Participant, for each type of position the sponsor wishes to fill. The request shall include a complete job description that specifies all tasks to be performed by the

participant. PROMISE JOBS has final authority to determine suitability of any work experience position offered by a sponsor. Work experience positions:

(1) Must contain the same job description and performance requirements that would exist if the sponsor were hiring an employee for the same position;

(2) Shall not be related to political, electoral, or partisan activities;

(3) Shall not be developed in response to or in any way be associated with the existence of a strike, lockout, or other bona fide labor dispute;

(4) Shall not violate any existing labor agreement between employees and employers;

(5) Shall comply with applicable state and federal health and safety standards;

(6) Shall not be used by sponsors to displace current employees or to infringe on the promotional opportunities of current employees;

(7) Shall not be used in place of hiring staff for established vacant positions; and

(8) Shall not result in placement of a participant in a position when any other person is on layoff from the same or an equivalent position in the same unit.

c. Participant selection. A participant's vocational skills and interests shall be matched as closely as possible with the job description and skills required by the sponsor.

(1) Participant responsibility. Participants shall interview for and accept positions offered by work experience sponsors. Participants shall present Form 470-0810, Referral for Work Experience (WEP) Placement, to the sponsor at the interview. The form shall be completed by the sponsor and returned to PROMISE JOBS.

(2) Sponsor responsibility. Although sponsors are expected to accept work experience referrals made by PROMISE JOBS, sponsors may refuse any referrals they deem inappropriate for the available position. Sponsors shall not discriminate against any program participant because of race, color, religion, sex, age, creed, physical or mental disability, political affiliation, or national origin. Sponsors who refuse a referral must notify PROMISE JOBS in writing of the reason for the refusal.

d. Hours of participation. When a participant is involved in work experience that is subject to the Fair Labor Standards Act (FLSA), the participant cannot be required to work more hours than the amount of the monthly FIP grant divided by federal or state minimum wage, whichever is higher. EXCEPTION: To determine the maximum hours that can be required of a single-parent family on FIP with a child under the age of six, add the value of the family's food assistance to the FIP grant amount before dividing by the minimum wage.

(1) A participant cannot be required to work more hours than those calculated under paragraph *"d"* of this subrule. Only hours up to or less than that calculation can be included in the participant's FIA.

(2) If two or more members of the same household participate in work experience, the total required hours of participation of the household cannot exceed the hours calculated according to paragraph *"d"* of this subrule.

(3) Each work experience assignment shall not exceed six months in duration.

e. Participant performance evaluations.

(1) Monthly evaluations. Sponsors shall complete a monthly evaluation of the participant's performance using Form 470-0805, Work Experience Participant Evaluation, and provide a copy to PROMISE JOBS and to the participant.

(2) Final evaluations. Sponsors shall complete Form 470-0805, Work Experience Participant Evaluation, at the time of termination for each work experience participant. When termination occurs at the sponsor's request, the sponsor shall specify the reason for termination and identify those areas of unsatisfactory performance. For participants who leave to accept regular employment or reach their work experience placement time limit, the sponsor's evaluation shall indicate whether or not a positive job reference would be provided if the participant requested one.

f. Supportive payments for work experience placements.

(1) Child care and transportation. Participants assigned to work experience shall receive a child care payment, if required, and a transportation payment for each month or part thereof as described at subrules 93.11(2) and 93.11(3). The portion of the transportation payment for job-seeking activities shall

be determined by including the day of the job search obligation in the normally scheduled days used in the formulas described at subrule 93.11(3).

(2) Required clothing and equipment. A participant may receive up to a limit of $100 per work-site assignment for clothing or equipment if required by the work experience site and not covered by the sponsor.

(3) Workers' compensation. The department of human services shall provide workers' compensation coverage for all PROMISE JOBS work experience participants.

g. Documenting participation. Documentation of participation shall be provided as described at subrule 93.10(2).

h. Completion of work experience. Persons who complete a work experience assignment may move to another activity as provided under the FIA, be assigned to a different work site, or be reassigned to the same work site, whichever is appropriate under the FIA.

i. Failure to participate in work experience. A participant who without good cause does not participate in work experience as identified in the FIA shall be considered to have chosen the limited benefit plan. Procedures at rule 441—93.14(239B) shall apply.

93.7(5) *Unpaid community service.* Unpaid community service shall provide participants with opportunities to establish or reestablish contact with the workforce while providing services that are of direct benefit to the community.

a. Work sites. Unpaid community service work sites shall be public or private nonprofit organizations. The PROMISE JOBS provider agencies shall provide community service work sites a written explanation of the following placement criteria. The placement:

(1) Shall comply with applicable state and federal health and safety standards;

(2) Shall not be related to political, electoral or partisan activities;

(3) Shall not be developed in response to or in any way associated with the existence of a strike, lockout, or other bona fide labor dispute;

(4) Shall not violate any existing labor agreement between employees and employers;

(5) Shall not be used to displace current employees or to infringe on their promotional opportunities;

(6) Shall not be used in place of hiring staff for established vacant positions; and

(7) Shall not result in placement of a participant in a position when any other person is on layoff from the same or an equivalent position in the same unit.

b. Locating the work site. The PROMISE JOBS provider agencies shall develop local listings of potential unpaid community service work sites. When a participant and the PROMISE JOBS worker agree that an unpaid community service placement is appropriate, the participant is responsible for locating and making arrangements with the work site. Formal interviews are not required to establish the relationship between the participant and the work site organization.

c. Length of assignment and weekly hours. The length of the work site assignment and the weekly hours of participation shall be determined through agreement among the work-site organization, the participant, and the PROMISE JOBS worker. When a participant is involved in community service that is subject to the Fair Labor Standards Act (FLSA), the participant cannot be required to work more hours than the amount of the participant's monthly FIP grant divided by federal or state minimum wage, whichever is higher. Only hours up to or less than the maximum calculated may be included in the participant's FIA. Exceptions are as follows:

(1) For a participant who is a single parent with a child under the age of six, the maximum hours that can be required are determined by adding the value of the participant's food assistance to the FIP grant amount before dividing by the minimum wage.

(2) Participants who are court-ordered to do community service shall work the number of hours required by the court.

e. Supportive payments. A child care payment and a transportation payment for each month of participation or part thereof shall be paid as described at rule 441—93.11(239B) if these services are required for participation.

f. Documenting participation. Documentation of participation shall be provided as described at subrule 93.10(2).

g. Failure to complete unpaid community service. Participants who without good cause do not participate in unpaid community service as specified in their FIA shall be considered to have chosen the limited benefit plan. Procedures at rule 441—93.14(239B) shall apply.

441—93.8(239B) Education and training activities. Education refers to any academic or vocational course of study that enables a participant to complete high school, improves a participant's ability to read and speak English, or prepares a participant for a specific professional or vocational area of employment. Though employment leading to economic self-sufficiency is the eventual goal of all FIAs, it is recognized that education increases a person's chance of finding employment, particularly employment that leads to economic self-sufficiency. Any participant who requests participation in educational activities shall be evaluated to determine the likelihood of success. If the request is approved, a training plan shall be developed and included in the participant's FIA.

93.8(1) *Participant requirements.* The decision to include education in an FIA shall take into account the results of the educational evaluation pursuant to paragraph *"b"* of this subrule and the current educational level of the participant. Prior academic or vocational training is not, in itself, a reason for denial or approval of educational services. All family members who are approved for education shall be eligible for all program benefits, even when two or more family members are simultaneously participating and even if participation is at the same educational facility and in the same program. For education to be approved for inclusion in an FIA, the following requirements shall be met.

a. Vocational goal. For a participant enrolled in postsecondary education, the education must lead to a specific vocational goal. A degree in general studies or programs not leading to specific occupational outcomes cannot be included in a participant's FIA.

(1) Except as provided in subparagraph 93.8(1)*"a"*(2), a vocational goal must be in an occupational field for which available labor market information or emerging business trends in the participant's local area indicate employment potential. These trends or statistics must be provided by a legitimate source, such as but not limited to:

1. The department of workforce development,
2. Private employment agencies, or
3. Local employers providing jobs paying at least minimum wage for which the education is being requested.

(2) Information to support employment potential in the participant's local area is not required when:

1. The participant has a documented job offer in the field before entering the training; or
2. The participant is willing to relocate after training to an area where there is employment potential. Documentation for the new location shall meet the requirements in subparagraph 93.8(1)*"a"*(1).

(3) For participants attending high school or GED activities, adult basic education or English as a second language, the vocational goal is to improve employability by successfully completing the activity.

b. Evaluation. A participant under the age of 19 does not need to complete an educational evaluation in order to have high school completion included in the FIA. For every other training activity, an educational evaluation shall be completed according to this paragraph before the activity is included as part of a participant's FIA.

(1) A participant who chooses to enter educational activities before obtaining approval is not eligible to receive supports as described in subrule 93.8(6), cannot use that activity to meet the FIA participation obligation, and shall be expected to participate in other FIA activities.

(2) A participant who is already involved in education at the time of FIP application or enters education before approval must meet the requirements in this rule before the educational activities can be included in the FIA. Once approved, the current educational activity may then be included in the participant's FIA, and the participant will be eligible to receive supports as described in subrule 93.8(6).

93.8(2) *Provider requirements.* Both public and private agencies may provide educational activities.

a. Type of provider. Education may be included in the FIA if obtained from a provider that is approved or registered with the state or is accredited by an appropriate accrediting agency. Training provided by a community action program, church, or other agency may be included in the FIA only if the PROMISE JOBS worker determines that:

(1) The training is adequate and leads to the completion of the participant's vocational goal; and

(2) The training provider possesses appropriate and up-to-date equipment; has qualified instructors, adequate facilities, a complete curriculum, acceptable grade point requirements, and a good job-placement history; and demonstrates expenses of training that are reasonable and comparable to the costs of similar programs.

b. Time and attendance. The participant's actual hours attending an educational activity must be verified pursuant to subrule 93.10(2). If the educational activity is structured in such a way that verification cannot be obtained or the educational provider is unwilling to provide time and attendance verification, the educational activity cannot be included in the participant's FIA.

93.8(3) *Approvable activities.* Training plans shall include only training activities that can be considered as meeting the FIA obligations for participation. The following activities may be included in a training plan:

a. Adult basic education.

b. Continuing education units when needed for the participant to be recertified or retrained to reenter a field in which the participant was previously trained or employed or to maintain certification needed to remain employed.

c. Correspondence courses when the courses are required but not offered by an educational facility attended by the participant.

d. English as a second language.

e. High school or GED completion. Any participant who does not have a high school diploma or GED shall be encouraged to obtain a diploma. A participant who is 18 years of age or older may be approved to return to regular high school only when the participant can graduate within one year of the normal graduation date. GED or high school courses and other types of vocational training may run concurrently.

f. On-line or distance learning. Distance learning includes training such as, but not limited to, that conducted over the Iowa communications network, on-line courses, or Web conferencing. The training:

(1) Must include interaction between the instructor and the student, such as required chats or message boards;

(2) Must include mechanisms for evaluation and measurement of student achievement; and

(3) Must be offered in Iowa unless the conditions in paragraph *"g"* of this subrule apply. An on-line training program shall be considered an out-of-state training program when any of the required training or testing occurs out-of-state.

g. Out-of-state training. Out-of-state training is approvable only when:

(1) Similar training is not available in Iowa,

(2) Relocation required to attend an in-state facility would be unnecessary if attending an out-of-state facility, or

(3) The only in-state facilities within commuting distance are private schools where tuition costs are higher than at an out-of-state facility within commuting distance.

h. Postsecondary education up to and including a baccalaureate degree program.

(1) A participant with no postsecondary education may be approved for training resulting in a certificate of program completion or an academic degree, such as an associate or baccalaureate degree. Participants who have not completed a high school education or GED may be required to do so before courses leading to an associate degree or higher are approved.

(2) A participant who has a baccalaureate degree or higher is considered employable. No further training shall be approved unless the participant's physical or mental status has changed to such an extent that the past education is no longer appropriate. The participant must provide supportive evidence from either a qualified medical or mental health professional or the state rehabilitation agency.

(3) A participant who has successfully completed a postsecondary educational program that provides less than a baccalaureate degree may be approved for further training if the participant meets one of the following criteria:

1. The previous training is in an occupation that is outdated.
2. The previous training is in a field where current labor market information or emerging business trends show little or no employment opportunity.
3. The training requested is a progression in a specific career that moves a participant from entry-level positions to higher levels of pay, skill, responsibility, or authority.
4. The participant's background makes employment in the area in which the participant is trained impossible.
5. Changes in the participant's physical or mental status make the past training no longer appropriate. The participant must provide supportive evidence from a qualified medical or mental health professional or the state rehabilitation agency.

i. Prerequisite courses required by the selected training program.

j. Remedial coursework for one term when needed as determined by testing conducted by the training facility.

k. Summer school.

93.8(4) *Nonapprovable activities.* Nonapprovable training activities shall not be included in the FIA. When an activity in which the participant is enrolled becomes nonapprovable, PROMISE JOBS shall cancel the current training plan and require the participant to renegotiate the FIA to include other activities. Form 470-0602, Notice of Decision: Services, shall be issued to inform the participant that the request for education is canceled. Nonapprovable activities include the following:

a. A course or training that the participant has previously completed.

b. Any course or training in a field in which the participant does not intend to seek employment after the training is completed. An exception may be made when the reason for not seeking employment is to receive further education when the education:

(1) Is a planned progression in a specific career path; and

(2) Will not lead to an advanced degree beyond a baccalaureate.

c. A training program that does not relate to the identified vocational goal.

d. Educational activities for which the participant has failed to earn the grades required for admission.

e. Education in a field in which the participant will not be able to be employed due to known criminal convictions or founded child or dependent adult abuse.

f. Out-of-state training except as allowed under paragraph 93.8(3)*"g."*

g. Training for jobs paying less than state minimum wage.

h. Training that will not be completed until after the participant leaves FIP. Training programs that exceed the known length of time during which the participant will remain eligible for FIP assistance shall be approved only if:

(1) The time remaining in the training is minimal and tuition has already been paid.

(2) There is a reasonable plan for how the program will be completed without the assistance and support from FIP or PROMISE JOBS. A reasonable plan may include, but not be limited to, school loans, grants, and scholarships.

93.8(5) *Training plan content.* Once a participant is approved for training, a training plan shall be developed and written into the participant's FIA. The training plan shall include:

a. Academic enrollment hours. Participants are encouraged to maintain as full an academic workload as is possible in order to complete their education in a timely manner. However, a person may choose to participate in education along with other activities such as employment, job-seeking skills, or other FIA activities.

b. Approved training plan activities.

c. The specific educational goal as defined in paragraph 93.8(1)*"a."*

d. A date by which the participant expects to complete training. This end date depends on:

(1) Time frames specified for a program as established by the educational facility.

(2) Whether the participant is attending full-time or part-time.

(3) Problems or barriers to involvement as identified in subrule 93.4(5) or 93.14(1).

e. Testing schedule. Participants enrolled in ABE or ESL programs must be able to complete training in the time determined by the testing schedule unless the PROMISE JOBS worker and, if appropriate, the participant's academic advisor or instructor agree that additional time may be allowed. Under no circumstances, however, shall more than 6 additional months be allowed. Additional time shall not be allowed if, as a result, months required to complete training would exceed 24 months for ABE or 12 months for ESL.

93.8(6) *Supportive payments.* PROMISE JOBS may provide payment for certain expenses when needed to participate in approved education and training activities as described in this subrule and in subrule 93.11(4).

a. Eligibility.

(1) Eligibility for PROMISE JOBS supportive payments for education and training begins with the date when the participant begins training under an approved plan or is removed from a waiting list as described at paragraph 93.4(4)*"d,"* whichever is later.

(2) Participant eligibility for payment of transportation and child care payments begins as described in subparagraph 93.8(6)*"a"*(1) and shall be terminated when a training plan is canceled.

(3) Each participant in postsecondary vocational training is limited to 24 fiscal months of PROMISE JOBS payment of expenses needed for participation. The 24 fiscal months do not have to be consecutive. See paragraph *"b"* of this subrule for additional limits on child care expenses.

(4) When more than one facility offers a particular program, payment is limited to the amount required to attend the nearest educational facility except when attending a facility that is farther away will allow the family to reach self-sufficiency earlier.

b. Child care. Participants assigned to educational activities shall receive a child care payment, if required, for each month or part thereof as described at subrule 93.11(2). EXCEPTION: Each PROMISE JOBS participant is limited to 24 fiscal months of child care assistance.

(1) All child care assistance payments issued under the PROMISE JOBS program count toward this limit.

(2) All child care assistance payments issued for child care provided on or after March 1, 2009, count toward this limit, including payments issued while the person was not a PROMISE JOBS participant, pursuant to 441—subparagraph 170.2(2)*"b"*(1).

c. Transportation. Participants assigned to educational activities shall receive a transportation payment for each month or part thereof as described at subrule 93.11(3) unless transportation payments are available from another source.

(1) When a participant receives a transportation payment from another program which equals or exceeds that possible under PROMISE JOBS, transportation shall not be paid by PROMISE JOBS for any month covered by the other program.

(2) When the amount received from another program is less than that possible under PROMISE JOBS, a supplemental payment may be made as long as the combined payment does not exceed that normally paid by PROMISE JOBS.

(3) When a participant is enrolled in high school, a transportation payment shall not be allowed if transportation is available from another source, such as the school district. If child care needs or the needs of the child or the participant make it impractical or inappropriate for the participant to use transportation provided by the school district, a transportation payment may be authorized.

d. Training expenses. Participants enrolled in high school completion, GED, ABE, ESL, or postsecondary vocational training may be eligible for payment of the following expenses of training when required for participation, subject to limits in subrule 93.11(4):

(1) Enrollment fees,

(2) School application fees,

(3) Educational grant or scholarship application fees,

(4) Licensing, certification and testing fees,

(5) Travel costs required for certification or testing, and

(6) Certain practicum expenses as described in subparagraph 93.11(4)*"a"*(3).

e. Direct education costs. Participants enrolled in high school completion, GED, ABE, ESL, or short-term training programs of 29 weeks or less may also be eligible for payment for direct education costs, including:

(1) Tuition,

(2) Books,

(3) Fees including graduation,

(4) Basic school supplies,

(5) Specific supplies related to obtaining credit for a course and required of all students in a course, and

(6) Required uniforms.

f. Supplies purchased with PROMISE JOBS funds. Participants who successfully complete their training plans may keep any books or supplies, including tools, which were purchased with PROMISE JOBS funds. Participants who leave their training program before completion and do not obtain training-related employment within 60 days of leaving training shall return all reusable supplies, including books and tools, but not clothing, purchased by PROMISE JOBS.

(1) The PROMISE JOBS worker is authorized to donate to nonprofit organizations any items determined to be unusable by the PROMISE JOBS program.

(2) When tools are not returned, the amount of the PROMISE JOBS payment shall be considered an overpayment unless the participant verifies theft of the tools through documentation of timely report to a law enforcement agency.

93.8(7) *Documentation.*

a. Plan. The following information shall be documented in the participant's file.

(1) Evaluation results, pursuant to paragraph 93.8(1)*"b"*

(2) Current educational level.

(3) Justification for approval of additional postsecondary education pursuant to subrule 93.5(3).

(4) Academic probationary status pursuant to subrule 93.8(8).

(5) Justification for denial of education. Form 470-0602, Notice of Decision: Services, shall be issued to the participant to deny the request for education.

b. Participation. A participant shall provide documentation of the actual hours of participation in education and homework and of grades and academic progress as described in subrule 93.10(2).

93.8(8) *Academic probation.* A participant may be placed on academic probation for at least one term, or a comparable time limit appropriate to the educational program, after which the participant shall be reevaluated for continued inclusion in education activities. This subrule does not apply to parents under the age of 18 who are attending high school completion programs.

a. Placing a participant on academic probation. The PROMISE JOBS worker may choose to place a participant on academic probation in the following circumstances:

(1) The educational evaluation completed according to paragraph 93.8(1)*"b"* identifies some factors with the participant's ability or past circumstances that could make successful completion of the training difficult but the participant's motivation is high and changes in the participant's life situation indicate a realistic probability of success.

(2) The participant was previously unable to maintain the cumulative grade point average required by a training facility in training comparable to that being requested.

(3) The participant enrolled but did not complete a previous education activity without good cause.

(4) At the end of a term, or of a comparable period applicable to the educational program, the participant is receiving less than a 2.0 grade point average or less than a higher average that is required by the specific training facility or curriculum.

b. Probation outcomes. The participant shall be removed from probation for satisfactory performance if, by the end of the established probationary period, the participant is receiving at least a 2.0 grade point average or a higher average as required by the specific training facility or curriculum.

(1) Reevaluation. If the participant is not receiving the required grade point by the end of the probationary period, the participant shall be reevaluated to determine continued eligibility for

participation in education using the same type of information used to originally evaluate the likelihood of academic success as identified in paragraph 93.8(1)*"b."* Documentation shall meet the requirements as stated in subrule 93.8(7).

(2) Continued probation. Probation may be continued when reevaluation indicates that education is appropriate. The PROMISE JOBS worker may also consider continued probation when:

1. Temporary barriers such as illness or family emergencies that interfered with successful participation have been resolved.

2. Long-term barriers to successful participation have been identified and accommodations developed and implemented.

3. The counselor or the lead instructor in the educational program verifies that there is an excellent likelihood the student will raise the grade point to the acceptable level in the next term or a comparable time limit appropriate to the educational program.

(3) Cancellation of a training plan. The participant's current training plan shall be canceled if the participant has failed to maintain at least a 2.0 grade point average or a higher average required by the specific training facility or curriculum, and reevaluation indicates no mitigating circumstances as listed in subparagraph 93.8(8)*"b"*(2). When a training plan is canceled, the participant will be required to renegotiate the family investment agreement to include either a new, more appropriate training plan or other FIA activities. Form 470-0602, Notice of Decision: Services, shall be issued to the participant to inform the participant that the approval for education is canceled.

93.8(9) *Limited benefit plan.* Participants in education choose a limited benefit plan through the following actions.

a. Failure to participate. The participant fails to maintain education activities or follow training plan requirements as specified in the participant's FIA, and the participant does not have good cause. Procedures at rule 441—93.14(239B) shall apply.

b. Misuse of payments. The participant misuses expense payments to the extent that the training plan is no longer achievable or knowingly provides receipts or any other written statements that have been altered, forged, or, in any way, are not authentic.

441—93.9(239B) Other FIA activities.

93.9(1) *Parenting skills training.*

a. Parents aged 20 or older. For parents who are aged 20 or older when the FIA is signed, activities that strengthen the participant's ability to be a better parent can be considered approvable training under PROMISE JOBS and may be included in the FIA as long as the participant is active in at least one other PROMISE JOBS component. Parents aged 20 or older who do not carry out the parenting skills training described in the FIA shall be considered to have chosen the limited benefit plan, unless family circumstances warrant renegotiation and amendment of the FIA.

b. Parents aged 19 or younger. Parents aged 19 or younger when the FIA is signed are required to include parenting skills training in the FIA, but may be excused from the requirement when documentation of satisfactory completion of parenting skills training is provided before the FIA is signed.

(1) Priority for orientation or assessment. In any month, PROMISE JOBS shall give priority for orientation or assessment services to parents who are already aged 19 in order to establish their responsibility for parenting classes before they are aged 20. This applies to those who are scheduled for orientation, to those who are still in assessment, and to those who have an FIA that must be renegotiated and amended.

(2) FIA requirement. The FIA shall be written or renegotiated and amended to include specific plans for parenting skills training and shall identify the training provider's name and beginning and ending dates of the training. The scheduled training may be in the future to accommodate availability of provider resources. However, it shall occur as soon as is compatible with the circumstances of the family, the other activities in the FIA, and the availability of provider resources, except as specified at paragraph 93.4(4)*"d."*

(3) Parents aged 19 or younger who are participating in a parenting skills training program at the time the FIA is signed shall be allowed to continue in that program, if they choose, as long as the provider is listed in paragraph 93.9(1)*"c"* or meets the requirements of paragraph 93.9(1)*"c"* and documentation of enrollment is provided. The time frames as described in paragraph 93.9(1)*"d"* shall be used to determine the remaining training time to be included in the FIA.

(4) Participation in other activities. Parents aged 19 or younger are not required to be participating in another PROMISE JOBS component to be eligible for parenting skills training. Other PROMISE JOBS components are included in the FIA according to policies at subrule 93.4(4).

c. Approved providers. The sources listed in this paragraph are approvable providers for parenting skills training.

(1) High school departments of family and consumer sciences that offer child development, family relationships, or parenting classes and alternative high school programs for pregnant and parenting teens. Services shall be limited to a minimum of one semester and a maximum of two semesters.

(2) Community colleges, other associate-degree institutions, and baccalaureate-degree institutions that offer child development, family relationships, or parenting classes. Services shall be limited to one semester or two quarters.

(3) Area education agencies; child abuse prevention programs; child and adult food program sponsors; child care resource and referral agencies; family resource centers; maternal and child health centers; family development and self-sufficiency program grantees and other family development providers; Head Start, Head Start parent and child centers, and Early Head Start programs; Iowa State University Extension services such as, but not limit to, the "Best Beginnings" program; private nonprofit social service agencies; and young parent support and information organizations. Services shall be limited to:

1. A minimum of 6 contact hours or six weeks, whichever comes first, and
2. A maximum of 26 contact hours or six calendar months, whichever comes first.

d. Other providers of parenting skills training are approvable as long as they:

(1) Have five of these six elements: child growth and development, child health and nutrition, child safety, positive discipline, relationships, and life skills.

(2) Offer training within the following time frames:

1. A minimum of 6 contact hours or six weeks, whichever comes first, and
2. A maximum of 26 contact hours or six calendar months, whichever comes first.

e. Supportive payments. For participants described in paragraphs 93.9(1)*"a"* and 93.9(1)*"b,"* a child care payment and a transportation payment for each month of participation, or part thereof, as described at subrule 93.11(3), shall be paid if these services are not available from another entity and are required for participation.

(1) Other expenses. Payment for tuition, fees, or books and supplies shall be made only when parenting skills training is not available from a free source in the local area. PROMISE JOBS shall not pay for any expenses that are covered by student financial aid in postsecondary educational institutions as provided elsewhere in these rules.

(2) Continuation of payments. If the participant chooses to continue with the parenting skills training program beyond the designated period of participation described in paragraph 93.9(1)*"c,"* PROMISE JOBS responsibility for payment of expense payments shall not extend beyond the designated period unless completion is delayed by acceptable instances for nonparticipation as stipulated at rule 441—93.14(239B) or barriers to participation at subrule 93.4(5).

f. Participation in parenting skills training. The planned duration of the parenting skills training shall be determined by agreement between the participant and the training provider within the limits described in paragraphs 93.9(1)*"c"* and 93.9(1)*"d."*

(1) In consultation with the PROMISE JOBS worker, the participant and the provider shall design a written agreement and provide a copy to PROMISE JOBS. The agreement shall designate the period during which the mandatory parenting skills training requirement will be fulfilled. The period specified in the agreement or notice of decision shall be included in the FIA.

(2) Participants who fail to carry out this step in the FIA shall be considered to have chosen the limited benefit plan.

g. Failure to complete parenting skills training. Parents aged 19 or younger who do not include parenting skills training in the FIA or do not carry out the parenting skills training described in the FIA shall be considered to have chosen the limited benefit plan. Procedures at rule 441—93.14(239B) shall apply.

93.9(2) *Family development.* Family development services are support services for PROMISE JOBS families at risk of long-term dependency on public assistance. The services are designed to promote, empower, and nurture the family to self-sufficiency and healthy reintegration into the community.

a. PROMISE JOBS may arrange for family development services from entities that meet one of the following criteria wherever these are available. Family development services shall be:

(1) Provided by a family development specialist certified by the University of Iowa College of Social Work, National Resource Center on Family-Based Services; or

(2) Provided under a plan that has been approved by the family development and self-sufficiency (FaDSS) council of the department of human rights.

b. Acceptance of family development services by participants is voluntary except as described at subparagraph 93.4(4)*"c"*(4).

93.9(3) *Family planning counseling.* Referral for family planning counseling is an optional service that shall be offered to each applicant or participant. It is not a component of PROMISE JOBS.

a. The department of human services worker or the PROMISE JOBS worker shall:

(1) Discuss orally and in writing the financial implications of newly born children on the participant's family during PROMISE JOBS orientation or assessment, using a form approved by the department; and

(2) Review information about the basics of family planning; and

(3) Provide a listing of resources in the participant's county of residence or the service delivery area.

b. The FIA shall record participant response to the option of referral for family planning counseling. It is not acceptable for the FIA to have family planning counseling as the only step of the FIA.

c. Supportive payments. No supportive payments are allowed for family planning counseling.

d. Participation. Limited benefit plan policies do not apply to participants who choose not to include family planning counseling in the FIA or who do not carry out the steps of family planning counseling.

441—93.10(239B) Required documentation and verification.

93.10(1) *Written notification to participants.*

a. Notice of meetings, assignments, and issues. PROMISE JOBS shall notify participants in writing of all scheduled meetings, of FIA activity and work-site assignments, and of any participation issues as described at rule 441—93.13(239B). PROMISE JOBS shall also notify the participant in writing when the participant is required to provide medical documentation, verification of hours of participation, employment verification, or any other verification.

(1) PROMISE JOBS shall allow a participant five working days from the date notice is mailed to appear for scheduled meetings unless the participant agrees to an appointment that is scheduled to take place in less than five working days.

(2) PROMISE JOBS shall allow a participant five working days from the date notice is mailed to appear for an FIA activity or work-site assignment or to provide medical documentation, verification of hours of participation, employment verification, or any other verification.

(3) PROMISE JOBS shall allow additional time upon request from the participant when the participant is making every effort but is unable to fulfill requirements within the established time frame.

b. Notice of decision. PROMISE JOBS shall send written notice to each participant in accordance with 441—Chapter 7 when services are approved, rejected, renewed, changed, canceled, or terminated

for failure to cooperate or participate. PROMISE JOBS services are approved when the participant is assigned to begin participation in an activity as written in the FIA.

93.10(2) *Verification of participation and progress.* Hours of participation and a participant's progress in FIA activities must be documented and verified. When the participant is responsible for providing the verification, PROMISE JOBS shall notify the participant in writing as required in subrule 93.10(1).

a. FIA activities directly monitored by PROMISE JOBS. When the FIA activities are provided or directly monitored by PROMISE JOBS staff, such as job club or workplace essentials, the staff will document the participant's hours of attendance and progress in the case file.

b. FIA activities not directly monitored by PROMISE JOBS. When FIA activities are provided by a service provider other than PROMISE JOBS, the provider shall verify the participant's hours of attendance with Form 470-2617, PROMISE JOBS Time and Attendance Report, unless another method is required by this rule.

(1) The provider is expected to specify the participant's hours of attendance and to sign and date the Time and Attendance Report.

(2) The participant is responsible for providing the signed and dated form to PROMISE JOBS within ten calendar days following the end of each month, unless the provider provides the form to PROMISE JOBS within this time frame.

(3) EXCEPTION: If the participant is under age 20 and in high school or GED classes, the participant may verify the hours by completing and submitting the PROMISE JOBS Time and Attendance Report monthly. The training provider does not need to sign the form.

c. Documentation of job search. The participant shall complete and provide documentation of any job search activities that cannot be documented by the PROMISE JOBS worker. The participant shall provide Form 470-3099, Job Search Record, within five working days after the last working day of any week during which the participant has made a job search. The PROMISE JOBS worker shall consider the Job Search Record complete if the form includes:

(1) Sufficient information to identify the employer that was contacted or the activity that was completed,

(2) The date that the contact was made or the date the activity was completed,

(3) The amount of time spent, and

(4) The participant's signature.

d. Employment verification. Participants shall verify actual hours of employment at the time that employment begins, upon FIP approval if employed at the time of application, when changes in hours occur, and no less than once every six months thereafter. Participants may use employer statements or copies of pay stubs, Employer Statement of Earnings Form 470-2844, or may sign Form 470-0429, Consent to Obtain and Release Information, so that the employer may provide information directly to the PROMISE JOBS worker. Participants shall provide verification of actual hours of employment within five working days of the written request from PROMISE JOBS.

e. Documentation of self-employment. At the time of the participant's FIA review, a self-employed participant shall provide documentation of actual hours worked and gross income and business expenses from the last 30 days. Data from more than 30 days may be requested if the last month is not indicative of normal business. The participant shall provide documentation within five working days of the written request from PROMISE JOBS.

f. Distance learning. When a participant is involved in a distance-learning program, PROMISE JOBS will accept the documentation issued by the distance-learning institution verifying that the student participated in the sessions.

(1) Documentation may include the attendance records or log-in and log-out records available on line or in an electronic format. Documentation may also be obtained through an agreement with a support agency that monitors the student's actual participation.

(2) The participant is responsible for providing the documentation within ten calendar days following the end of each month unless the institution provides the documentation to PROMISE JOBS within this time frame.

g. Failure to provide required documentation or verification. Participants who fail to provide documentation or verification as described in this subrule after written notification from PROMISE JOBS as described in subrule 93.10(1) shall be considered to have chosen the limited benefit plan. Procedures at rule 441—93.14(239B) shall apply.

93.10(3) *Verification of problems or barriers*. Participants may be required to provide written verification or supporting documentation of reported problems or barriers to participation, such as but not limited to lack of transportation, family emergency, or existence of a mental or physical disability or limitation or substance abuse.

a. Medical documentation. A participant shall secure and provide written documentation signed by a qualified medical or mental health professional to verify a claimed illness or disability within five working days of a written request by PROMISE JOBS. This time limit may be extended due to individual circumstances, such as the need to obtain an updated evaluation. Acceptable verification includes Form 470-0447, Report on Incapacity, or other statement signed by a qualified medical or mental health professional to verify the existence of an illness, disability, or limitation.

b. Other documentation. A participant shall secure and provide written documentation to verify a claimed problem or barrier to participation within five working days of a written request by PROMISE JOBS. Acceptable documentation may include a signed statement from a third party with knowledge of the problem or barrier.

c. Failure to verify problem or barrier or to provide medical documentation. Failure to provide verification of a problem or barrier or to provide medical documentation as described at subrule 93.10(3) does not directly result in the imposition of a limited benefit plan. Examples of actions that do not directly result in a limited benefit plan include, but are not limited to, failure to provide Form 470-0447, Report on Incapacity, or other statement from a medical or mental health professional to verify the existence of an illness or disability, or a statement from a third party with knowledge about the problem or barrier.

(1) Participants who claim an inability to participate on a full-time basis due to a claimed problem or barrier and who fail to provide verification or medical documentation upon written request may be required to renegotiate the FIA to include full-time participation in FIA activities. Failure to renegotiate the FIA may result in a limited benefit plan.

(2) Participants who claim a problem or barrier caused their failure to participate for the full number of hours identified in their FIA and who fail to provide verification of the problem or barrier or medical documentation upon written request may not be excused for the failure to participate. If the failure is not excused, the failure will result in imposition of a limited benefit plan if the failure meets the criteria described at subrule 93.13(2).

441—93.11(239B) Supportive payments. In order to facilitate successful participation, PROMISE JOBS may provide payment for the expenses listed in this rule. Participants shall submit Form 470-0510, Estimate of Cost, to initiate payments or change the amount of payment for expenses other than child care.

93.11(1) *Eligibility.* Participants are eligible for supportive payments needed for participation in activities in their FIA, subject to the limits in this chapter.

a. Applicants in a limited benefit plan who must complete significant contact with or action in regard to PROMISE JOBS for FIP eligibility to be considered, as described at 441—paragraphs 41.24(8)*"a"* and *"d,"* are eligible for expense payments for the 20 hours of activity. However, PROMISE JOBS services and supportive payments are only available when it appears the applicant will otherwise be eligible for FIP.

b. Applicants who have received 60 months of FIP are eligible for PROMISE JOBS services and payments under the circumstances described at 441—subrule 41.30(3).

93.11(2) *Child care.* Payments for child care shall be issued through the child care assistance program as described at 441—Chapter 170.

a. Payment shall be provided for child care if:

(1) Care is needed for participation in any PROMISE JOBS activity other than orientation,

(2) Payment is not specifically prohibited elsewhere in these rules, and

(3) Payment is not available from another source.

b. Payment shall be issued to the child care provider after the service has been received, as described in 441—subrule 170.4(7).

93.11(3) *Transportation.* Participants may receive a transportation payment for each day that transportation is needed for participation in a PROMISE JOBS activity. Transportation payments shall be determined according to the circumstances of each participant. If necessary, payments shall cover transportation for the participant and child from the participant's home to the child care provider and to the PROMISE JOBS site or activity.

a. Exclusions.

(1) A transportation payment is not available for orientation or for assessment activities that occur on the same day as orientation.

(2) A transportation payment is not available for employment. Participants who are employed shall be entitled to the work expense deduction described at 441—paragraph 41.27(2)*"a"* to cover transportation costs associated with employment.

b. Rate of payment. Payments shall not exceed the rate that the provider would charge a private individual.

(1) Public transportation. For those who use public transportation, the payment shall be based on the normally scheduled days of participation in the PROMISE JOBS activity for the period covered by the payment, using the rate schedules of the local transit authority to the greatest advantage, including use of weekly and monthly passes or other rate reduction opportunities.

(2) Private transportation. For participants who use a privately owned motor vehicle or who hire private transportation, the transportation payment shall be based on a formula which uses the normally scheduled days of participation in the PROMISE JOBS activity for the period covered by the payment multiplied by the participant's anticipated daily round-trip miles and then multiplied by the mileage rate of 30 cents per mile.

c. Special transportation needs. Participants who require, due to a mental or physical disability, a mode of transportation other than a vehicle they operate themselves shall be eligible for payment of a supplemental transportation payment when documented actual transportation costs are greater than transportation payments provided under these rules and transportation is not available from another source.

(1) Medical evidence. To be eligible for a supplemental payment, the participant must provide medical evidence of the need for an alternate mode of transportation due to disability or incapacity. EXCEPTION: A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of disability. The evidence must be from a qualified medical or mental health professional or the state rehabilitation agency. The evidence may be submitted either by letter from the qualified medical or mental health professional or on Form 470-0447, Report on Incapacity.

(2) Resources for examination. When an examination is required and other resources are not available to meet the expense of the examination, the PROMISE JOBS worker shall authorize the examination and submit a claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

(3) Payment rates. Actual costs of transportation by a public or private agency shall be allowed. Costs of transportation provided by private automobile shall be allowed as described in subparagraph 93.11(3)*"b"*(2).

d. Issuance of payments. The transportation payment shall be issued before the first scheduled day of participation in an activity. For participants in the same activity for more than one month, transportation payments shall be issued before the first day of the month of scheduled participation except as described below.

(1) Transportation payments for assessment shall be issued in advance in weekly increments, with payments for the second or third week of assessment being issued as soon as it is determined that the participant will be required to participate in the second or third week of assessment.

(2) Payments for the third and subsequent months of an ongoing activity shall not be authorized before receipt of time and attendance verification, as described at subrule 93.10(2), for the month before the issuance month. EXAMPLE: A transportation payment for June, normally issued after May 15 to be available to the participant by June 1, will not be authorized until time and attendance verification for the month of April has been received in the PROMISE JOBS office.

(3) The amounts of payments for the third and subsequent months of an ongoing activity shall be adjusted by subtracting from normally scheduled days any number of days which represents a difference between the number of scheduled days of activity in the month before the issuance month and the number of actual days attended in that month. EXAMPLE: A transportation payment is issued in May based on 16 scheduled days of participation for June. The participant attends only 14 days of the activity. When preparing to issue the August transportation allowance, the worker subtracts two days from the normally scheduled August activities to calculate the payment. If ten days of participation are scheduled, the transportation payment issued in July for August is calculated using eight days.

(4) Because adjustment for actual attendance is not possible in the last two months of an ongoing activity, transportation payments for the last two months of an ongoing activity shall be subject to transportation overpayment provisions of paragraph 93.11(3)*"e."*

EXCEPTION: A transportation overpayment does not occur for any month in which the participant leaves the PROMISE JOBS activity in order to enter employment.

e. Transportation overpayment. Payment for transportation shall be considered an overpayment subject to recovery in accordance with rule 441—93.12(239B) in the following instances:

(1) When the participant attends none of the scheduled days of participation in a PROMISE JOBS activity, the entire transportation payment shall be considered an overpayment. Recovery of the overpayment shall be initiated when it becomes clear that subsequent participation in the activity is not possible for reasons such as, but not limited to, family investment program ineligibility, establishment of a limited benefit plan, or exemption from PROMISE JOBS participation requirements.

(2) When the participant fails to attend 75 percent of the normally scheduled days of participation in either of the last two months of an ongoing PROMISE JOBS activity or in any transportation payment period of an activity which has not been used for payment adjustment as described at paragraph 93.11(3)*"d,"* an overpayment is considered to have occurred. The amount to recover shall be the difference between the amount for the actual number of days attended and the amount for 75 percent of normally scheduled days.

93.11(4) *Training and education expenses.* Participants shall use PROMISE JOBS payments that they receive to pay authorized expenses.

a. Classroom training. PROMISE JOBS payments for classroom training are limited as follows:

(1) Tuition payments for high school completion, GED, ABE, ESL, or short-term training programs of 29 weeks or less shall not exceed the rate charged by the Iowa community college located nearest the participant's residence which offers a course or program comparable to the one in which the participant plans to enroll. If an Iowa community college does not offer a comparable program, the maximum tuition rate payment shall not exceed the Iowa resident rate charged by the out-of-state area school located nearest the participant's residence.

(2) A standard payment for basic school supplies of $10 per term or actual cost, whichever is higher, shall be allowed for those participants who request it. A claim for actual costs higher than $10 must be verified by receipts.

(3) A per diem payment of $10 for living costs during a practicum shall be allowed when the practicum is required by the curriculum of the training facility, would require a round-trip commuting time of three hours or more per day, and is not available closer to the participant's home. If practicum earnings or other assistance is available to meet practicum living costs, no payment shall be made.

(4) Payments may be authorized to meet the costs of travel required for certification and testing, not to exceed the transportation payment as described at subrule 93.11(3) and the current state employee reimbursement rate for meals and lodging.

(5) Funds may not be used to purchase supplies to enable a participant to begin a private business.

(6) No payment shall be made for jewelry, pictures, rental of graduation gowns, elective courses that require expenditures for field trips or special equipment, such as photography or art supplies, or other items that are not required to complete training for a vocational goal.

b. Retroactive payments. Retroactive payments for transportation and allowable direct education costs shall be allowed only under the following conditions:

(1) If plan approval or removal from a waiting list occurs after the start of the term due to administrative delay or worker delay, payments shall be approved retroactive to the start of the term for which the plan is approved or removal from the waiting list is authorized. If the participant has already paid costs with private resources, the participant shall be reimbursed.

(2) If plan approval is delayed due to the fault of the participant, payment eligibility shall begin with the first day of the month during which the plan is approved or the month in which the participant is removed from a waiting list as described at paragraph 93.4(4)*"d,"* whichever is later. In this instance, there shall be no reimbursement for costs already paid by the participant.

c. Receipts. Participants shall furnish receipts for expenditures that they pay, except for transportation payments. Failure to provide receipts will preclude additional payments. Receipts may be requested for payments paid directly to the training provider if the PROMISE JOBS worker determines it is appropriate.

d. Payments directly to facility. PROMISE JOBS is authorized to provide payment for expenses allowable under these rules to the training facility for the educational expenses of tuition and fees and books and supplies which are provided by the facility and billed to the PROMISE JOBS participant. Payment may also be made to the participant in those situations where payment to the participant is determined to be appropriate by the PROMISE JOBS worker.

93.11(5) *Other expenses.*

a. Birth certificates. PROMISE JOBS funds shall be used to pay costs of obtaining a birth certificate when the birth certificate is needed in order for the participant to complete the workforce development registration process described in subrule 93.3(6).

b. Required clothing and equipment. A participant may receive up to a limit of $100 per work-site assignment for clothing or equipment if required by the work experience site and not covered by the sponsor.

c. Workers' compensation. The department of human services shall provide workers' compensation coverage for all PROMISE JOBS work experience participants.

d. Workforce Investment Act. PROMISE JOBS funds may also be used to pay expenses for PROMISE JOBS participants enrolled in federal Workforce Investment Act (WIA) funded services or activities when those expenses are allowable under these rules.

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441—93.12(239B) Recovery of PROMISE JOBS expense payments. When an applicant, a participant, or a provider receives an expense payment for transportation or other supportive expenses that is greater than allowed under these rules or receives a duplicate payment of an expense payment, an overpayment is considered to have occurred and recovery is required. There are two categories of PROMISE JOBS expense payments subject to recovery: (1) transportation, and (2) other supportive expense payments.

93.12(1) The PROMISE JOBS worker shall notify the department of inspections and appeals (DIA) to record the overpayment in the overpayment recovery system. The outstanding balance of any overpayments that occurred before July 1, 1990, shall be treated in the same manner.

93.12(2) The department of inspections and appeals shall notify the participant or the provider when it is determined that an overpayment exists, as described at 441—subrule 7.5(6).

a. Notification shall include the amount, date, and reason for the overpayment. Upon the participant's request, the local office shall provide additional information regarding the computation of the overpayment.

b. The participant may appeal the computation of the overpayment and any action to recover the overpayment through benefit reduction in accordance with 441—subrule 7.5(6). If a participant or

provider files an appeal request, the PROMISE JOBS unit shall notify the DIA within three working days of receipt of the appeal request.

93.12(3) A PROMISE JOBS overpayment shall be recovered through repayment in part or in full. Repayments received by the PROMISE JOBS unit shall be transmitted to the Department of Human Services, Cashier's Office, Room 14, 1305 E. Walnut Street, Des Moines, Iowa 50319-0144.

a. Overpayments of PROMISE JOBS child care issued for any month before July 1999 shall be subject to recovery rules of the PROMISE JOBS program.

b. Overpayments of child care assistance issued for July 1999, and any month thereafter, are subject to recovery rules of the child care assistance program set forth in rule 441—170.9(234).

93.12(4) When a participant or a provider offers repayment in part or in full before the end of the 30-day appeal period, the PROMISE JOBS unit or the department of human services' local office shall accept the payment. If a subsequent appeal request is received, the PROMISE JOBS unit shall notify the DIA and shall not accept any further payments on the claim. The amount of the voluntary payment shall not be returned to the participant or provider unless the final decision on the appeal directs the department to do so.

93.12(5) When a participant or a provider has been referred to the DIA to initiate recovery, the DIA shall use the same methods of recovery as are used for the FIP program, described at DIA administrative rules 481—71.1(10A) to 71.9(10A), except that the FIP grant shall not be reduced to effect recovery without the participant's written permission.

a. When the participant requests grant reduction on Form 470-0495, Repayment Contract, the grant will be reduced for repayment as described in 441—subrule 46.25(3), paragraphs *"a," "b,"* and *"c."*

b. The DIA is authorized to take any reasonable action to effect recovery of provider overpayments such as, but not limited to, informal agreements, civil action, or criminal prosecution. However, the DIA shall not take any collection action on a provider overpayment that would jeopardize the participant's continued participation in the PROMISE JOBS program.

441—93.13(239B) Resolution of participation issues. PROMISE JOBS participants who do not carry out the responsibilities of the FIA shall be considered to have chosen the limited benefit plan, as described at 441—subrule 41.24(8). The participation issues listed in this rule are those that are important for effective functioning in the workplace or training facility and for the completion of the FIA.

93.13(1) *Notification of participation issue.* When participants appear to be choosing a limited benefit plan by not carrying out the FIA responsibilities, the PROMISE JOBS worker shall send one written reminder or letter as specified in subrule 93.10(1) except when the participant has failed to verify hours of employment or participation as described in 441—paragraph 92.13(2)*"m."* The reminder or letter shall:

a. Clearly identify the participation issue and the specific action needed to resolve it,

b. Clarify expectations,

c. Attempt to identify barriers to participation that should be addressed in the FIA,

d. Explain the consequences of the limited benefit plan, and

e. Offer supervisory intervention.

93.13(2) *Participation issues.* Actions that may cause participants to be considered as having chosen the limited benefit plan are:

a. Tardiness. Participants who are more than 15 minutes late to a scheduled FIA activity for a third time within three months of the first tardiness, after receiving one written reminder at the time the second tardiness occurred.

b. Failure to attend scheduled activities. Participants who do not, for a second time after receiving one written reminder at the first occurrence, appear for scheduled appointments, participate in assessment activities, including taking required vocational or aptitude tests, complete or provide required forms other than those described at subrule 93.10(3) or are absent from activities designated in the FIA.

c. Absence from work experience. Participants who do not, for a second time after receiving one written reminder at the first occurrence, notify work experience sponsors or the PROMISE JOBS worker of an absence within one hour of the time at which they are due to appear.

d. Disruptive behavior. Participants who exhibit disruptive behavior for a second time after receiving one written reminder at the first occurrence. "Disruptive behavior" means the participant hinders the performance of other participants or staff, refuses to follow instructions, uses abusive language, or is under the influence of alcohol or drugs.

e. Unsatisfactory performance or participation. Participants whose performance or participation in an FIA activity continues to be unsatisfactory after PROMISE JOBS sends one letter as described in subrule 93.13(1).

f. Physical threats. Participants who make physical threats to other participants or staff and do not demonstrate that the participant is not at fault by providing written documentation from a doctor, licensed psychologist, probation officer, or law enforcement official after PROMISE JOBS sends one letter as described in subrule 93.13(1).

(1) "Physical threat" means having a dangerous weapon in one's possession and either threatening with or using the weapon or committing assault.

(2) The documentation must verify that the act was caused by either a temporary problem or a serious problem or barrier that needs to be included in the FIA. The documentation must also provide reasonable assurance that the threatening behavior will not occur again.

g. Accepting work experience assignments. Participants who do not accept work experience assignments when the work experience is part of the FIA and do not demonstrate a problem or barrier that caused the failure after PROMISE JOBS sends one letter.

h. Work experience interviews. Participants who do not appear for work experience interviews for a second time after receiving a written reminder at the first occurrence.

i. Employment issues. Participants who do not follow up on job referrals, who refuse offers of employment or terminate employment, or who are discharged from employment due to misconduct.

(1) For the purposes of these rules, "misconduct" means a deliberate act or omission by the employed participant that constitutes a material breach of the duties and obligations arising out of the employee's contract of employment. To be considered misconduct, the employee's conduct must demonstrate deliberate violation or disregard of standards of behavior that the employer has the right to expect of employees. Mere inefficiency, unsatisfactory conduct, failure to perform well due to inability or incapacity, ordinary negligence in isolated instances, or good-faith errors in judgment or discretion shall not be deemed misconduct for the purpose of these rules.

(2) At the time of the occurrence, PROMISE JOBS shall send a letter to the participant regarding the misconduct. The letter shall give the participant an opportunity to resolve the issue by accepting a previously refused employment offer if available, returning to previously terminated employment if available, obtaining comparable employment, or demonstrating a problem or barrier that caused the failure.

j. Failure to secure child care. Participants who do not secure adequate child care when registered or licensed facilities are available after PROMISE JOBS sends one written reminder and when PROMISE JOBS has provided the participant with resources for locating adequate child care.

k. Inappropriate use of funds. Participants for whom child care, transportation, or educational services become unavailable as a result of failure to use PROMISE JOBS funds or child care assistance funds to pay the provider or failure to provide required receipts and who do not demonstrate a problem or barrier that caused the failure after PROMISE JOBS sends one letter.

l. Failure to follow training plan. Education participants who do not follow the requirements of a training plan in the FIA as described at rule 441—93.8(239B).

m. Failure to verify hours of participation. Participants who fail to provide verification of hours of employment or hours of participation in other FIA activities as described at subrule 93.10(2) after being notified in writing of the requirement to provide verification as described at subrule 93.13(1) are not provided with a written reminder or letter before imposition of the limited benefit plan. PROMISE JOBS may void a limited benefit plan imposed under this paragraph if the FIA-responsible person

provides the documentation within ten days of the effective date of the limited benefit plan as described at 441—paragraph 41.24(8)*"f."*

n. Failure to renegotiate the FIA. When a participant fails to respond to the PROMISE JOBS worker's request to renegotiate the FIA because the participant has not attained self-sufficiency by the date established in the FIA, a limited benefit plan shall be imposed regardless of whether the request to renegotiate is made before or after expiration of the FIA.

93.13(3) *Choosing a limited benefit plan.*

a. Before determining that a participant has chosen the limited benefit plan due to a potential participation issue, the PROMISE JOBS worker shall make every effort to negotiate a solution. Local PROMISE JOBS management has the option to involve an impartial third party to assist in a resolution process. Arrangements shall be indicated in the local services plan of the local service delivery region. As part of the resolution process, the PROMISE JOBS worker shall determine:

(1) Whether the participant has a problem that provides good cause for the participation issue, as described in rule 441—93.14(239B). If so, the participant shall be encouraged to take actions to fulfill the FIA.

(2) Whether participant circumstances indicate that a barrier to participation exists, as described in subrule 93.4(5). If so, the FIA shall be negotiated to address the barrier.

b. The participant may be considered to have chosen the limited benefit plan when all of the following occur:

(1) The participant is notified of a participation issue as described in subrule 93.13(1);

(2) The participant does not resolve the participation issue;

(3) The participant does not present acceptable evidence of a problem providing good cause for the issue as described in rule 441—93.14(239B); and

(4) The participant does not present acceptable evidence of a barrier to participation as described in subrule 93.4(5) or fails to renegotiate the FIA to address the identified barrier.

c. If the resolution process does not lead to fulfillment of the FIA, the case shall be referred for review by the administering or contracted service provider agency.

(1) The procedure may include review by state-level staff of the administering or contracted agency or by a regional PROMISE JOBS manager, a PROMISE JOBS supervisor, an income maintenance supervisor, or a combination of any of the above. Approval of any review procedure at less than the state level shall occur only after the service delivery region demonstrates satisfactory performance of the resolution process.

(2) The department of human services retains control and oversees review procedures even when another agency is contracted with to provide PROMISE JOBS services.

d. If the above steps do not lead to fulfillment of the FIA, the FIP participant is considered to have chosen the limited benefit plan and the notice of decision shall be initiated. The notice of decision shall inform the participant of:

(1) The action needed to reconsider the limited benefit plan as described at 441—subparagraph 41.24(8)*"d"*(1).

(2) Appeal rights under the limited benefit plan are described at rule 441—93.15(239B).

441—93.14(239B) Problems that may provide good cause for participation issues.

93.14(1) *Problems leading to less than full participation.* Problems affecting participation shall be considered to be of a temporary or incidental nature when the participation can easily be resumed. The following problems may provide good cause for participation of less than the full number of hours identified in the FIA:

a. Illness of the participant. When a participant is ill more than three consecutive days or if illness is habitual, the PROMISE JOBS worker may require medical documentation of the illness.

b. Illness of family member. When a participant is required in the home due to illness of another family member, the PROMISE JOBS worker may require medical documentation.

c. Family emergency, using reasonable standards of an employer.

d. Bad weather, using reasonable standards of an employer.

e. Absence or tardiness due to participant's or spouse's job interview. When possible, the participant shall provide notice of the interview at least 24 hours in advance including the name and address of the employer conducting the interview. When 24-hour notice is not possible, notice must be given as soon as possible and before the interview.

f. Leave due to the birth of a child. When a child is born after referral, necessary absence shall be determined in accordance with the Family Leave Act of 1993.

g. Court appearance.

h. Attendance at school functions of the participant's children or children in the participant's household.

i. Attendance at required meetings with the department of human services or PROMISE JOBS.

j. Absence due to up to ten holidays per year.

(1) The participant must normally have been scheduled to work, or participate in an unpaid work activity on the given day and the work site or facility is closed due to a holiday, or open but the participant is allowed to take the participant's normally scheduled hours off on a different day.

(2) The holidays included are New Year's Day, Martin Luther King Day, President's Day, Memorial Day, Fourth of July, Labor Day, Veterans Day, Thanksgiving, the day after Thanksgiving, and Christmas.

93.14(2) *Problems leading to refusing or quitting a job or limiting or reducing hours.* The following problems may provide good cause for participation issues of refusing or quitting a job or limiting or reducing hours:

a. Required travel time from home to the job or available work experience or unpaid community service site exceeds one hour each way. This includes additional travel time necessary to take a child to a child care provider.

b. Except as described in 441—subrule 41.25(5), work offered is at a site subject to a strike or lockout, unless the strike has been enjoined under Section 208 of the Labor-Management Relations Act (29 U.S.C. 78A, commonly known as the Taft-Hartley Act), or unless an injunction has been issued under Section 10 of the Railway Labor Act (45 U.S.C. 160).

c. The work site violates applicable state or federal health and safety standards or workers' compensation insurance is not provided.

d. The job is contrary to the participant's religious or ethical beliefs.

e. The participant is required to join, resign from or refrain from joining a legitimate labor organization.

f. Work requirements are beyond the mental or physical capabilities as documented by medical evidence or other reliable sources.

g. Discrimination by an employer based on age, race, sex, color, disability, religion, national origin or political beliefs.

h. Work demands or conditions render continued employment unreasonable, such as working without being paid on schedule.

i. Circumstances beyond the control of the participant, such as interruption of regular mail delivery or other disruptions of services.

j. Employment change or termination is part of the FIA.

k. Job does not pay at least the minimum amount customary for the same work in the community.

l. The participant terminates employment in order to take a better-paying job, even though hours of the new job may be less than those in the previous job.

m. The employment would result in the family of the participant experiencing a net loss of cash income. Net loss of cash income results if the family's gross income less necessary work-related expenses is less than the cash assistance the person was receiving at the time the offer of employment is made. Gross income includes, but is not limited to, earnings, unearned income, and cash assistance. Gross income does not include food stamp benefits and in-kind income.

n. The employment changes substantially from the terms of hire, such as a change in work hours or work shift or a decrease in pay rate.

93.14(3) *Other problems.* The PROMISE JOBS worker may identify circumstances that could negatively impact the participant's achievement of self-sufficiency that are not described in subrule

93.14(1) or 93.14(2). When this occurs, the case shall be referred to the administrator of the division of financial, health and work supports for a determination as to whether the problems are acceptable reasons for:

a. Not participating,

b. Refusing or quitting a job, or

c. Discharge from employment due to misconduct as described at paragraph 93.13(2)*"i."*

441—93.15(239B) Right of appeal. In accordance with 441—Chapter 7, each applicant or participant is entitled to appeal and to be granted a hearing over disputes regarding: (1) services being received; (2) services which have been requested and denied, reduced, canceled, or inadequately provided; and (3) acts of discrimination on the basis of race, sex, national origin, religion, age or handicapping condition.

93.15(1) *Informal resolution process.* When there is a disagreement between the participant and the immediate PROMISE JOBS worker regarding the participant's FIA or participation in PROMISE JOBS components, the participant may request an interview with the supervisor and a decision on the dispute. The supervisor shall schedule a face-to-face interview with the participant within 7 days and issue a decision in writing within 14 days of the participant's request.

93.15(2) *Appeal on the content of the family investment agreement.* A participant shall have the right to appeal the content of the FIA when the informal resolution process described at subrule 93.15(1) does not resolve a disagreement between the participant and the PROMISE JOBS worker.

93.15(3) *Appeal of an alleged violation of PROMISE JOBS program policy.* Participants shall have the right to file a written appeal concerning any alleged violation of a PROMISE JOBS program policy that is imposed as a condition of participation. The responsible agency shall provide the participant with written documentation that specifies the participation requirement in dispute.

93.15(4) *Appeal rights under the limited benefit plan.* A participant has the right to appeal the establishment of the limited benefit plan only once, at the time the department issues the timely and adequate notice that establishes the limited benefit plan. However, when the reason for the appeal is based on incorrect grant computation, an error in determining the eligible group, or another worker error, a hearing shall be granted when the appeal otherwise meets the criteria for hearing.

93.15(5) *Request for a hearing on work conditions or availability of workers' compensation coverage.* A participant who is enrolled in the PROMISE JOBS program may request a hearing if dissatisfied with working conditions, the availability of workers' compensation coverage or the wage rate used in determining hours of work experience program participation.

a. When any involved party is dissatisfied with the department's final decision, the dissatisfied party shall be informed of the right to appeal the issue to the Secretary of Labor, Office of Administrative Law Judges, U.S. Department of Labor, Vanguard Building, Room 600, 111 20th Street N.W., Washington, DC 20036, within 20 days of receipt of the decision. The department may assist with the appeal upon request.

b. For the purposes of this rule, the department's final decision shall be considered received the second day after the date that the written decision was mailed, unless the intended recipient can demonstrate that it was not received on the second day after the mailing date. When the second day falls on a Sunday or legal holiday, the time shall be extended to the next mail delivery day.

c. The option to appeal to the Secretary of Labor does not preclude an individual from exercising any right to judicial review provided in Iowa Code chapter 17A or as described in 441—Chapter 7.

441—93.16(239B) Resolution of a limited benefit plan.

93.16(1) *Resolution process for a first limited benefit plan.* For participants who choose a first limited benefit plan, the notice of decision shall inform the participant of the action needed to reconsider the limited benefit plan as described at 441—subparagraph 41.24(8)*"d"*(1).

a. The notice of decision establishing a first limited benefit plan shall inform the FIP participant that the participant may reconsider at any time from the date timely and adequate notice is issued establishing the limited benefit plan. The notice of decision shall inform the participant that the

participant shall contact the department or appropriate PROMISE JOBS office to reconsider the limited benefit plan.

b. When the participant contacts either the income maintenance worker or the PROMISE JOBS office, the participant shall be scheduled to begin or resume development of the FIA as described elsewhere in these rules.

c. When the FIA is signed, the PROMISE JOBS worker shall notify the department and the limited benefit plan shall be terminated. FIP benefits shall be effective as described at 441—subparagraph 41.24(8)*"d"*(1).

93.16(2) *Resolution process for a subsequent limited benefit plan.* The notice of decision establishing a subsequent limited benefit plan shall inform the FIP participant of the six-month ineligibility period and that the participant may reconsider at any time following the six-month ineligibility period. To reconsider, the participant must complete significant contact with or action in regard to the PROMISE JOBS program as described at 441—subparagraph 41.24(8)*"d"*(3).

a. When the six-month ineligibility period ends and the participant contacts either the income maintenance worker or the PROMISE JOBS office, the participant shall be scheduled to sign a new or updated FIA and to begin significant action as described at 441—subparagraph 41.24(8)*"d"*(3).

b. When the FIA is signed and the participant has satisfactorily completed the significant action, the PROMISE JOBS worker shall notify the department and the limited benefit plan shall be terminated. FIP benefits shall be effective as described at 441—subparagraph 41.24(8)*"d"*(3).

441—93.17(239B) Worker displacement grievance procedure. The PROMISE JOBS program shall provide a grievance procedure to address and resolve public complaints regarding the displacement of regular workers with program participants in a work experience placement.

93.17(1) The procedure shall provide that:

a. Complaints must be filed in writing and received by the PROMISE JOBS service provider within one year of the alleged violation.

b. A representative of the PROMISE JOBS service provider must schedule a face-to-face interview with the complainant within 7 days of the date the complaint is filed, to provide the opportunity for informal resolution of the complaint.

c. Written notice of the location, date and time of the face-to-face interview must be provided.

d. An opportunity must be provided to present evidence at the face-to-face interview.

e. The representative of the PROMISE JOBS service provider shall issue a decision in writing within 14 days of the date a complaint is filed.

f. A written explanation must be provided to all involved parties of the right to file a written appeal, according to 441—Chapter 7, if the opportunity for informal resolution is declined, if a party receives an adverse decision from the PROMISE JOBS service provider, or if there is no decision within the 14-day period.

(1) To be considered, an appeal must be filed with the department within 10 days of the mailing date of the adverse decision or within 24 days of the date a complaint is filed

(2) An appeal hearing will not be granted until informal resolution procedures have been exhausted, unless a decision has not been issued within 24 days of the complaint filing date.

93.17(2) The department shall issue a final decision within 90 days of the date the complaint was filed with the PROMISE JOBS service provider.

93.17(3) Any dissatisfied party shall be informed of the right to appeal the decision of the department to the Secretary of Labor, Office of Administrative Law Judges, U.S. Department of Labor, Vanguard Building, Room 600, 111 20th Street N.W., Washington, DC 20036, within 20 days of the receipt of the department's final decision.

a. For the purposes of this rule, the department's final decision shall be considered received the second day after the date that the written decision was mailed, unless the intended recipient can demonstrate that it was not received on the second day after the mailing date. When the second day falls on a Sunday or legal holiday, the time shall be extended to the next mail delivery date.

b. The option to appeal to the Secretary of Labor does not preclude an individual from exercising any right to judicial review as provided in Iowa Code chapter 17A or as described in 441—Chapter 7.

93.17(4) Upon notice of a complaint or grievance, the PROMISE JOBS office must provide the complaining party with a copy of the grievance procedures, notification of the right to file a formal complaint and instruction on how to file a complaint.

93.17(5) Upon filing a complaint, and at each stage thereafter, each complainant must be notified in writing of the next step in the complaint procedure.

93.17(6) The identity of any person who has furnished information relating to, or assisting in, an investigation of a possible violation must be kept confidential to the extent possible, consistent with due process and a fair determination of the issues.

93.17(7) All employers who participate in the PROMISE JOBS program shall provide assurances that all regular employees are aware of this grievance procedure.

These rules are intended to implement Iowa Code section 239B.17 to 239B.22.

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CHAPTER 153
FUNDING FOR LOCAL SERVICES

[Prior to 7/1/83, see Social Services[770] Ch 131]
[Previously appeared as Ch 131—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
SOCIAL SERVICES BLOCK GRANT

PREAMBLE

This division sets forth the requirements for reporting required for receipt of federal social services block grant (SSBG) funds and service availability and allocation methodology related to those funds.

441—153.1(234) Definitions.

"Direct services" means services provided by staff of the department of human services to clients. This includes the administrative support necessary to maintain and oversee services. Direct services are funded with state and federal dollars.

"State purchase services" means those services the department purchases in every county statewide. State purchase services are funded with state and federal funds.

441—153.2(234) Development of preexpenditure report.

153.2(1) The department of human services shall develop the social services block grant preexpenditure report on an annual basis. The report shall be developed in accordance with the Code of Federal Regulations, Title 45, Part 96, Subpart G, as amended to July 20, 2000. The report shall describe the services to be funded, in what areas services are available and the amount of funding available. The plan shall also indicate the source of funding.

153.2(2) The department shall issue a proposed preexpenditure report before publication of the final report. The proposed report shall be available for public review and comment:

a. In each local office where a service area manager is based during regular business hours for a two-week period; and

b. On the department's Internet Web site, www.dhs.iowa.gov.

153.2(3) The time and scope of public review will be announced each year. The announcement will indicate the time the proposed report can be viewed. The department:

a. Shall make this information available on the department's Internet Web site, www.dhs.iowa.gov, and post signs in each local human services office; and

b. May publish advertisements in each service area listing the time of review.

153.2(4) The department shall accept comments about the preexpenditure report during the specified public review and comment period. Individuals or groups may submit written comments to the service area manager or to the Division of Fiscal Management, Iowa Department of Human Services, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114. The service area manager may arrange public hearings where testimony will be accepted.

153.2(5) The department shall consider the public comment when developing the final preexpenditure report.

153.2(6) A copy of the final preexpenditure report will be available:

a. In each local office where a service area manager is based; and

b. On the department's Internet Web site, www.dhs.iowa.gov.

441—153.3(234) Amendment to preexpenditure report.

153.3(1) The preexpenditure report may be amended throughout the year. The department may file an amendment changing the kind, scope or duration of a service. Decisions to change a direct service or state purchase service will be made by the department.

Prior to filing an amendment the department and the county boards of supervisors will evaluate available funds and the effect any change will have on clients.

153.3(2) An amendment in the preexpenditure report will be posted in the local offices affected by the amendment at least 30 days prior to the effective date of the change. However, in the event funding for the service has been exhausted, an amendment shall be posted immediately notifying the public that the service will no longer be available. The service area manager will, whenever possible, give advance notice of a service termination made necessary because funds have been exhausted. When a service is added or extended, an amendment may be posted immediately and a 30-day posting period is not required.

153.3(3) Individuals or groups may submit written comments to the service area manager or to the Division of Fiscal Management, Iowa Department of Human Services, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

153.3(4) Nothing in this rule will supersede the requirement for notifying clients of adverse action as provided in 441—130.5(234).

441—153.4(234) Service availability.

153.4(1) A client shall apply for services in the appropriate office of the Iowa department of human services.

a. The department shall determine eligibility according to 441—130.3(234).

b. The department shall develop a case plan to monitor the client's progress toward achieving goals as identified in 441—130.7(234).

153.4(2) An eligible client shall receive a service for which the client is eligible, subject to the provisions of 441—Chapter 130, when the service is listed in the geographic area in which the client resides. The geographic area for direct and state purchase is the state.

153.4(3) To the extent federal law prohibits use of federal funds for provision of social service block grant services to persons the department has defined as eligible, state funds shall be used to pay for these services.

441—153.5(234) Allocation of block grant funds.

153.5(1) The department shall follow a cost allocation plan for determining the appropriate administrative costs to be funded with block grant money.

153.5(2) Funding for services shall be allocated in accordance with the annual budgeting process. The department's annual budget is available for review on the department's Internet Web site at www.dhs.iowa.gov. Costs may be shifted in and between service areas to ensure continued statewide availability of services.

441—153.6(234) Local purchase planning process. Rescinded IAB 7/8/92, effective 7/1/92.

441—153.7(234) Advisory committees. Rescinded IAB 3/6/02, effective 7/1/02.

441—153.8(234) Expenditure of supplemental funds. When supplemental funds are issued through the social services block grant as emergency disaster relief, the department shall administer the funds in compliance with the terms of the federal award rather than the provisions of this division.
[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—153.9 and **153.10** Reserved.

These rules are intended to implement Iowa Code section 234.6.

DIVISION II
DECATEGORIZATION OF CHILD WELFARE AND JUVENILE JUSTICE FUNDING

PREAMBLE

Decategorization of child welfare and juvenile justice funding is an initiative intended to establish systems of delivering human services based upon client needs that replace systems based upon a multitude of categorical funding programs and funding sources, each with different service definitions

and eligibility requirements. Decategorization is designed to redirect child welfare and juvenile justice funding to services that are more preventive, family-centered, and community-based in order to reduce use of restrictive approaches that rely on institutional, out-of-home, and out-of-community care.

441—153.11(232) Definitions. For the purposes of this division, the following definitions apply:

"Budget accountability" means that expenditures for decategorization services from a decategorization project's funding pool during the state fiscal year do not exceed the total amount of funding available in the funding pool for the state fiscal year.

"Carryover funding" means moneys designated for a project's decategorization services funding pool that remain unencumbered or unobligated at the close of the state fiscal year.

"Chief juvenile court officer" mean the judicial department official responsible for managing and supervising juvenile court services operations within one of the eight judicial districts.

"Decategorization" means an initiative established pursuant to Iowa Code section 232.188 that is designed to redirect child welfare and juvenile justice funding to services that are more preventive, family-centered, and community-based in order to reduce use of more restrictive approaches.

"Decategorization agreement" means the agreement entered into among representatives of the department of human services, juvenile court services, and the county government in one or more counties to implement a decategorization project in accordance with the requirements of Iowa Code Supplement section 232.188 and this division.

"Decategorization project" means the county or counties that have entered into a decategorization agreement to implement the decategorization initiative in the county or multicounty area covered by the agreement.

"Decategorization services funding pool" or *"funding pool"* means the funding designated for a decategorization project from all sources.

"Department" means the department of human services.

"Governance board" means a decategorization governance board, which is the group that enters into and implements a decategorization agreement.

"Service area manager" means the department official responsible for managing the department's programs, operations, and child welfare budget within one of the eight department service areas.

"Unencumbered or unobligated" means funding within a decategorization services funding pool that is not spent by the project's governance board for a specific program or purpose by the close of the state fiscal year.

441—153.12(232) Implementation requirements. The decategorization initiative shall be implemented through the creation and operation of decategorization projects. One or more counties may jointly agree to form a decategorization project to implement the initiative. The decategorization initiative shall be implemented in accordance with the following requirements:

153.12(1) *Decategorization agreement.* Representatives from the department, juvenile court services, and county government within the county or counties interested in forming a decategorization project shall develop a written agreement to work together to implement decategorization.

153.12(2) *Department approval.* A decategorization project must request and receive approval from the department director.

153.12(3) *Governance board.* A decategorization project shall be implemented by a decategorization governance board.

a. The department director shall ensure that each decategorization project has an operating governance board that includes:

(1) Representatives designated by administrators of the department and of juvenile court services; and

(2) Officials with the authority to represent county government in the affected county or counties.

b. Decategorization projects may choose to expand their governance boards to include representatives from other entities.

153.12(4) *Department information.* The service area manager shall provide the governance board with:

a. Information concerning the department service area's funding allocation for department-administered child welfare service programs; and

b. A copy of the service area's child welfare and juvenile justice annual plan.

153.12(5) *Juvenile justice information.* The chief juvenile court officer shall provide the governance board with information on the judicial district's allocation of funding for juvenile justice service programs.

153.12(6) *Support and coordination.* The department service area manager and the chief juvenile court officer shall:

a. Work with the governance board throughout each state fiscal year to coordinate planning and to target resources most effectively.

b. Regularly provide the governance board with available data concerning child welfare and juvenile justice needs, service trends and expenditures, child welfare and juvenile justice outcomes, and other relevant issues.

c. Work with the governance board to:

(1) Support board planning and service development; and

(2) Promote effective alignment of available financial resources to enhance preventive, family-centered, and community-based services.

441—153.13(232) Role and responsibilities of decategorization project governance boards. The governance board of a decategorization project shall have the following authority and responsibilities:

153.13(1) *Rules of operation.* The governance board shall establish and adopt written rules of operation that are available to the public.

153.13(2) *Open meetings and records.* The governance board shall adhere to statutory requirements for government bodies concerning open meetings and open records procedures as specified in Iowa Code chapters 21 and 22.

153.13(3) *Coordination.* The governance board shall coordinate project planning, decategorization service decisions, and budget planning activities with the service area manager and the chief juvenile court officer for the county or counties comprising the project.

153.13(4) *Right to services.* The governance board shall implement the decategorization initiative in a manner that does not limit the legal rights of children and families to receive services.

153.13(5) *Community service planning.* The governance board shall undertake community planning activities within the county or counties comprising the project. These activities shall be designed to develop services that are more preventive, family-centered, and community-based.

a. As part of decategorization community planning, the governance board shall partner with other community stakeholders to develop service alternatives that provide less restrictive levels of care for children and families within the project area. The governance board shall involve community representatives, including representatives for families and youth and for county organizations, in the development of specific and quantifiable short-term and long-term plans for:

(1) Enhancing preventive, family-centered, and community-based services; and

(2) Reducing reliance on out-of-community care and restrictive interventions.

b. In community planning, the governance board may use information from federal reviews of Iowa's child welfare system and indicators and outcomes from other community planning efforts. The governance board shall coordinate its community planning efforts as much as possible with those of other planning entities in the community, such as but not limited to:

(1) Communities of promise;

(2) Community empowerment;

(3) United Way;

(4) Community partnerships for protecting children;

(5) Comprehensive school improvement planning;

(6) Comprehensive substance abuse agency planning; and

(7) Substance-abuse-free environment (SAFE) program planning.

153.13(6) *Annual service plan.* The governance board shall oversee the development and submission of an annual child welfare and juvenile justice services plan that meets the requirements of rule 441—153.18(232). The governance board shall involve community representatives and county organizations in the development of the plan for the use of the decategorization services funding pool.

153.13(7) *Fiscal management.* The governance board shall manage and have authority over the project's decategorization services funding pool.

a. The governance board shall develop a plan to maintain budget accountability by ensuring during each state fiscal year that there is ongoing accountability for results, fiscal monitoring, and oversight of expenditures from the decategorization services funding pool.

b. Budget planning and decategorization services funding decisions shall be coordinated with the affected service area managers and chief juvenile court officers or their designees throughout each state fiscal year.

c. The governance board shall ensure that expenditures do not exceed the amount of funding available within the funding pool.

d. If necessary, the governance board shall approve actions to reduce expenditures, discontinue programs, or take other action to manage expenditures within the available decategorization services funding pool during each state fiscal year.

153.13(8) *Annual report.* The governance board shall oversee the development and submission of an annual progress report for the decategorization project that meets the requirements of rule 441—153.19(232).

441—153.14(232) Realignment of decategorization project boundaries. If a governance board votes to change the composition of counties participating in the project, the governance board shall send a letter to the department director that describes the nature of the proposed project realignment and is signed by each board member who supports the proposed realignment.

153.14(1) If the realignment request involves the move of one or more counties from one decategorization project to another, the governance board of the project receiving the county or counties shall send a letter to the department director expressing support for the realignment.

153.14(2) The department director shall review the request and within 30 days shall provide a written decision to the project governance boards involved.

a. In evaluating the request, the department director shall consider the reasons expressed for the proposed realignment and the community and budgetary impacts of the realignment.

b. The director may consult with governance board representatives and others before making a decision.

441—153.15(232) Decategorization services funding pool.

153.15(1) *Creation and composition of pool.* The department shall create the decategorization services funding pool for a project by combining funding resources that may be made available to the project from one or more of the following funding sources:

a. The project's allocation of any funding designated for decategorization in a state appropriation. When the general assembly designates a portion of the department's child welfare appropriation specifically for decategorization services, the designated funds shall be allocated to decategorization project services funding pools. Unless otherwise specified by legislation, the designated funds shall be allocated among decategorization projects based solely on each project's share of the population of children under the age of 18.

b. Child welfare and juvenile justice services funds that are:

(1) Specifically designated and committed in writing to the project by the service area manager; and

(2) Accepted by the project's governance board.

c. Any juvenile justice program funds that are:

(1) Specifically designated and committed in writing to the decategorization project by a chief juvenile court officer; and

(2) Accepted by the project's governance board.

d. Any carryover funds available to the project from funding transfers and from operation of decategorization services during the previous state fiscal year.

e. Funds made available to the project from any other funding source, such as another state agency or a grant awarded to the project. Funds awarded to the project under this provision may be subject to specific conditions, reporting requirements, and expenditure limits specified by the entity that awards funding.

153.15(2) *Use of funding pool.* A governance board shall use the funding pool in accordance with the following requirements:

a. The funding pool shall be used to provide services that meet at least one of the following criteria:

(1) Services are flexible;

(2) Services are individualized;

(3) Services are family-centered;

(4) Services are preventive;

(5) Services are community-based;

(6) Services are comprehensive; or

(7) Services promote coordinated service systems for children and families in order to reduce the use of restrictive approaches that rely on institutional, out-of-home, and out-of-community care.

b. The governance board may use the funding pool for enhancements to the child welfare and juvenile justice service systems within the project.

c. The funding pool shall not be used for any of the following services:

(1) Institutional services;

(2) Out-of-home services; or

(3) Out-of-community services.

d. The funding pool shall be expended in accordance with statutes and rules regarding vendor solicitation and service contracting, including Iowa Code chapter 8 and department of administrative services rules at 11—Chapters 106 and 107, Iowa Administrative Code.

153.15(3) *Designation and transfer of department funds.* A service area manager may choose during each state fiscal year to designate and transfer a portion of the service area's child welfare and juvenile justice service allocation to a decategorization project's funding pool. When designating funds, the service area manager and the governance board shall follow these procedures:

a. The service area manager shall provide written notification of any funding designations to the governance boards within the service area by June 1 of the state fiscal year. The service area manager shall specify any special terms and conditions of the funding designation in the written notification to the governance board.

b. The governance board shall consider the offer of designated funding and provide written notification of acceptance or rejection to the service area manager by June 30 of the state fiscal year.

c. If the governance board accepts the designated funding, the funds shall:

(1) Be transferred to the project's decategorization services funding pool; and

(2) Be under the sole management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

d. Any funding from such transfers that remains unencumbered or unobligated at the close of the state fiscal year shall be carryover funding in accordance with subrule 153.15(5).

153.15(4) *Designation and transfer of juvenile justice funds.* A chief juvenile court officer may choose to designate and transfer a portion of the judicial district's juvenile justice program funding to a decategorization project's services funding pool. When designating funds, the chief juvenile court officer and the governance board shall follow these procedures:

a. The chief juvenile court officer shall provide written notification of any funding designations to the governance boards within the judicial district by June 1 of the state fiscal year. The chief juvenile

court officer shall specify any special terms and conditions of the funding designation in the written notification to the governance board.

b. The governance board shall consider the offer of funding and shall provide the chief juvenile court officer with written notification of acceptance or rejection of the funding by June 30 of the state fiscal year.

c. If the governance board accepts the designated funding, the funds shall:

(1) Be transferred to the project's decategorization services funding pool; and

(2) Be under the sole management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

d. Any funding from such transfers that remains unencumbered or unobligated at the close of the state fiscal year shall be carryover funding in accordance with subrule 153.15(5).

153.15(5) *Carryover funding.* Funds allocated to a decategorization project from a legislative appropriation for decategorization services and funds designated and transferred to a decategorization project's funding pool that remain unencumbered or unobligated at the close of a state fiscal year are referred to as "carryover funding." The following procedures shall apply to the determination and use of decategorization carryover funding:

a. Upon the close of a state fiscal year, the department shall determine the exact amount of funding that is unencumbered or unobligated in each project's decategorization services funding pool. The department shall collaborate with governance boards to reconcile expenditure records and determine the amount of carryover funding for each decategorization project.

b. Before December 15 of each state fiscal year, the department shall provide each governance board with written notification of the official amount of carryover funding available from the previous state fiscal year.

c. Carryover funding shall not revert to the state general fund but shall remain available to the governance board until the close of the succeeding state fiscal year.

d. Carryover funding shall be under the authority of the project's governance board. These funds shall be available for expenditure for child welfare and juvenile justice systems enhancements and other purposes of the project as determined by the governance board.

e. Any carryover funding not expended by a decategorization project by the close of the succeeding state fiscal year shall revert to the fiscal authority of the department. The department shall return these funds to the state general fund.

441—153.16(232) Relationship of decategorization funding pool to other department child welfare funding. With the exception of any portion of the service area's child welfare allocation that is allocated by law for decategorization services, each service area's child welfare allocation shall be managed under the authority of the respective service area manager as follows:

153.16(1) *Allocation.* Each service area manager receives an allocation from the state appropriation for child welfare and juvenile justice services funding to meet child welfare and juvenile justice needs within all counties comprising the service area. The service area manager is responsible for meeting service needs throughout the service area within that allocation.

153.16(2) *Budgeting.* The service area manager may establish internal child welfare and juvenile justice services budget targets for the counties comprising the service area. Based on budget monitoring and changes in circumstances, the service area manager may revise the child welfare and juvenile justice budget targets within the service area to provide for the safety, permanency, and well-being of children served in the child welfare and juvenile justice systems.

153.16(3) *Transfer to project.* A service area manager may choose to designate and to transfer a portion of the service area's child welfare allocation to the funding pool of a decategorization project. The service area manager may ask a governance board to accept specific terms and conditions concerning use of this funding. Once funding is transferred to a governance board, the funding is under the management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

153.16(4) *Communication with the governance board.* The service area manager shall regularly communicate with the governance boards within the service area to provide updated data and other information on child welfare and juvenile justice funding amounts, service expenditures and trends, and other issues in order to assist the governance board in service and budget planning.

441—153.17(232) Relationship of decategorization funding pool to juvenile court services funding streams. Funds allocated by the department among the eight judicial districts for the court-ordered services and graduated sanctions programs shall be managed under the authority of the chief juvenile court officer for each judicial district as follows:

153.17(1) *Allocation.* Each chief juvenile court officer receives an allocation from the state appropriation for the court-ordered services and graduated sanction programs. The chief juvenile court officer is responsible for managing needs for these programs throughout the judicial district within that allocation.

153.17(2) *Budgeting.* The chief juvenile court officer may establish internal budget targets for expenditures from the court-ordered services and graduated sanction programs for the counties comprising the judicial district. Based on budget monitoring and changes in circumstances, a chief juvenile court officer may revise the budget targets established within the judicial district to provide programs most effectively for children within the district.

153.17(3) *Transfer to project.* A chief juvenile court officer may choose to designate and to transfer a portion of the judicial district's allocation for court-ordered services and graduated sanction programs to the funding pool of a decategorization project. The chief juvenile court officer may ask a governance board to accept specific terms and conditions concerning use of this funding. Once funding is transferred to a governance board, the funding is under the management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

153.17(4) *Communication with the governance board.* The chief juvenile court officer shall regularly communicate with the governance boards within the judicial district to provide data and other information on juvenile justice program allocation amounts, service expenditures and trends, and other issues that may assist the governance boards in service and budget planning.

441—153.18(232) Requirements for annual services plan. Each decategorization project shall annually develop and submit a child welfare and juvenile justice decategorization services plan.

153.18(1) *Content of plan.* The decategorization services plan shall describe:

a. The project's proposed use of funding from the decategorization services funding pool during the state fiscal year.

b. The community planning and needs assessment process that was used in developing the annual decategorization services plan, including information on:

(1) The community members and organizations that participated in developing the plan; and

(2) Efforts to coordinate with other community planning initiatives affecting children and families.

c. The project's specific and quantifiable short-term plans and desired results for the state fiscal year and how these plans align with the project's long-term plans to improve outcomes for vulnerable children and families by enhancing service systems.

d. The methods that the project will use to track results and outcomes during the year.

e. The project's plans for monitoring and maintaining fiscal accountability, which shall include monitoring:

(1) The performance and results achieved by contractors that receive funding; and

(2) Expenditures from the decategorization services funding pool throughout the state fiscal year.

f. The project's plans to expend projected carryover funds by the conclusion of the state fiscal year.

153.18(2) *Submission of plan.* The decategorization services plan shall be submitted to the department's child welfare administrator and to the Iowa empowerment board by October 1 of each state fiscal year.

441—153.19(232) Requirements for annual progress report. Each decategorization project shall develop and submit an annual progress report.

153.19(1) *Content of report.* At a minimum, the progress report shall:

a. Summarize the project's key activities and the progress toward reaching the project's desired outcomes during the previous state fiscal year.

b. Describe key activities, outcomes, and expenditures for programs and services that received funding from the governance board during the previous state fiscal year.

c. Describe any lessons learned and planning adjustments made by the governance board during the previous state fiscal year.

153.19(2) *Submission of report.* The progress report shall be submitted to the department's child welfare administrator and to the Iowa empowerment board by December 1 of each state fiscal year.

These rules are intended to implement Iowa Code Supplement section 232.188.

441—153.20 to **153.30** Reserved.

DIVISION III
MENTAL ILLNESS, MENTAL RETARDATION, AND
DEVELOPMENTAL DISABILITIES—LOCAL SERVICES
[Rescinded IAB 3/6/02, effective 5/1/02]

441—153.31 to **153.50** Reserved.

DIVISION IV
STATE PAYMENT PROGRAM FOR LOCAL MENTAL HEALTH, MENTAL RETARDATION, AND
DEVELOPMENTAL DISABILITIES SERVICES TO ADULTS WITHOUT LEGAL SETTLEMENT

PREAMBLE

The state payment program provides 100 percent state funds to pay for local mental health, mental retardation, and developmental disabilities services for eligible adults who have no legal settlement in Iowa. The state payment program is intended to enable all eligible residents to receive services from the county mental health, mental retardation and developmental disabilities services fund through the county central point of coordination, regardless of the resident's legal settlement status.

Three basic principles underlie the state payment program.

First, duration of residency, including legal settlement, is not an eligibility factor for local mental health, mental retardation, and developmental disabilities service programs. The state payment program ensures that each of the local mental health, mental retardation, and developmental disabilities services provided by an Iowa county to residents who have legal settlement is also available to residents of that county who do not have legal settlement.

Second, each state is responsible to provide care and services for its own residents. Iowa provides for residents of Iowa.

Third, one's own family is of primary importance to one's well-being. Thus, the state payment program emphasizes that care and services for a person be provided near the person's own family, unless this is contraindicated or impossible to provide.

441—153.51(331) Definitions.

"Adult" means a person who is 18 years of age or older and is a United States citizen or a qualified alien as defined in 8 U.S.C. §1641.

"Applicant" means a person for whom payment is requested from the state payment program.

"Approved county management plan" means the county plan for mental health, mental retardation, and developmental disabilities services developed pursuant to Iowa Code section 331.439 that has been approved by the department's director.

"Central point of coordination" or *"CPC"* means the administrative entity designated by a county board of supervisors or by the boards of supervisors of a consortium of counties to act as the single entry point to the service system established under an approved county management plan.

"County of residence" means the county in Iowa where, at the time an adult applies for or receives services, the adult is living and has established an ongoing presence with the declared, good-faith intention of living permanently or for an indefinite period. The county of residence of an adult who is a homeless person is the county where the adult usually sleeps. "County of residence" does not mean the county where the adult is present for the purpose of:

1. Attending a college or university; or
2. Receiving services in a hospital, a correctional facility, a nursing facility, an intermediate care facility for persons with mental retardation, or a residential care facility.

The county of residence may be transferred using procedures set forth in subrule 153.53(5).

"Department" means the Iowa department of human services.

"Division" means the division of mental health and disability services of the department of human services.

"Homeless person" means a person who lacks a fixed, regular, and adequate nighttime residence and who has a primary nighttime residence that is one of the following:

1. A supervised publicly or privately operated shelter designed to provide temporary living accommodations.
2. An institution that provides a temporary residence for persons intended to be institutionalized.
3. A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

"Legal representative" means a person recognized by law as standing in the place or representing the interests of another; for example, a guardian, conservator, custodian, parent of a minor, or the executor, administrator or next of kin of a deceased person.

"Legal settlement" is a legal status as defined in Iowa Code sections 252.16 and 252.17.

"Member" means a person authorized by the division to receive benefits from the state payment program.

"Provider" means a provider of mental health, mental retardation, or developmental disabilities services that has a valid contract for the service with a county to provide services under a county management plan.

"Resident," for purposes of division IV of this chapter, means a person who is present in the state and who has established an ongoing presence with the declared, good-faith intention of living in Iowa permanently or for an indefinite period.

441—153.52(331) Eligibility requirements. To be eligible for the state payment program, an applicant must meet all of the following conditions.

153.52(1) *Adult status.* The applicant shall be an adult as defined in 441—153.51(331).

153.52(2) *Residency.* The applicant shall be a resident of Iowa, present in the state and without legal settlement in an Iowa county. The applicant shall not be in Iowa for purposes of a visit or vacation nor be traveling through the state to another destination at the time of application for services.

153.52(3) *Eligibility under county management plan.* The applicant shall meet the eligibility criteria established in the approved county management plan for the applicant's county of residence.

153.52(4) *Payment source.* The applicant shall have no other political entity, organization, or other source responsible for provision of or payment for the needed services nor be eligible to have the service funded or provided at no additional cost to the state by another state-funded or federally funded facility or program. The department may, on a case-by-case basis, attempt collection from a legally responsible entity.

441—153.53(331) Application procedure.

153.53(1) *Initiation of application.* The county CPC or the CPC's designee shall be responsible for applying for state payment program funding for any person who may be eligible and whose county of residence is that county.

a. When an applicant is awaiting discharge from a state mental health institute or state resource center, the facility's social worker shall initiate the application and forward it to the CPC of the applicant's

county of residence for completion. If the applicant has no clear county of residence, the application shall be forwarded to the county where the applicant intends to establish residency upon discharge. This county may be designated by the applicant's declaration.

b. Applications shall be made only with the knowledge and consent of the applicant or the applicant's legal representative.

153.53(2) *Application requirements.* The CPC or the CPC's designee shall complete the application, preferably in electronic format. A complete application shall include:

a. A funding request for the applicant showing:

(1) The services being requested,

(2) The total monthly dollar amount needed for the services requested, and

(3) The chart of accounts codes from the county billing system for the requested services.

b. A copy of a legal settlement worksheet that is completed in accordance with provisions of Iowa Code chapter 252 and other applicable laws and rulings of courts; and

c. The client profile report (or equivalent) from a CPC application that contains information necessary for the division to enter the member into the data system used for payment processing.

153.53(3) *Application submission.* The CPC or the CPC's designee shall submit the complete application as defined in subrule 153.53(2) to the division within 15 business days of the date the CPC or designee receives a completed and signed CPC application form containing a properly completed legal settlement worksheet.

153.53(4) *Application date.*

a. Waiting list not in effect. When a waiting list is not in effect, the application date shall be the latest of the following dates:

(1) The date on court commitment documents,

(2) The date on the CPC application form, or

(3) 60 days before the division receives the complete application, if the complete application is received more than 60 days after the date on the CPC application form.

b. Waiting list in effect. When a waiting list is in effect pursuant to subrule 153.54(5), the date of application shall be:

(1) The date on court commitment documents, or

(2) The date the application is moved off the waiting list.

153.53(5) *Transfer of county of residence.* The designated county of residence for an adult may be transferred when it seems more reasonable for the county in which the person is receiving services to assume management of the services.

a. Examples of situations where transfer may be reasonable include, but are not limited to:

(1) The person receiving services has been in a facility for more than a year; and the person no longer has any connection to the county of residence, such as relatives who live there, and, so far as anyone can tell, has no desire to return to the county of residence.

(2) The person receiving services was in the state and county of residence for such a short time before needing services that no real attachment was established in the county of residence.

(3) The person is a student attending a college or university but lives and works in the community 12 months per year.

b. If the county of residence desires a transfer and the county in which the person is receiving services agrees, the county accepting the transfer shall notify the department's state payment program manager. The new county of residence shall complete the application procedures, if necessary, and maintain responsibility for the person's case.

c. If the county of residence desires a transfer and the county in which the services are being received does not agree, the county of residence may appeal for resolution to the residency team established by the mental health, mental retardation, developmental disabilities, and brain injury commission. Either county may appeal the decision of the residency team using the procedures in 441—Chapter 7.

[**ARC 8319B**, IAB 12/2/09, effective 11/1/09]

441—153.54(331) Eligibility determination.

153.54(1) *Approval by county.*

a. The CPC or the CPC's designee shall determine whether an applicant is eligible for services based on the eligibility guidelines contained in the approved county management plan for the applicant's county of residence.

b. The county shall apply any policies and procedures regarding waiting lists to state payment program applicants in the same manner as it applies them to persons who have legal settlement in that county.

153.54(2) *Certification by the department.* Within 15 business days after receipt of a complete application as specified in subrule 153.53(2), division staff shall certify the applicant's eligibility for the state payment program to the central point of coordination.

a. The applicant's legal settlement status shall be ascertained in accordance with Iowa Code sections 252.16 and 252.17 and with other applicable laws, rulings of courts and opinions of the Iowa attorney general.

b. An application shall be approved only when funds are available. When funds are insufficient, the application shall be placed on a statewide waiting list pursuant to subrule 153.54(5).

153.54(3) *Effective date of eligibility.*

a. An applicant's eligibility for state payment program funding shall be effective from the date of application.

b. A member shall remain eligible until:

(1) The member has not received services for 12 months; or

(2) The CPC in the county of residence notifies the state payment program manager that the member is no longer eligible.

153.54(4) *Notification of eligibility decisions.* The CPC or the CPC's designee shall notify the applicant or member of the following decisions in accordance with CPC requirements and procedures:

a. Certification of the applicant's eligibility.

b. A change in a member's services, including termination of service.

153.54(5) *Waiting list.* Funds available for the program shall first be used to continue assistance to persons currently receiving assistance from the program. The department shall start a waiting list when the state payment program appropriation funds are fully encumbered.

a. Notice of waiting list. The department shall notify county CPCs:

(1) Before implementing a waiting list, and

(2) Promptly when the department determines a waiting list is no longer required.

b. Placement on the waiting list. When a waiting list is in effect, all new applications shall be placed on the waiting list, with the following exceptions:

(1) Applicants who are subject to an involuntary commitment when the CPC includes a copy of the evaluation and placement court order documentation with the application packet to verify that the applicant has been involuntarily placed. If this documentation is not included, the application will be placed on the waiting list.

(2) Applicants awaiting community placement from an involuntary inpatient setting.

c. Movement off the waiting list. The department shall review the waiting list every 30 days. As funds are determined available, applications shall be moved off the statewide waiting list. Applicants shall be served on a first-come, first-served basis, as determined by the date and time the complete application is received in the division office.

(1) In cases where applications are received simultaneously, the applicants will be prioritized by the birth month and day (earliest birth date first).

(2) If there are multiple applicants with the same birth month and day, the last four digits of the applicants' social security numbers will be used, with the lowest number being considered first.

d. Notification of applicant status. The department shall notify the CPC of each applicant's status quarterly, unless an application can be removed from the waiting list sooner. When the department notifies the CPC that an application can be removed from the waiting list, the CPC shall:

(1) Verify with the applicant that the services are still needed, and

(2) Notify the applicant that service funding is available for services identified.

[**ARC 8319B**, IAB 12/2/09, effective 11/1/09]

441—153.55(331) Eligible services. Services eligible for reimbursement under the state payment program are the services defined in the approved county management plan of the applicant's county of residence.

153.55(1) *Purchased services.*

a. Service management may be provided through a county CPC process during the period for which services are paid.

b. The county may pay for services as long as the member is eligible and the following criteria are met:

(1) The member is receiving a service that requires funding from the state payment program.

(2) The service is provided under the approved county management plan of the member's county of residence.

(3) The member's county of residence provides or pays for the service from the county mental health, mental retardation, and developmental disabilities services fund for persons who have legal settlement in the county.

(4) Service providers bill the other payment systems for which the member is eligible before billing the county of residence.

153.55(2) *Excluded costs.* The following costs are excluded from payment by the state payment program:

a. Services received before the effective date of eligibility.

b. The cost of local services that the member is eligible to have funded by private sources or by other state or federal programs or funds such as medical assistance program services or services provided in a state institution.

441—153.56(331) Program administration.

153.56(1) *CPC responsibilities.*

a. Financial participation on the part of the member shall be governed by the financial participation provisions of the approved county management plan of the member's county of residence.

b. The CPC or the CPC's designee shall submit to the division's state payment program manager by the fifth business day of each month a report on the eligible services paid for during the previous month. The report shall be submitted electronically and shall include the following data in each record:

(1) The calendar month and year in which the county made the payment.

(2) The name of the county submitting the information.

(3) The member's name.

(4) The member's state identification number.

(5) The member's identification number as assigned under subparagraph 153.56(2)*"a"*(2).

(6) The member's diagnostic group code.

(7) The provider's name.

(8) The chart of accounts code for each service paid.

(9) The number of units paid (if applicable).

(10) The beginning date of each service for which the county paid.

(11) The ending date of each service for which the county paid.

(12) The dollar amount paid.

c. The CPC or the CPC's designee shall include payments made on behalf of members in the data warehouse annual reports required by 441—Chapter 25, Division IV.

153.56(2) *Department responsibilities.* As the sponsoring agency, the department shall be responsible for:

a. Enrolling members as necessary to produce payment to the counties, including:

(1) Maintaining member information in the data system for payment;

(2) Notifying counties of the member identification number required for billing; and

(3) Closing data system files on members as directed by the counties, or when the member has not had any payments processed for a 12-month period.

b. Verifying receipt of monthly payment report files. Within 15 business days of receipt of each county's monthly payment report file, the department shall:

(1) Identify the county's payment amount for that month and the number of clients included in the payment; and

(2) Notify the county of any clients whose costs were denied and the reason for the denial.

c. Generating and reconciling payments to the counties.

d. Receiving and auditing reports of member activity and expenditures from the counties.

153.56(3) *Payment to counties.* The following policies shall govern payment to counties for services furnished to members:

a. Monthly payment. Beginning in May 2007, the department shall make a monthly payment to each county based on the expense report for the previous month that was submitted by the county pursuant to paragraph 153.56(1)*"b."* The department shall process monthly payments by the twentieth day of each month.

b. Prospective payment. The department may make a prospective payment to the county for cash flow purposes by July 10 of each year.

(1) The prospective payment shall be based on the sum of the expense reports that the department received from the county in April, May, and June of that year.

(2) For the state fiscal year ending June 30, 2007, the payments made to the county on or before April 1, 2007, shall be considered the prospective payment.

c. Payment reconciliation. The department and counties shall reconcile the total of the prospective payment and monthly payments made to a county with the total actual expenses paid by the county for that same period.

d. Payment adjustment. Beginning in April of each year, the department may adjust the monthly payment to the county to:

(1) Spend down the balance of the prospective payments previously made; or

(2) Make additional payment to ensure that the county has sufficient moneys for cash flow purposes.

e. Deductions. For the state fiscal year ending June 30, 2007, moneys that the county received but did not expend, according to the report required by paragraph 153.56(1)*"b,"* shall be deducted from the county's subsequent payment.

441—153.57(331) Reduction, denial, or termination of benefits. The member's state payment program benefits may be denied, terminated or reduced according to the provisions of the approved county management plan of the member's county of residence.

441—153.58(331) Appeals.

153.58(1) Decisions regarding eligibility of any applicant and decisions adversely affecting applicants or members who are not eligible may be appealed pursuant to 441—Chapter 7.

153.58(2) Decisions (other than eligibility) adversely affecting applicants or members shall be appealed pursuant to the county CPC's appeal provisions.

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CHAPTER 1
IOWA PROPANE EDUCATION AND RESEARCH COUNCIL

599—1.1(101C) Definitions. As used in these rules, unless the context otherwise requires:

"Council" means the Iowa propane education and research council established pursuant to Iowa Code Supplement section 101C.3.

"Education" means any activity designed to provide consumers and members of the propane industry information regarding propane, propane equipment, mechanical and technical practices, and uses of propane.

"Energy star certification" means meeting energy efficiency standards and guidelines pursuant to the Energy Star Program developed and jointly administered by the United States Environmental Protection Agency and United States Department of Energy.

"Fire marshal" means the state fire marshal as provided in Iowa Code section 100.1.

"Odorized propane" means propane to which an odorant has been added.

"Propane" means a hydrocarbon with a chemical composition that is predominately C_3H_8, whether recovered from natural gas or crude oil, and includes liquefied petroleum gases and mixtures.

"Propane industry" means those persons involved in the production, transportation, and sale of propane, and in the manufacture and distribution of propane utilization equipment.

"Propane industry trade association" means an organization exempt from tax under Section 501(c)(3) or 501(c)(6) of the Internal Revenue Code that represents the propane industry.

"Qualified propane industry organization" means the Iowa Propane Gas Association or any other similarly constituted industry trade association that represents at least 35 percent of the total volume of odorized propane sold at retail in this state.

"Research" means any type of study, investigation, program, or other activity designed to advance the image, desirability, usage, marketability, efficiency, or safety of propane or to further the development of information related to such activities.

"Retail propane dispenser" means a person who sells odorized propane to the ultimate consumer but is not engaged primarily in the business of such sales.

"Retail propane marketer" means a person engaged primarily in the sale of odorized propane to the ultimate consumer or to a retail propane dispenser.

"Weatherization" means activities designed to promote or enhance energy efficiency in a residence or other building including but not limited to the installation of attic, wall, foundation, crawlspace, water heater, and pipe insulation; air sealing including caulking and weather-stripping of windows and doors; installation of windows and doors that qualify for energy star certification; the performance of home energy audits; programmable thermostat installation; and carbon monoxide and radon inspection and detection system installation.

[**ARC 8350B**, IAB 12/2/09, effective 1/6/10]

599—1.2(101C) Organization and operation.

1.2(1) The council shall consist of ten voting members appointed by the fire marshal, nine of whom represent retail propane marketers and one of whom shall be the administrator of the division of community action agencies of the department of human rights. Qualified propane industry organizations shall together nominate all members of the council other than the administrator. A vacancy in the unfinished term of a council member shall be filled for the remainder of the term in the same manner as the original appointment was made.

1.2(2) Other than the administrator, council members shall be full-time employees or owners of a propane industry business or representatives of an agricultural cooperative actively engaged in the propane industry. An employee of a qualified propane industry organization shall not serve as a member of the council. An officer of the board of directors of a qualified propane industry organization or propane industry trade association shall not serve concurrently as a member of the council.

1.2(3) In nominating members of the council, qualified propane industry organizations shall give due consideration to nominating council members who are representative of the propane industry, including representation of all of the following:

a. Interstate and intrastate retail propane marketers.

b. Large and small retail propane marketers, including agricultural cooperatives.

c. Diverse geographic regions of the state.

1.2(4) The fire marshal or a designee may serve as an ex officio, nonvoting member of the council.

1.2(5) The following persons shall be ex officio, nonvoting members of the council designated for three-year terms as follows:

a. A professional firefighter designated by the Iowa Association of Professional Fire Chiefs.

b. A volunteer firefighter designated by the Iowa Firemen's Association.

c. An experienced plumber involved in plumbing training programs designated by the Iowa State Building and Construction Trades Council.

d. A heating, ventilation, and air conditioning professional involved in heating, ventilation, and air conditioning training programs designated by the Iowa State Building and Construction Trades Council.

e. A community college instructor with experience in conducting fire safety programs designated by the Iowa Association of Community College Presidents.

f. A representative of a property and casualty insurance company with experience in insuring sellers of propane gas designated by the Iowa Insurance Institute.

1.2(6) A council member, other than the administrator, shall not receive compensation for the council member's service and shall not be reimbursed for expenses relating to the council member's service.

1.2(7) A member of the council shall not be a salaried employee of the council or of any organization or agency which receives funds from the council.

1.2(8) A council member shall serve a term of three years and shall not serve more than two full consecutive terms. A council member filling an unexpired term may serve not more than a total of seven consecutive years. A former council member may be appointed to the council if the former member has not been a member of the council for a period of at least two years.

1.2(9) Initial appointments to the council shall be for terms of one, two, and three years that are staggered to provide for the future appointment of at least two members each year.

1.2(10) The voting members of the council shall select a chairperson and other officers as necessary from the voting members and shall adopt rules and bylaws for the conduct of business and the implementation of this chapter. The council may establish committees and subcommittees comprised of members of the council and may establish advisory committees comprised of persons other than council members. The council shall establish procedures for the solicitation of propane industry comments and recommendations regarding any significant plans, programs, or projects to be funded by the council.
[**ARC 8350B**, IAB 12/2/09, effective 1/6/10]

599—1.3(101C) Program and project development and implementation.

1.3(1) The council shall develop programs and projects, including programs to enhance consumer and employee safety and training, and enter into agreements for administering such programs and projects as provided in this chapter; provide for research and development of clean and efficient propane utilization equipment; inform and educate the public about safety and other issues associated with the use of propane; and develop programs and projects that provide assistance to persons who are eligible for the low-income home energy assistance program.

1.3(2) The council may develop energy efficiency programs dedicated to weatherization, acquisition and installation of energy-efficient customer appliances that qualify for energy star certification, installation of low-flow faucets and showerheads, and energy efficiency education. The council may by rule establish quality standards in relation to weatherization and appliance installation.

1.3(3) The programs and projects shall be developed to attain equitable geographic distribution of their benefits to the fullest extent practicable. The council shall coordinate its programs and projects with propane industry trade associations and others as the council deems appropriate to provide efficient delivery of services and to avoid unnecessary duplication of activities. The council shall give priority to

the development of programs and projects related to research and development, safety, education, and training.

1.3(4) At the beginning of each fiscal year, the council shall prepare a budget plan for the next fiscal year, including the probable cost of all programs, projects, and contracts to be undertaken. The council shall submit the proposed budget to the fire marshal for review and comment. The fire marshal may recommend appropriate programs, projects, and activities to be undertaken by the council.

1.3(5) The council shall also perform the functions required of a state organization under the federal Propane Education and Research Act of 1996, be the repository of funds received under that Act, and separately account for those funds. The council shall coordinate the operation of the program with the federal council as contemplated by 15 U.S.C. Section 6405. These rules shall be administered and construed as complementary to the federal Propane Education and Research Act of 1996, 15 U.S.C. Section 6401 et seq. These rules shall not be construed to preempt or supersede any other program relating to propane education and research organized and operated under the laws of this state.
[**ARC 8350B**, IAB 12/2/09, effective 1/6/10]

599—1.4(101C) Records, audits and public access to information.

1.4(1) The council shall keep minutes, books, and records that clearly reflect all of the acts and transactions of the council which are public records open to public inspection. The books and records shall indicate the geographic areas where benefits were conferred by each individual program or project in detail sufficient to reflect the degree to which each program or project attained equitable geographic distribution of its benefits. The books of the council shall be audited by a certified public accountant at least once each fiscal year and at such other times as the council may designate. The cost of the audit shall be paid by the council. Copies of the audit shall be provided to all council members, to all qualified propane industry organizations, and to other members of the propane industry upon request. In addition, a copy of the audit and a report detailing the programs and projects conducted by the council and containing information reflecting the degree to which equitable geographic distribution of the benefits of each program or project was attained shall be submitted each fiscal year to the chief clerk of the house of representatives and the secretary of the senate.

1.4(2) The council shall prepare and submit an annual report to the fire marshal and the auditor of state summarizing the activities of the council conducted pursuant to this chapter. The report shall show all income, expenses, and other relevant information concerning assessments collected and expended under these rules. The report shall also include a summary of energy efficiency programs if developed by the council.

1.4(3) The council is subject to the open meeting requirements of Iowa Code chapter 21.
[**ARC 8350B**, IAB 12/2/09, effective 1/6/10]

599—1.5(101C) Funding, assessments collection and investment procedures.

1.5(1) The council and its activities shall be funded by an annual assessment of one-tenth of one cent on each gallon of odorized propane sold.

1.5(2) The owner of odorized propane at the time of odorization or at the time of import shall calculate the amount of the assessment based on the volume of odorized propane sold for use in this state.

1.5(3) The assessment, when made, shall be listed as a separate line item on the bill of sale for the odorized propane and titled "Iowa propane education and research assessment."

1.5(4) Assessments shall be collected by the owner from purchasers of the odorized propane and shall be paid by the owner to the council on a monthly basis by the twenty-fifth day of the month following the month the assessment was collected.

1.5(5) If payment is not made to the council by the due date as required by this subrule, an interest penalty of 1 percent of any amount unpaid shall be imposed against the owner for each month or fraction of a month after the due date, until final payment is made.

1.5(6) Assessments shall be remitted payable to the Iowa Propane Education and Research Council at P.O. Box 57188, Des Moines, Iowa 50317. A completed form for remission, provided by the council upon request, shall accompany the remittance.

1.5(7) Pending the disbursement of assessments collected, the council shall invest moneys collected through assessments and any other moneys received by the council in any of the following:

a. Obligations of the United States or any agency of the United States.

b. General obligations of any state or political subdivision of any state.

c. Any interest-bearing account or certificate of deposit of a bank that is a member of the federal reserve system.

d. Obligations that are fully guaranteed as to principal and interest by the United States.

599—1.6(101C) Termination of the council. On the council's own initiative or on petition to the council by retail propane marketers representing 35 percent of the volume of odorized propane sold in this state, the council shall, at its own expense, arrange for a referendum to be conducted by an independent auditing firm agreed upon by the retail propane marketers, to determine whether the council should be terminated or suspended. Voting rights in the referendum shall be based on the volume of odorized propane sold in this state by each retail propane marketer during the previous calendar year. Each retail propane marketer voting in the referendum shall certify to the independent auditing firm the volume of odorized propane sold by that person as represented by that person's vote. Upon the approval of those retail propane marketers representing more than one-half of the total volume of odorized propane sold in this state, the council shall be terminated or suspended and the general assembly shall consider the repeal of this chapter during its next regular session.

599—1.7(101C) Enforcement, restricted activities and bonding.

1.7(1) The district court is vested with the jurisdiction specifically to enforce this chapter and to prevent or restrain any person from violating this chapter. A successful action for compliance may also require payment by the defendant of the costs incurred by the council in bringing the action.

1.7(2) Moneys collected by the council shall not be used in any manner for influencing legislation or elections, except that the council may recommend statutory changes that would further the purposes of these rules to the general assembly.

1.7(3) In all cases, the price of propane shall be determined by market forces. Consistent with antitrust laws, the council shall not take any action regarding, and this chapter shall not be interpreted as establishing, an agreement to pass along to consumers the cost of the assessment provided for in Iowa Code Supplement section 101C.4.

1.7(4) Any person occupying a position of trust under any provision of these rules shall provide a bond in an amount required by the council. The costs of obtaining the bond shall be paid out of council funds.

599—1.8(101C) Not a state agency. The Iowa propane education and research council is not a state agency.

599—1.9(101C) Penalty. A person who willfully violates the provisions of these rules or willfully renders or furnishes a false or fraudulent report, statement, or record required by the fire marshal pursuant to this chapter is guilty of a simple misdemeanor.

These rules are intended to implement Iowa Code Supplement chapter 101C.

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CHAPTER 7
IMPASSE PROCEDURES

621—7.1(20) General. Except as provided in the second paragraph of subrule 7.5(6), the rules set forth in this chapter are applicable only in the absence of an impasse agreement between the parties or the failure of either to utilize its procedures. Nothing in these rules shall be deemed to prohibit the parties, by mutual agreement, from proceeding directly to binding arbitration at any time after impasse.

621—7.2(20) Fees of neutrals. Transferred to 621—1.8(20,279), IAB 11/14/90, effective 12/19/90.

621—7.3(20) Mediation.

7.3(1) *Request for mediation.* Either party to an impasse may request the board in writing to appoint a mediator to the impasse.

An original and one copy of the request for mediation shall be filed with the board and shall, in addition to the request for mediation, contain:

a. The name, address, and telephone number of the requesting party, and the name, address, business and residential telephone numbers of its bargaining representative or chairperson of its bargaining team.

b. The name, address, and telephone number of the opposing party to the impasse, and the name, address, business and residential telephone numbers of its bargaining representative or chairperson of its bargaining team.

c. A description of the collective bargaining unit or units involved and the approximate number of employees in each unit.

d. A concise and specific listing of the negotiated items upon which the parties have reached impasse.

7.3(2) *Date, signature and notice.* The request for mediation shall be dated and signed by an authorized representative of the requesting party. The requesting party shall also serve a copy of the request upon other parties to the negotiations either by personal delivery or by ordinary mail.

7.3(3) *Appointment of mediator.* Upon receipt of a request for mediation, the board may appoint an impartial and disinterested person as mediator of the dispute and notify all parties of the appointment of the mediator. The board shall determine the effective date of this appointment.

7.3(4) *Confidential nature of mediation.* Any information, either written or oral, disclosed by the parties to the mediator in the performance of mediation duties shall not be discussed by the mediator voluntarily or by compulsion unless approved by the parties involved.

The mediator shall not disclose any information with regard to any mediation conducted on behalf of any party to any cause pending in a proceeding before a court, board, investigatory body, arbitrator or fact finder without the written consent of the public employment relations board. Without such written consent, the mediator shall respectfully decline, by reason of this rule, to divulge any information disclosed by a party in the performance of the mediator's duties.

7.3(5) *Mediation proceedings.* The mediator may hold separate or joint meetings with the parties or their representatives, and those meetings shall not be public. Mediation meetings shall be conducted at a time and place designated by the mediator. If an impasse exists ten days after the effective date of the appointment of a mediator, the mediator shall so notify the board.

7.3(6) *Board mediator.* When the mediator is an employee of the Public Employment Relations Board, that mediator shall not participate in any contested case arising out of any transaction or occurrence relating to those mediation activities.

7.3(7) *Costs of mediation.* The mediator shall submit in writing to the board a list of fees and expenses.

[**ARC 8317B**, IAB 12/2/09, effective 11/1/09; **ARC 8338B**, IAB 12/2/09, effective 11/10/09]

621—7.4(20) Fact-finding.

7.4(1) *Appointment of fact finder.* Upon notification by the mediator that the dispute remains unresolved, or if the dispute remains unresolved ten days after the effective date of the appointment of

the mediator, the board shall appoint a fact finder, except in disputes where all or a portion of the public employees in the bargaining unit are teachers licensed under Iowa Code chapter 260 and the public employer is a school district, community college, or area education agency. Where the parties and the mediator agree, the board shall appoint the mediator to serve as fact finder. The board may permit the parties to select their fact finder from a list of qualified neutrals maintained by the board. The board retains the authority to appoint a fact finder as provided in Iowa Code section 20.21.

7.4(2) *Powers of the fact finder.* The fact finder shall have the power to conduct a hearing, administer oaths and request the board to issue subpoenas. The subject of fact-finding shall be the impasse items unresolved by mediation. By mutual agreement, the fact finder may also assist the parties in negotiating a settlement.

7.4(3) *Notice of hearing and exchange of proposal.* The appointment of the fact finder shall be effective the date of the commencement of the fact-finding hearing. The board or fact finder shall establish the time, place and date of hearing and shall notify the parties of the same. The parties shall exchange copies of all proposals to be presented to the fact finder at least five days prior to the commencement of the fact-finding hearing; provided, however, that the parties may continue to bargain and nothing in this section shall preclude a party from making a concession or amending its proposals in the course of further bargaining. No party shall present a proposal to the fact finder which has not been offered to the other party in the course of negotiations.

7.4(4) *Briefs and statements.* The fact finder may require the parties to submit a brief or a statement on the unresolved impasse items.

7.4(5) *Hearing.* A fact-finding hearing shall be open to the public and shall be limited to matters which will enable the fact finder to make recommendations for settlement of the dispute.

7.4(6) *Report of the fact finder.* Within 15 days of appointment, the fact finder shall issue to the parties a "Report of Fact Finder" consisting of specific findings of fact concerning each impasse item, and separate therefrom, specific recommendations for resolution of each impasse item. In addition, the report shall recite the impasse items resolved by the parties during fact-finding and withdrawn from further impasse procedures. The report shall also identify the parties and their representatives and recite the time, date, place and duration of hearing sessions. The fact finder shall serve a copy of the report to the parties and file the original with the board.

7.4(7) *Action on fact finder's report.* Upon receipt of the fact finder's report, the public employer and the certified employee organization shall immediately accept the fact finder's recommendations or shall within five days submit the fact finder's recommendations to the governing body and members of the certified employee organization for acceptance or rejection. "Immediately" shall mean a period of not longer than 72 hours from said receipt. Notice to members of the employee organization shall be as provided in 621—subrule 6.4(20).

7.4(8) *Publication of report by board.* If the public employer and the employee organization fail to conclude a collective bargaining agreement ten days after their receipt of the fact finder's report and recommendations, the board shall make the fact finder's report and recommendations available to the public.

7.4(9) *Cost of fact-finding.* The fact finder shall submit to the parties a written statement of fee and expenses with a copy sent to the board. The parties shall share the costs of fact-finding equally.

621—7.5(20) Binding arbitration.

7.5(1) *Request for arbitration.* At any time following the making public by the board of the fact finder's report and recommendations, either party to an impasse may request the board to arrange for binding arbitration. In disputes unresolved after mediation where all or a portion of the public employees in the bargaining unit are teachers licensed under Iowa Code chapter 260 and the public employer is a school district, community college, or area education association, such request may be made not less than ten days after the effective date of the appointment of the mediator but must be made not later than April 16 of the year when the resulting collective bargaining agreement is to become effective.

7.5(2) *Form and contents of request.* The request for arbitration shall be in writing and shall include the name, address and signature of the requesting party and the capacity in which acting.

7.5(3) *Service of request.* The requesting party shall serve a copy of the request for arbitration upon the opposing party by ordinary mail.

7.5(4) *Preliminary information.* Within four days of the filing of the request with the board for arbitration, each party shall submit to the board the following information:

a. Final offers shall not be amended. A party shall not submit an offer for arbitration which has not been offered to the other party in the course of negotiations.

b. Two copies of the final offer of the party on each impasse item.

c. Two copies of the agreed upon provisions of the proposed collective bargaining agreement.

d. The name of the parties' selected arbitrator, or name of a single arbitrator where the parties agree to submit the dispute to a single arbitrator.

e. Certificate of service upon the opposing party of items *"b"* and *"d"* above.

7.5(5) *Selection of chairperson.* Within eight days of the filing of the request for arbitration, the arbitrators selected by each party shall attempt to agree upon the selection of a third person to act as chairperson of the arbitration panel. If the parties to the impasse fail to agree upon an arbitration chairperson within the time allotted under this rule, the board shall submit a list of three persons who have agreed to act as arbitration chairperson to the parties. The parties shall then select the arbitration chairperson from the list as provided by the Act.

7.5(6) *Date and conduct of hearings.* Impasse items are deemed submitted to binding arbitration on the date of the commencement of the arbitration hearing, regardless of its duration. In disputes where the public employer is a community college, or where all or a portion of the public employees in the bargaining unit are teachers licensed under Iowa Code chapter 260 and the public employer is a school district or area education agency, the submission of impasse items to binding arbitration shall occur not later than May 13 of the year when the resulting collective bargaining agreement is to become effective.

Arbitration hearings shall be open to the public and shall be recorded either by mechanized means or by a certified shorthand reporter. The arbitration hearing shall be limited to those factors listed in Iowa Code section 20.22 and such other relevant factors as may enable the arbitrator or arbitration panel to select the fact finder's recommendation (if fact-finding has taken place) or the final offer of either party for each impasse item. Arbitrators appointed pursuant to impasse procedures agreed upon by the parties shall likewise consider the factors listed in section 20.22.

7.5(7) *Continued bargaining.* The parties may continue to bargain on the impasse items before the arbitrator or arbitration panel until the arbitrator or arbitration panel announces its decision. Should the parties reach agreement on an impasse item, they shall immediately report their agreement to the arbitrator or arbitration panel. The arbitrator or arbitration panel shall add the agreed upon term to the collective bargaining contract and shall no longer consider the final offers of the parties or the fact finder's recommendation on that impasse item.

7.5(8) *Report of the arbitrator or arbitration panel.* Within 15 days after its first meeting (unless such time period is waived by the parties), the arbitrator or arbitration panel shall issue the award and serve each party and the board with a copy by ordinary mail. In reaching the panel decision, the chairperson may communicate telephonically, by mail, or may meet individually or collectively with the other panel members.

7.5(9) *Dismissal of arbitrator or arbitration panel.* In the event of a failure of the arbitrator or arbitration panel to issue the award within 15 days of the first meeting, the arbitrator or chairperson of the arbitration panel shall notify the board and the parties of this failure. Either party may thereafter request a new arbitrator or arbitration panel. Unless the parties agree otherwise, the procedures in subrules 7.5(1) to 7.5(5) shall apply; provided, however, that the parties may submit new final offers and nominate different arbitrators. No arbitrator or arbitration panel shall issue a partial award except by mutual consent of the parties.

7.5(10) *Costs of arbitration.* The arbitrator shall submit to the parties a written statement of fees and expenses with a copy sent to the board. The parties shall share the costs of arbitration equally.

621—7.6(20) Impasse procedures after completion deadline.

7.6(1) *Objections.* Any objection by a party to the conduct of fact-finding or arbitration proceedings which will not be completed by the applicable deadline for completion of impasse procedures shall be filed with the board and served upon the other party. Such filing and service shall take place no later than 20 days prior to the applicable deadline for completion of impasse procedures, 10 days after the effective date of the appointment of the mediator, or 10 days after the filing with the board of a request for arbitration, whichever occurs later. For purposes of this rule, a request for arbitration which is filed prior to the applicable filing period specified in subrule 7.5(1) shall be deemed filed on the first day of that filing period. Failure to file an objection in a timely manner may constitute waiver of such objection, in which case the applicable deadline for completion of impasse procedures shall not apply.

7.6(2) *Response to objection.* The nonobjecting party may, within 10 days following the filing of an objection with the board, file a response asserting that, because of deliberate delay on the part of the objecting party, or unavoidable casualty, misfortune or other events beyond the parties' control, impasse procedures should continue beyond the applicable deadline. A response may additionally or alternatively assert that the deadline relied upon by the objecting party is inapplicable for reasons set forth in the response, or may assert other reasons why impasse procedures should not be terminated. If a response is not filed within the time allowed by this subrule, the board may issue an order terminating further impasse procedures.

7.6(3) *Procedure.* Filing of an objection before the applicable deadline for completion of impasse procedures shall not affect the obligation of each party to continue the impasse procedures. Further, the board may postpone hearing on the objection if it determines that a fact finder's recommendation or arbitration award may be rendered on or before the applicable deadline; in making that determination, the board will attempt to expedite any remaining impasse proceedings, but no party shall be required to waive or shorten any mandatory statutory time periods which apply to that party.

7.6(4) *Hearings.* Insofar as is applicable, hearings on a party's objection shall be conducted pursuant to 621—Chapter 2. The nonobjecting party shall proceed first and shall have the burden to show that fact-finding or arbitration should not be terminated. The board shall then issue a final order that further impasse procedures should be either terminated or completed.

621—7.7(20) Impasse procedures for state employees.

7.7(1) *Procedures.* Statutory procedures in Iowa Code sections 20.20 to 20.22, and independent impasse procedures negotiated by the parties must provide that the impasse be submitted to binding arbitration and the arbitration hearing concluded no later than February 28, and that any arbitrator's award will be issued on or before March 15. This rule does not preclude the parties from mutually agreeing to a date other than February 28, but the agreement must result in an arbitration award on or before March 15.

7.7(2) *Independent procedures.* Independent impasse procedures negotiated by the parties must provide that the impasse will be submitted to binding arbitration, and any hearing thereon concluded no later than February 28, and that any arbitrator's award will be issued on or before March 15.

7.7(3) *Statutory procedures.* In the absence of independent procedures, the procedures in sections 20.20 to 20.22 and rules 7.1(20) to 7.5(20) shall apply, except that a single party request for mediation must be filed no later than December 14 and the appointment of a fact finder by the board will be made by December 24, effective the date of hearing, which shall be no later than January 10. A request for binding arbitration must be filed by February 1, and any impasse must be submitted to the arbitrator(s), and hearing concluded no later than February 28.

7.7(4) *New certifications.* Statutory impasse procedures under these rules shall not be available if the employee organization has been certified later than December 1. This rule does not preclude the parties from negotiating independent impasse procedures if an employee organization is certified after December 1 and the procedures will result in an arbitration award on or before March 15.

7.7(5) *Negotiability disputes.* Disputes concerning the negotiability of any subject of bargaining shall be submitted to the board for determination pursuant to 621—6.3(20) no later than March 1. An arbitration award rendered prior to final determination of the negotiability dispute will be made

conditional upon such determination. Notwithstanding the provisions of 621—2.19(20), no stay of impasse procedures will be granted during the pendency of any negotiability dispute, petition for declaratory order, or prohibited practice complaint.

This rule is intended to implement Iowa Code section 20.17.

These rules are intended to implement Iowa Code chapter 20.

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[1] Effective date of 7.2 delayed by the Administrative Rules Review Committee 45 days after convening of the next General Assembly pursuant to §17A.8(9).

PUBLIC HEALTH DEPARTMENT[641]

Rules of divisions under this department "umbrella" include Substance Abuse[643], Professional Licensure[645], Dental Examiners[650], Medical Examiners[653], Nursing Board[655] and Pharmacy Examiners[657]

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PLUMBING AND MECHANICAL SYSTEMS BOARD—WAIVERS OR VARIANCES FROM ADMINISTRATIVE RULES

641—31.1(17A,105,272C) Definitions. For purposes of this chapter:

"Board" means the Iowa plumbing and mechanical systems board.

"Waiver or variance" means action by the board 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. For simplicity, the term "waiver" shall include both a waiver and a variance.

[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

641—31.2(17A,105,272C) Scope of chapter. This chapter outlines generally applicable standards and a uniform process for the granting of individual waivers from rules adopted by the board in situations where no other more specifically applicable law provides for waivers. To the extent another more specific provision of law governs the issuance of a waiver from a particular rule, the more specific provision shall supersede this chapter with respect to any waiver from that rule.

[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

641—31.3(17A,105,272C) Applicability of chapter. The board may only grant a waiver from a rule if the board has jurisdiction over the rule and the requested waiver is consistent with applicable statutes, constitutional provisions, or other provisions of law. The board may not waive requirements created or duties imposed by statute.

[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

641—31.4(17A,105,272C) Criteria for waiver or variance. In response to a petition completed pursuant to rule 641—31.6(17A,105,272C), the board may in its sole discretion issue an order waiving in whole or in part the requirements of a rule if the board finds, based on clear and convincing evidence, all of the following:

1. The application of the rule would impose an undue hardship on the person for whom the waiver is requested;
2. The waiver from the requirements of the rule in the specific case would not prejudice the substantial legal rights of any person;
3. The provisions of the rule subject to the petition for a 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 a means other than that prescribed in the particular rule for which the waiver is requested.

[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

641—31.5(17A,105,272C) Filing of petition. A petition for a waiver must be submitted in writing to the board as follows:

31.5(1) *License application.* If the petition relates to a license application, the petition shall be made in accordance with the filing requirements for the license in question and submitted to the board administrator.

31.5(2) *Contested cases.* If the petition relates to a pending contested case, the petition shall be filed in the contested case proceeding, using the caption of the contested case, and submitted to the board administrator.

31.5(3) *Other.* If the petition does not relate to a license application or a pending contested case, the petition may be submitted to the board's administrator.

[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

641—31.6(17A,105,272C) Content of petition. A petition for waiver shall include the following information where applicable and known to the requester:

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

2. A description and citation of the specific rule from which a waiver is requested.

3. The specific waiver requested, including the precise scope and duration.

4. The relevant facts that the petitioner believes would justify a waiver under each of the four criteria described in 641—31.4(17A,105,272C). This statement shall include a signed statement from the petitioner attesting to the accuracy of the facts provided in the petition, and a statement of reasons that the petitioner believes will justify a waiver.

5. A history of any prior contacts between the board and the petitioner relating to the regulated activity or license affected by the proposed waiver, including a description of each affected license held by the requester, any notices of violation, contested case hearings, or investigative reports relating to the regulated activity or license within the last five years.

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

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

8. The name, address, and telephone number of any person or entity that would be adversely affected by the granting of a petition.

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

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

[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

641—31.7(17A,105,272C) Additional information. Prior to issuing an order granting or denying a waiver, the board may request additional information from the petitioner relative to the petition and surrounding circumstances. If the petition was not filed in a contested case, the board may, on its own motion or at the petitioner's request, schedule a telephonic or in-person meeting between the petitioner and the board's administrator, a committee of the board, or a quorum of the board.

[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

641—31.8(17A,105,272C) Notice. The board shall acknowledge a petition upon its receipt in the office of the board's administrator. The board shall ensure that notice of the pending petition and a concise summary of its contents have been provided to all persons to whom notice is required by any provision of law within 30 days of the receipt of the petition. In addition, the board may give notice to other persons. To accomplish this notice provision, the board may require the petitioner to serve the notice on all persons to whom notice is required by any provision of law and provide a written statement to the board attesting that notice has been provided.

[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

641—31.9(17A,105,272C) Hearing procedures. The provisions of Iowa Code sections 17A.10 to 17A.18A regarding contested case hearings shall apply to any petition for a waiver filed within a contested case, and shall otherwise apply to agency proceedings for a waiver only when the board so provides by rule or order or is required to do so by statute.

[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

641—31.10(17A,105,272C) Ruling. An order granting or denying a waiver shall be in writing and shall contain a reference to the particular person and rule or portion thereof to which the order pertains, a statement of the relevant facts and reasons upon which the action is based, and a description of the precise scope and duration of the waiver if one is issued.

31.10(1) *Board discretion.* The final decision on whether the circumstances justify the granting of a waiver shall be made at the sole discretion of the board, upon consideration of all relevant factors. Each petition for a waiver shall be evaluated by the board based on the unique, individual circumstances set out in the petition.

31.10(2) *Burden of persuasion.* The burden of persuasion rests with the petitioner to demonstrate by clear and convincing evidence that the board should exercise its discretion to grant a waiver from a board rule.

31.10(3) *Narrowly tailored.* A waiver, if granted, shall provide the narrowest exception possible to the provisions of a rule.

31.10(4) *Administrative deadlines.* When the rule from which a waiver is sought establishes administrative deadlines, the board shall balance the special individual circumstances of the petitioner with the overall goal of uniform treatment of all similarly situated persons.

31.10(5) *Conditions.* The board may place any condition on a waiver that the board finds desirable to protect the public health, safety, and welfare.

31.10(6) *Time period of waiver.* A waiver shall not be permanent unless the petitioner can show that a temporary waiver would be impracticable. If a temporary waiver is granted, there is no automatic right to renewal. At the sole discretion of the board, a waiver may be renewed if the board finds that grounds for a waiver continue to exist.

31.10(7) *Time for ruling.* The board shall grant or deny a petition for a waiver as soon as practicable but, in any event, shall do so within 120 days of its receipt, unless the petitioner agrees to a later date. However, if a petition is filed in a contested case, the board shall grant or deny the petition no later than the time at which the final decision in that contested case is issued.

31.10(8) *When deemed denied.* Failure of the board to grant or deny a petition within the required time period shall be deemed a denial of that petition by the board. However, the board shall remain responsible for issuing an order denying a waiver.

31.10(9) *Service of order.* Within seven days of its issuance, any order issued under this chapter shall be transmitted to the petitioner or the person to whom the order pertains, and to any other person entitled to such notice by any provision of law.

[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

641—31.11(17A,105,272C) Public availability. All orders granting or denying a waiver petition shall be indexed, filed, and available for public inspection as provided in Iowa Code section 17A.3. Petitions for a waiver and orders granting or denying a waiver petition are public records under Iowa Code chapter 22. Some petitions or orders may contain information the board is authorized or required to keep confidential. The board may accordingly redact confidential information from petitions or orders prior to public inspection.

[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

641—31.12(17A,105,272C) Summary reports. Semiannually, the board shall prepare a summary report identifying the rules for which a waiver has been granted or denied, the number of times a waiver was granted or denied for each rule, a citation to the statutory provisions implemented by these rules, and a general summary of the reasons justifying the board's actions on waiver requests. If practicable, the report shall detail the extent to which the granting of a waiver has affected the general applicability of the rule itself. Copies of this report shall be available for public inspection and shall be provided semiannually to the administrative rules coordinator and the administrative rules review committee.

[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

641—31.13(17A,105,272C) Cancellation of a waiver. A waiver issued by the board pursuant to this chapter may be withdrawn, canceled, or modified if, after appropriate notice and hearing, the board issues an order finding any of the following:

1. The petitioner or the person who was the subject of the waiver order withheld or misrepresented material facts relevant to the propriety or desirability of the waiver; or
2. The alternative means for ensuring that the public health, safety and welfare will be adequately protected after issuance of the waiver order have been demonstrated to be insufficient; or
3. The subject of the waiver order has failed to comply with all conditions contained in the order.

[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

641—31.14(17A,105,272C) Violations. Violation of a condition in a waiver order shall be treated as a violation of the particular rule for which the waiver was granted. As a result, the recipient of a waiver under this chapter who violates a condition of the waiver may be subject to the same remedies or penalties as a person who violates the rule at issue.
[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

641—31.15(17A,105,272C) Defense. After the board issues an order granting a waiver, the order is a defense within its terms and the specific facts indicated therein for the person to whom the order pertains in any proceeding in which the rule in question is sought to be invoked.
[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

641—31.16(17A,105,272C) Judicial review. Judicial review of a board's decision to grant or deny a waiver petition may be taken in accordance with Iowa Code chapter 17A. Any appeal to district court shall be taken within 30 days from the date of issuance of the decision by the board pursuant to Iowa Code section 17A.19.
[**ARC 8359B**, IAB 12/2/09, effective 1/6/10]

These rules are intended to implement Iowa Code chapters 17A, 105, and 272C.

[Filed ARC 8359B (Notice ARC 8173B, IAB 9/23/09), IAB 12/2/09, effective 1/6/10]

CHAPTERS 32 to 36
Reserved

CHAPTER 5
FEES

645—5.1(147,152D) Athletic training license fees. All fees are nonrefundable.

5.1(1) License fee for license to practice athletic training is $120.

5.1(2) Temporary license fee for license to practice athletic training is $120.

5.1(3) Biennial license renewal fee for each biennium is $120.

5.1(4) Late fee for failure to renew before expiration is $60.

5.1(5) Reactivation fee is $180.

5.1(6) Duplicate or reissued license certificate or wallet card fee is $20.

5.1(7) Verification of license fee is $20.

5.1(8) Returned check fee is $25.

5.1(9) Disciplinary hearing fee is a maximum of $75.

This rule is intended to implement Iowa Code chapters 17A, 147, 152D and 272C.

645—5.2(147,158) Barbering license fees. All fees are nonrefundable.

5.2(1) License fee for an initial license to practice barbering, license by endorsement, license by reciprocity or an instructor's license is $60.

5.2(2) Biennial renewal fee for a barber license or barber instructor license is $60.

5.2(3) Temporary permit fee is $12.

5.2(4) Practical examination fee is $75.

5.2(5) Demonstrator permit fee is $45 for the first day and $12 for each day thereafter for which the permit is valid.

5.2(6) Barber school license fee is $600.

5.2(7) Barber school annual renewal fee is $300.

5.2(8) Barbershop license fee is $72.

5.2(9) Biennial renewal fee for a barbershop license is $72.

5.2(10) Late fee for failure to renew before expiration is $60.

5.2(11) Reactivation fee for a barber license is $120.

5.2(12) Reactivation fee for a barbershop license is $132.

5.2(13) Reactivation fee for a barber school license is $360.

5.2(14) Duplicate or reissued license certificate or wallet card fee is $20.

5.2(15) Verification of license fee is $20.

5.2(16) Returned check fee is $25.

5.2(17) Disciplinary hearing fee is a maximum of $75.

This rule is intended to implement Iowa Code section 147.80 and Iowa Code chapter 158.

[**ARC 8349B**, IAB 12/2/09, effective 1/6/10]

645—5.3(147,154D) Behavioral science license fees. All fees are nonrefundable.

5.3(1) License fee for license to practice marital and family therapy or mental health counseling is $120.

5.3(2) Temporary license fee for license to practice marital and family therapy or mental health counseling is $120.

5.3(3) Biennial license renewal fee for each biennium is $120.

5.3(4) Late fee for failure to renew before expiration is $60.

5.3(5) Reactivation fee is $180.

5.3(6) Duplicate or reissued license certificate or wallet card fee is $20.

5.3(7) Verification of license fee is $20.

5.3(8) Returned check fee is $25.

5.3(9) Disciplinary hearing fee is a maximum of $75.

This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 154D and 272C.

[**ARC 8152B**, IAB 9/23/09, effective 10/28/09]

645—5.4(151) Chiropractic license fees. All fees are nonrefundable.

5.4(1) License fee for license to practice chiropractic is $270.

5.4(2) Fee for issuance of annual temporary certificate is $120.

5.4(3) Biennial license renewal fee is $120.

5.4(4) Late fee for failure to renew before the expiration date is $60.

5.4(5) Reactivation fee is $180.

5.4(6) Duplicate or reissued license certificate or wallet card fee is $20.

5.4(7) Fee for verification of license is $20.

5.4(8) Returned check fee is $25.

5.4(9) Disciplinary hearing fee is a maximum of $75.

This rule is intended to implement Iowa Code chapters 17A, 151 and 272C.

645—5.5(147,157) Cosmetology arts and sciences license fees. All fees are nonrefundable.

5.5(1) License fee for license to practice cosmetology arts and sciences, license by endorsement, license by reciprocity, or an instructor's license is $60.

5.5(2) Biennial license renewal fee for each license for each biennium is $60.

5.5(3) Late fee for failure to renew before expiration is $60.

5.5(4) Reactivation fee for applicants licensed to practice cosmetology is $120; for salons, $144; and for schools, $330.

5.5(5) Duplicate or reissued license certificate or wallet card fee is $20.

5.5(6) Fee for verification of license is $20.

5.5(7) Returned check fee is $25.

5.5(8) Disciplinary hearing fee is a maximum of $75.

5.5(9) Fee for license to conduct a school teaching cosmetology arts and sciences is $600.

5.5(10) Fee for renewal of a school license is $270 annually.

5.5(11) Salon license fee is $84.

5.5(12) Biennial license renewal fee for each salon license for each biennium is $84.

5.5(13) Demonstrator and not-for-profit temporary permit fee is $42 for the first day and $12 for each day thereafter that the permit is valid.

5.5(14) An initial fee or a reactivation fee for certification to administer microdermabrasion or utilize a certified laser product or an intense pulsed light (IPL) device is $25 for each type of procedure or certified laser product or IPL device.

5.5(15) An initial fee or a reactivation fee for certification of cosmetologists to administer chemical peels is $25.

This rule is intended to implement Iowa Code section 147.80 and chapter 157.

645—5.6(147,152A) Dietetics license fees. All fees are nonrefundable.

5.6(1) License fee for license to practice dietetics, license by endorsement, or license by reciprocity is $120.

5.6(2) Biennial license renewal fee for each biennium is $120.

5.6(3) Late fee for failure to renew before expiration is $60.

5.6(4) Reactivation fee is $180.

5.6(5) Duplicate or reissued license certificate or wallet card fee is $20.

5.6(6) Verification of license fee is $20.

5.6(7) Returned check fee is $25.

5.6(8) Disciplinary hearing fee is a maximum of $75.

This rule is intended to implement Iowa Code section 147.8 and Iowa Code chapters 17A, 152A and 272C.

645—5.7(147,154A) Hearing aid dispensers license fees. All fees are nonrefundable.

5.7(1) Application fee for a license to practice by examination, endorsement, or reciprocity is $156.

5.7(2) Examination fee (check or money order made payable to the International Hearing Society) is $95.

5.7(3) Renewal of license fee is $60.

5.7(4) Temporary permit fee is $42.

5.7(5) Late fee is $60.

5.7(6) Reactivation fee is $120.

5.7(7) Duplicate or reissued license certificate or wallet card fee is $20.

5.7(8) Verification of license fee is $20.

5.7(9) Returned check fee is $25.

5.7(10) Disciplinary hearing fee is a maximum of $75.

This rule is intended to implement Iowa Code chapter 154A.

645—5.8(147) Massage therapy license fees. All fees are nonrefundable.

5.8(1) License fee for license to practice massage therapy is $120.

5.8(2) Biennial license renewal fee for each biennium is $60.

5.8(3) Temporary license fee for up to one year is $120.

5.8(4) Late fee for failure to renew before expiration is $60.

5.8(5) Reactivation fee is $120.

5.8(6) Duplicate or reissued license certificate or wallet card fee is $20.

5.8(7) Verification of license fee is $20.

5.8(8) Returned check fee is $25.

5.8(9) Disciplinary hearing fee is a maximum of $75.

5.8(10) Initial application fee for approval of massage therapy education curriculum is $120.

This rule is intended to implement Iowa Code chapters 17A, 147 and 272C.

645—5.9(147,156) Mortuary science license fees. All fees are nonrefundable.

5.9(1) License fee for license to practice funeral directing is $120.

5.9(2) Biennial funeral director's license renewal fee for each biennium is $120.

5.9(3) Late fee for failure to renew before expiration is $60.

5.9(4) Reactivation fee for a funeral director is $180 and for a funeral establishment or cremation establishment is $150.

5.9(5) Duplicate or reissued license certificate or wallet card fee is $20.

5.9(6) Verification of license fee is $20.

5.9(7) Returned check fee is $25.

5.9(8) Disciplinary hearing fee is a maximum of $75.

5.9(9) Funeral establishment or cremation establishment fee is $90.

5.9(10) Three-year renewal fee of funeral establishment or cremation establishment is $90.

This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 156 and 272C.

645—5.10(147,155) Nursing home administrators license fees. All fees are nonrefundable.

5.10(1) License fee for license to practice nursing home administration is $120.

5.10(2) Biennial license renewal fee for each license for each biennium is $60.

5.10(3) Late fee for failure to renew before expiration is $60.

5.10(4) Reactivation fee is $120.

5.10(5) Duplicate or reissued license certificate or wallet card fee is $20.

5.10(6) Verification of license fee is $20.

5.10(7) Returned check fee is $25.

5.10(8) Disciplinary hearing fee is a maximum of $75.

5.10(9) Provisional license fee is $120.

This rule is intended to implement Iowa Code section 147.80 and Iowa Code chapter 155.

645—5.11(147,148B) Occupational therapy license fees. All fees are nonrefundable.

5.11(1) License fee for an OT or OTA license to practice occupational therapy is $120.
5.11(2) Biennial license renewal fee to practice occupational therapy is $60.
5.11(3) Biennial license renewal fee for an occupational therapy assistant is $60.
5.11(4) Late fee for failure to renew before expiration is $60.
5.11(5) Reactivation fee is $120.
5.11(6) Duplicate or reissued license certificate or wallet card fee is $20.
5.11(7) Verification of license fee is $20.
5.11(8) Returned check fee is $25.
5.11(9) Disciplinary hearing fee is a maximum of $75.
This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 148B and 272C.

645—5.12(147,154) Optometry license fees. All fees are nonrefundable.
5.12(1) License fee for license to practice optometry, license by endorsement, or license by reciprocity is $300.
5.12(2) Biennial license renewal fee for each biennium is $144.
5.12(3) Late fee for failure to renew before expiration date is $60.
5.12(4) Reactivation fee is $204.
5.12(5) Duplicate or reissued license certificate or wallet card fee is $20.
5.12(6) Verification of license fee is $20.
5.12(7) Returned check fee is $25.
5.12(8) Disciplinary hearing fee is a maximum of $75.
This rule is intended to implement Iowa Code chapters 17A, 147, 154 and 272C.

645—5.13(147,148A) Physical therapy license fees. All fees are nonrefundable.
5.13(1) License fee for license to practice physical therapy or as a physical therapist assistant is $120.
5.13(2) Biennial license renewal fee for a physical therapist is $60.
5.13(3) Biennial license renewal fee for a physical therapist assistant is $60.
5.13(4) Late fee for failure to renew before expiration is $60.
5.13(5) Reactivation fee is $120.
5.13(6) Duplicate or reissued license certificate or wallet card fee is $20.
5.13(7) Verification of license fee is $20.
5.13(8) Returned check fee is $25.
5.13(9) Disciplinary hearing fee is a maximum of $75.
This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 148A and 272C.

645—5.14(148C) Physician assistants license fees. All fees are nonrefundable.
5.14(1) Application fee for a license is $120.
5.14(2) Fee for a temporary license is $120.
5.14(3) Renewal of license fee is $120.
5.14(4) Late fee for failure to renew before expiration is $60.
5.14(5) Reactivation fee is $180.
5.14(6) Duplicate or reissued license certificate or wallet card fee is $20.
5.14(7) Fee for verification of license is $20.
5.14(8) Returned check fee is $25.
5.14(9) Disciplinary hearing fee is a maximum of $75.
This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 148C and 272C.

645—5.15(147,149) Podiatry license fees. All fees are nonrefundable.
5.15(1) License fee for license to practice podiatry, license by endorsement, license by reciprocity or temporary license is $120.
5.15(2) Biennial license renewal fee is $168 for each biennium.

5.15(3) Late fee for failure to renew before expiration is $60.

5.15(4) Reactivation fee is $228.

5.15(5) Duplicate or reissued license certificate or wallet card fee is $20.

5.15(6) Verification of license fee is $20.

5.15(7) Returned check fee is $25.

5.15(8) Disciplinary hearing fee is a maximum of $75.

5.15(9) Temporary license renewal fee is $84 per year.

This rule is intended to implement Iowa Code section 147.8 and Iowa Code chapters 17A, 149 and 272C.

645—5.16(147,154B) Psychology license fees. All fees are nonrefundable.

5.16(1) License fee for license to practice psychology is $120.

5.16(2) Biennial license renewal fee is $170.

5.16(3) Late fee for failure to renew before expiration is $60.

5.16(4) Reactivation fee is $230.

5.16(5) Duplicate or reissued license certificate or wallet card fee is $20.

5.16(6) Verification of license fee is $20.

5.16(7) Returned check fee is $25.

5.16(8) Disciplinary hearing fee is a maximum of $75.

5.16(9) Processing fee for exemption to licensure is $60.

5.16(10) Certification fee for a health service provider is $60.

5.16(11) Biennial renewal fee for certification as a certified health service provider in psychology is $60.

5.16(12) Reactivation fee for certification as a certified health service provider in psychology is $60.

This rule is intended to implement Iowa Code section 147.80 and chapters 17A, 154B and 272C.

645—5.17(147,152B) Respiratory care license fees. All fees are nonrefundable.

5.17(1) Initial or endorsement license fee to practice respiratory care is $120, plus the cost for evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

5.17(2) Biennial license renewal fee for each biennium is $60.

5.17(3) Late fee for failure to renew before expiration is $60.

5.17(4) Reactivation fee is $120, plus the cost for evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI) if the license has been on inactive status for two or more years.

5.17(5) Duplicate or reissued license certificate or wallet card fee is $20.

5.17(6) Verification of license fee is $20.

5.17(7) Returned check fee is $25.

5.17(8) Disciplinary hearing fee is a maximum of $75.

This rule is intended to implement Iowa Code section 147.8 and Iowa Code chapters 17A, 152B and 272C.

645—5.18(147,154E) Sign language interpreters and transliterators license fees. All fees are nonrefundable.

5.18(1) License fee for license to practice interpreting or transliterating is $120.

5.18(2) License fee for temporary license to practice interpreting or transliterating is $120.

5.18(3) Biennial license renewal fee for each biennium is $120.

5.18(4) Late fee for failure to renew before expiration is $60.

5.18(5) Duplicate or reissued license certificate or wallet card fee is $20.

5.18(6) Verification of license fee is $20.

5.18(7) Returned check fee is $25.

5.18(8) Disciplinary hearing fee is a maximum of $75.

5.18(9) Reactivation fee is $180.

This rule is intended to implement Iowa Code chapters 17A, 147, 154E and 272C.

645—5.19(147,154C) Social work license fees. All fees are nonrefundable.

5.19(1) License fee for license to practice social work is $120.

5.19(2) Biennial license renewal fee for a license at the bachelor's level is $72; at the master's level, $120; and independent level, $144.

5.19(3) Late fee for failure to renew before expiration is $60.

5.19(4) Reactivation fee for the bachelor's level is $132; for the master's level, $180; and independent level, $204.

5.19(5) Duplicate or reissued license certificate or wallet card fee is $20.

5.19(6) Verification of license fee is $20.

5.19(7) Returned check fee is $25.

5.19(8) Disciplinary hearing fee is a maximum of $75.

This rule is intended to implement Iowa Code section 147.80 and chapters 17A, 154C and 272C.

645—5.20(147) Speech pathology and audiology license fees. All fees are nonrefundable.

5.20(1) License fee for license to practice speech pathology or audiology, temporary clinical license, license by endorsement, or license by reciprocity is $120.

5.20(2) Biennial license renewal fee for each biennium is $96.

5.20(3) Late fee for failure to renew before expiration is $60.

5.20(4) Reactivation fee is $156.

5.20(5) Duplicate or reissued license certificate or wallet card fee is $20.

5.20(6) Verification of license fee is $20.

5.20(7) Returned check fee is $25.

5.20(8) Disciplinary hearing fee is a maximum of $75.

5.20(9) Temporary clinical license renewal fee is $60.

5.20(10) Temporary permit fee is $30.

This rule is intended to implement Iowa Code chapters 17A, 147 and 272C.

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BARBERS

CHAPTER 21
LICENSURE

[Prior to 7/29/87, Health Department[470] Ch 152]
[Prior to 2/20/02, see 645—Chapter 20]

645—21.1(158) Definitions. For purposes of these rules, the following definitions shall apply:

"Active license" means a license that is current and has not expired.

"Board" means the board of barbering.

"Examination" means any of the tests used by the board to determine minimum competency prior to the issuance of a barber or barber instructor license.

"Grace period" means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

"Inactive license" means a license that has expired because it was not renewed by the end of the grace period. The category of "inactive license" may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

"Licensee" means any person licensed to practice as a barber in the state of Iowa.

"License expiration date" means June 30 of even-numbered years.

"Licensure by endorsement" means the issuance of an Iowa license to practice as a barber to an applicant who is or has been licensed in another state.

"NIC" means the National-Interstate Council of State Boards of Cosmetology, Inc.

"Reactivate" or *"reactivation"* means the process as outlined in rule 21.16(17A,147,272C) by which an inactive license is restored to active status.

"Reciprocal license" means the issuance of an Iowa license to practice barbering to an applicant who is currently licensed in another state and which state has a mutual agreement to license persons who have the same or similar qualifications to those required in Iowa.

"Reinstatement" means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

"Testing service" means a national testing service selected by the board.

[**ARC 8349B**, IAB 12/2/09, effective 1/6/10]

645—21.2(158) Requirements for licensure.

21.2(1) The following criteria shall apply to licensure:

a. Applicants shall complete a board-approved application form. Application forms may be obtained from the board's Web site (http://www.idph.state.ia.us/licensure) or directly from the board office. The application and licensure fees shall be sent to the Board of Barbering, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

b. Applicants shall present proof of completion of the tenth grade or equivalent education. In the event the applicant is a refugee or immigrant from a country where high school records no longer exist, the applicant shall be considered to have met this requirement when the applicant submits an affidavit attesting to the fact that the applicant has met the tenth-grade requirement.

c. Applicants shall provide an official copy of the transcript or diploma sent directly from the school to the board showing proof of completion of training at a barber school licensed by the board. If the applicant graduated from a school that is not licensed by the board, the applicant shall direct the school to provide an official transcript showing completion of a course of study that meets the requirements of rule 645—23.8(158).

d. Applicants shall pass both the NIC theory examination and the NIC practical examination with a score of 70 percent or better on each examination.

e. An applicant shall provide verification of license(s) from every state in which the applicant has been licensed as a barber, sent directly from the state(s) to the Iowa board of barbering office.

f. Applications for a barber license must be received in the board office a minimum of five business days prior to the NIC practical examination.

g. Licensees who were issued their licenses within six months prior to renewal shall not be required to renew their licenses until the renewal month two years later.

h. Incomplete applications that have been on file in the board office for more than two years shall be:

(1) Considered invalid and shall be destroyed; or

(2) Maintained upon written request of the applicant. The applicant is responsible for requesting that the file be maintained.

21.2(2) Foreign-trained barbers shall:

a. Provide an equivalency evaluation of their educational credentials by one of the following: International Educational Research Foundation, Inc., Credentials Evaluation Service, P.O. Box 3665, Culver City, CA 90231-3665, telephone (310)258-9451, Web site www.ierf.org or E-mail at info@ierf.org; or World Education Services (WES) at (212)966-6311, electronically at www.wes.org or by writing to WES, P.O. Box 745, Old Chelsea Station, New York, NY 10113-0745. The professional curriculum must be equivalent to that stated in these rules. An applicant shall bear the expense of the curriculum evaluation.

b. Provide a notarized copy of the certificate or diploma awarded to the applicant from a barber school in the country in which the applicant was educated.

c. Receive a final determination from the board regarding the application for licensure.

21.2(3) Requirements for an instructor's license. Applicants shall:

a. Complete all requirements stated in subrule 21.2(1), paragraphs *"a"* and *"d"*;

b. Present proof of graduation from an accredited high school or the equivalent thereof;

c. Be licensed in the state of Iowa as a barber for not less than two years; and

d. Pass both the NIC instructor theory examination and the NIC instructor practical examination with a score of 70 percent or better on each examination.

21.2(4) Instructors who were issued their licenses within six months prior to renewal shall not be required to renew their licenses until the renewal month two years later.

21.2(5) Incomplete applications that have been on file in the board office for more than two years shall be:

a. Considered invalid and shall be destroyed; or

b. Maintained upon written request of the applicant. The applicant is responsible for requesting that the file be maintained.

21.2(6) An applicant who meets the requirements for an instructor's license except for the instructor examinations may apply for a temporary permit to be an instructor. The temporary permit shall be valid for a maximum of six months from the issue date of the permit and shall not be renewable.

[**ARC 7578B**, IAB 2/25/09, effective 4/1/09; **ARC 8349B**, IAB 12/2/09, effective 1/6/10]

645—21.3(158) Examination requirements for barbers and barber instructors.

21.3(1) *Theory examination.* Applicants shall contact the testing service directly to schedule the computer-based NIC theory examination. The fee for scheduling the written theory examination shall be paid directly to the testing service. This fee is not included in the licensure fee and practical examination fee identified in 645—subrules 5.2(1) and 5.2(4).

21.3(2) *Practical examination.* Applicants who have completed the application process and passed the NIC theory examination with a score of 70 percent or better shall be eligible to sit for the NIC practical examination administered by the board.

a. Application, supporting documentation, and licensure and practical examination fees required by the board shall be received in the board office at least five days prior to the scheduled NIC practical examination date.

b. The board shall send a notice of the date and time of the practical examination to the address on record.

c. Applicants are required to receive a passing score of 70 percent on the practical examination to be eligible for licensure.

d. Applicants shall be notified in writing of the result of the practical examination.

e. Applicants who fail to appear for the practical examination must request in writing or by telephone to reschedule the examination. Examination fees are not refundable, but the rescheduled examination fee may be waived upon the applicant's showing of good cause for missing the previously scheduled examination. Proof of good cause shall be submitted to the board office with the request to reschedule the examination. The applicant shall be required to pay the reexamination fee if the applicant does not appear for the subsequent examination.

f. Persons who do not attain the passing score may reapply to take the practical examination. The examination fee cannot be refunded, and the applicant shall be required to pay the reexamination fee.

[**ARC 7578B**, IAB 2/25/09, effective 4/1/09; **ARC 8349B**, IAB 12/2/09, effective 1/6/10]

645—21.4(158) Educational qualifications. Rescinded IAB 2/25/09, effective 4/1/09.

645—21.5(158) Licensure by endorsement. The board may issue a license by endorsement to any applicant from the District of Columbia or another state, territory, province or foreign country who has held an active license under the laws of another jurisdiction for at least 12 months during the past 24 months and who:

21.5(1) Submits to the board a completed application and pays the licensure fee specified in 645—subrule 5.2(1).

21.5(2) Provides verification of license(s) from every state in which the applicant has been licensed as a barber, sent directly from the state(s) to the Iowa board of barbering office. Web-based verification may be substituted for verification direct from the jurisdiction's board office if the verification provides:

a. Licensee's name;

b. Date of initial licensure;

c. Current licensure status; and

d. Any disciplinary action taken against the license.

21.5(3) Beginning August 1, 2010, completes one hour of Iowa barbering laws and administrative rules and sanitation.

21.5(4) Passes a national written and practical examination.

[**ARC 7578B**, IAB 2/25/09, effective 4/1/09; **ARC 8349B**, IAB 12/2/09, effective 1/6/10]

645—21.6(158) Licensure by reciprocal agreement. Rescinded IAB 2/25/09, effective 4/1/09.

645—21.7(158) Temporary permits to practice barbering. An applicant must meet the following requirements:

1. The applicant is applying for initial licensure and is not licensed in another state.

2. The applicant has met the requirements for licensure except for passing the examinations required by the board. The temporary permit is valid from the date the application is approved for a maximum of six months and shall not be renewable.

[**ARC 8349B**, IAB 12/2/09, effective 1/6/10]

645—21.8(158) Demonstrator's permit. The board may issue a demonstrator's permit to a licensed barber for the purpose of demonstrating barbering to the public. The following criteria apply to the demonstrator's permit:

1. A demonstrator's permit shall be valid for a barbershop, person or an event. The location, purpose and duration shall be stated on the permit.
2. A demonstrator's permit shall be valid for no more than 10 days.
3. A completed application shall be submitted on a form provided by the board at least 30 days in advance of the intended use dates.
4. An application fee shall be submitted as set forth in these rules.
5. No more than four permits shall be issued to any applicant during a calendar year.

645—21.9(158) License renewal.

21.9(1) The biennial license renewal period for a license to practice barbering shall begin on July 1 of each even-numbered year and end on June 30 of each even-numbered year. All licensees shall renew on a biennial basis. The board shall send a renewal notice by regular mail to each licensee at the address on record at least 60 days prior to the expiration of the license. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive the notice does not relieve the licensee of the responsibility for renewing the license.

21.9(2) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—24.2(158). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

b. Submit the completed renewal application and renewal fee before the license expiration date.

c. Persons licensed to practice as barbers shall keep their renewal licenses displayed in a conspicuous public place at the primary site of practice.

d. Individuals who were issued a license within six months of the license renewal date will not be required to renew their licenses until the next renewal two years later.

21.9(3) Late renewal. The license shall become late when the license has not been renewed by the expiration date on the wallet card. The licensee shall be assessed a late fee as specified in 645—subrule 5.2(10). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

21.9(4) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license and shall send the licensee a wallet card by regular mail. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

21.9(5) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice as a barber in Iowa until the license is reactivated. A licensee who practices as a barber in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

[**ARC 7578B**, IAB 2/25/09, effective 4/1/09]

645—21.10(272C) Exemptions for inactive practitioners. Rescinded IAB 8/17/05, effective 9/21/05.

645—21.11(158) Requirements for a barbershop license.

21.11(1) A barbershop shall not operate unless the owner of the barbershop possesses a current barbershop license issued by the board. The following criteria shall apply to licensure:

a. The owner shall complete a board-approved application form. Application forms may be obtained from the board's Web site (http://www.idph.state.ia.us/licensure), or directly from the board office. The application and fee shall be submitted to the Board of Barbering, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

b. The barbershop shall meet the requirements for sanitary conditions established in 645—Chapter 22.

c. A barbershop license shall be issued for a specific location. A change in location or site of a barbershop shall result in the cancellation of the existing license and necessitate application for a new license and payment of the fee required by 645—subrule 5.2(8). A change of address without change of actual location shall not be construed as a new site.

d. A barbershop license is not transferable. A change in ownership of a barbershop shall result in the cancellation of the existing license and necessitate application for a new license and payment of the fee required by 645—subrule 5.2(8).

e. A change in the name of a barbershop shall be reported to the board within 30 days of the name change.

f. Upon closure of a barbershop, the barbershop license shall be submitted to the board office within 30 days.

g. A barbershop that was issued a license within six months prior to renewal shall not be required to renew the license until the renewal month two years later.

21.11(2) Incomplete applications that have been on file in the board office for more than two years shall be:

a. Considered invalid and shall be destroyed; or

b. Maintained upon written request of the candidate. The candidate is responsible for requesting that the file be maintained.

[**ARC 7578B**, IAB 2/25/09, effective 4/1/09]

645—21.12(158) Barbershop license renewal.

21.12(1) The biennial license renewal period for a barbershop license shall begin on July 1 of each even-numbered year and end on June 30 of the next even-numbered year.

21.12(2) The renewal application shall be mailed to the barbershop at least 60 days prior to the expiration of the license. Failure to receive the renewal application shall not relieve the barbershop of the obligation to pay the biennial renewal fee on or before the renewal date.

21.12(3) The completed application and renewal fee shall be submitted to the board office before the license expiration date.

21.12(4) The barbershop shall be in full compliance with this chapter and 645—Chapter 22 to be eligible for license renewal.

21.12(5) When all requirements for license renewal are met, a license wallet card will be sent by regular mail.

21.12(6) A barbershop that is issued an initial license within six months prior to the renewal date will not be required to renew the license until the next renewal two years later.

21.12(7) Barbershop license late renewal. If the renewal fee and renewal application are received within 30 days after the license renewal expiration date, the late fee for failure to renew before expiration shall be charged.

21.12(8) Inactive barbershop license. If the renewal application and fee are not postmarked within 30 days after the license expiration date, the barbershop license is inactive. To reactivate a barbershop license, the reactivation application and fee shall be submitted to the board office.

[**ARC 7578B**, IAB 2/25/09, effective 4/1/09]

645—21.13(147) Duplicate certificate or wallet card. Rescinded IAB 2/25/09, effective 4/1/09.

645—21.14(147) Reissued certificate or wallet card. Rescinded IAB 2/25/09, effective 4/1/09.

645—21.15(272C) License denial. Rescinded IAB 2/25/09, effective 4/1/09.

645—21.16(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

21.16(1) Submit a reactivation application on a form provided by the board.

21.16(2) Pay the reactivation fee that is due as specified in 645—subrule 5.2(11).

21.16(3) Provide verification of current competence to practice as a barber by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of eight hours of continuing education that meet the continuing education standards defined in rule 645—24.3(158,272C) within two years of application for reactivation.

b. If the license has been on inactive status for more than five years, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of eight hours of continuing education that meet the continuing education standards defined in rule 645—24.3(158,272C) within two years of application for reactivation; and

(3) Verification of passing the examinations required by the board within one year immediately prior to reactivation if the applicant does not have a current license and has not been in active practice in the United States during the past five years.

21.16(4) Licensees who are barber instructors shall obtain an additional four hours of continuing education in teaching methodology.

[**ARC 7578B**, IAB 2/25/09, effective 4/1/09; **ARC 8349B**, IAB 12/2/09, effective 1/6/10]

645—21.17(17A,147,272C) Reactivation of a barbershop license. To apply for reactivation of an inactive license, a licensee shall:

21.17(1) Submit a reactivation application on a form provided by the board.

21.17(2) Pay the reactivation fee that is due as specified in 645—subrule 5.2(12).

21.17(3) Meet the requirements for sanitary conditions established in 645—Chapter 22.

[**ARC 7578B**, IAB 2/25/09, effective 4/1/09]

645—21.18(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 21.16(17A,147,272C) prior to practicing as a barber in this state.

[**ARC 7578B**, IAB 2/25/09, effective 4/1/09]

These rules are intended to implement Iowa Code chapters 272C and 158.

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◊ Two or more ARCs

1 See Public Health Department[641], IAB

2 Effective date of rule 20.10(158) delayed 70 days by the Administrative Rules Review Committee at its meeting held December 11, 1991; delayed until adjournment of the 1992 General Assembly at the Committee's meeting held February 3, 1992.

CHAPTER 23
BARBER SCHOOLS
[Prior to 2/20/02, see 645—Chapter 20]

645—23.1(158) Definitions.

"Clinic area" means the area of the school where the paying customers will receive services.

"Inactive license" means a school license that has not been renewed as required or the license of a school that has failed to meet stated obligations for renewal within a stated time.

"School" means a school of barbering.

"School license" means a license to instruct students in barbering.

645—23.2(158) Licensing for barber schools. The board shall grant approval for the issuance of an original barber school license to be issued by the department when the following conditions have been met:

23.2(1) An application shall be submitted to the Board of Barbering, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075. The following information shall be submitted with the application:

a. The exact location of the proposed barber school;

b. A copy of the essential parts of the lease or other documents to provide proof that the owner of the school has occupancy rights for a minimum of one year;

c. A sworn affidavit that proves the existence of sufficient finances to acquire the facilities and equipment required by the board and to operate the proposed barber school for a minimum of one year; and

d. A complete plan of the physical facilities and an explanation detailing how the facilities will be utilized relative to the number of students and to the classroom and clinic space.

23.2(2) The applicant for a barber school license may be interviewed by the board before the original license will be issued.

23.2(3) No barber school shall be approved by the board of barbering unless it complies with the course of study requirements in rule 645—23.8(158).

23.2(4) The barber school shall be inspected prior to the issuance of the school license and shall meet the requirements of this chapter and 645—Chapter 22.

23.2(5) The barber school shall not accept students until the school is licensed.

23.2(6) The original license shall be granted for the location(s) identified in the school's application.

a. A change of location shall require submission of an application for a new school license and payment of the license fee.

b. A change of address without change of actual location shall not be construed as a new site.

23.2(7) A barber school license is not transferable. A change in ownership of a school shall require the issuance of a new license. Change in ownership shall be defined as any change of controlling interest in any corporation or any change of name of sole proprietorship or partnership. The board may request legal proof of ownership transfer.

23.2(8) Incomplete applications that have been on file in the board office for more than two years shall be considered invalid and shall be destroyed. The records will be maintained after two years only if the applicant submits a written request to the board.

23.2(9) A barber school that is issued an initial license within six months prior to the renewal date shall not be required to renew the license until the renewal month one year later.

645—23.3(158) School license renewal.

23.3(1) The annual license renewal period for a barber school license shall begin on July 1 and end on June 30 one year later.

23.3(2) A renewal of license application shall be mailed to the school at least 60 days prior to the expiration of the license. Failure to receive the renewal application shall not relieve the school of the obligation to pay the annual renewal fee on or before the renewal date.

a. The barber school renewal application and renewal fee shall be submitted to the board office before the license expiration date.

b. Barber schools shall be in full compliance with this chapter and 645—Chapter 22 to be eligible for renewal. When all requirements for license renewal are met, the barber school shall be sent a license renewal card by regular mail.

23.3(3) Late renewal. If the renewal fee and renewal application are received within 30 days after the license expiration date, the late fee for failure to renew before expiration shall be charged.

645—23.4(272C) Inactive school license.

23.4(1) If the renewal fee is received more than 30 days after the license expiration date, the school license is inactive. To reactivate the school license, the reactivation application and fee shall be submitted to the board.

23.4(2) A barber school that has not renewed the school license within the required time frame will have an inactive license and shall not provide schooling or services until the license is reactivated.
[**ARC 7578B**, IAB 2/25/09, effective 4/1/09]

645—23.5(147) Duplicate certificate or wallet card. Rescinded IAB 2/25/09, effective 4/1/09.

645—23.6(158) Physical requirements for barber schools. Each licensed barber school shall:

1. Provide a clinic area where paying customers will receive services. The clinic area shall be confined to the premises occupied by the school.
2. Be large enough and be equipped to provide room(s) separate from the clinic area for lectures and demonstration purposes.
3. Provide a library for students that contains textbooks, videos, current trade publications and business management materials. The contents of the library shall be current within the previous ten years and shall cover the topics necessary for the student to master the skill of barbering.
4. Have an administrative office.
5. Allow separation of laundry room from the clinic area by a full wall or partition if the school has a laundry room.
6. Provide closed cabinets or a separate room for storing supplies.
7. Meet the sanitation requirements in 645—Chapter 22.

[**ARC 7578B**, IAB 2/25/09, effective 4/1/09]

645—23.7(158) Minimum equipment requirements. Each barber school shall have, at a minimum, the following equipment:

1. The clinic area shall hold a minimum of ten workstations equipped for practice on the general public. Each workstation shall include one chair and backbar. The backbar will provide a cabinet for immediate linen supply and individual sterilizers for each workstation. There shall be no more than two students enrolled for each workstation.
2. Sinks shall be located in the clinic area and readily accessible for students to use.
3. Audiovisual equipment available for each classroom.
4. One classroom shall include charts showing illustrations of the skin, circulation of the blood, muscles and bones of the face, scalp, and neck.
5. One set of textbooks shall be available for each student and instructor.
6. One large bulletin board shall be conspicuously located for posting rules, notices, and similar bulletins.
7. One set of files shall be maintained for all required records.
8. Electric equipment shall include the following: one high-frequency electrode, one twin vibrator, one hood dryer, one infrared lamp and one ultraviolet lamp.
9. One automatic lather mixer shall be available for every ten chairs.
10. Bottles and containers shall be distinctly and correctly labeled to show intended use of the contents.

11. Covered waste containers shall be located in the clinic area.

[**ARC 7578B**, IAB 2/25/09, effective 4/1/09]

645—23.8(158) Course of study requirements. Each Iowa barber school licensed by the board of barbering shall conduct a course of study of at least 2,100 hours to be equally divided over a period of not less than ten months. The course of study shall include the following:

23.8(1) Supervised practical instruction totaling 1,675 hours shall include:

Scalp care and shampooing
Honing and stropping
Shaving
Facials, massage and packs
Science of hair structure
Haircutting
Hair tonics
Hair relaxing
Hair coloring and hair body processing
Hair styling
Fitting of hairpieces
Manicuring
Artificial nails (all aspects)
Waxing

23.8(2) Demonstrations and lectures totaling 380 hours shall include:

Law, ethics, economics, equipment, shop management and history of barbering
Sanitation, sterilization, personal hygiene and first aid
Bacteriology
Anatomy
Skin, scalp, and hair and their common disorders
Electricity, as applied to barbering
Chemistry and pharmacology
Scalp care
Honing and stropping
Shaving
Facials, massage and packs
Hair relaxing
Science of hair structure
Haircutting
Hair tonics
Instruments, soaps, shampoos, creams, lotions and tonics
Nails
Waxing

23.8(3) Special lectures totaling 45 hours must include lectures by a qualified person in the following areas: tax consulting, advertising, insurance, business management, salesmanship and barbering.

[**ARC 8349B**, IAB 12/2/09, effective 1/6/10]

645—23.9(158) Instructors.

23.9(1) All instructors in a barber school shall be licensed by the department.

23.9(2) The number of instructors for each barber school shall be based upon total enrollment, with a minimum of 2 instructors employed on a full-time basis for up to 30 students and 1 additional instructor for each additional 15 students or fraction thereof. An applicant who is waiting to take the instructor examination and who is working on a temporary permit may be counted as an instructor for the instructor-to-student ratio.

23.9(3) An instructor shall:

a. Be responsible for and in direct charge of all theory and practical classrooms and clinics at all times;

b. Familiarize students with the different standard supplies and equipment used in barbershops;

c. Work on clients only when instructing or otherwise assisting students in the school;

d. Carefully grade and return to students all examinations and other written papers;

e. Be attired in distinct and identifiable attire.

645—23.10(158) Students.

23.10(1) Before a student is obligated to pay the school, the barber school shall inform the student of the disclosure requirements found in Iowa Code section 714.25.

23.10(2) No one connected with a barber school shall guarantee occupational positions to students or guarantee financial aid in equipping a shop.

23.10(3) Students shall:

a. Be attired in clean and neat uniforms at all times during school hours.

b. Not be compensated by the school for services performed on clients.

c. Not be required to perform janitorial services for the school, but may be required to keep their own areas clean and sanitary during school hours. If a student chooses to provide janitorial services, the hours shall not count toward the total course hours.

d. Receive no credit for decorating for marketing and merchandising that relates to the promotion of barber school services or for recruiting students.

e. Receive no credit for participating in demonstrations of barbering for the sole purpose of recruiting students.

f. Be provided regularly scheduled breaks and a minimum of 30 minutes for lunch.

645—23.11(158) Attendance requirements.

23.11(1) A barber school shall have a written, published attendance policy.

23.11(2) The barber school shall establish regular school hours. No student shall be required to attend more than nine hours on any given school day.

23.11(3) Each student shall receive a minimum of eight hours of classroom instruction per week. Classroom instruction shall include lectures, individual instruction and written examinations.

23.11(4) Student attendance policies shall be applied uniformly and fairly.

23.11(5) Accurate and appropriate credit shall be given for all hours earned.

23.11(6) Students shall earn all hours credited to their total course hours and shall not have hours deducted as a penalty.

645—23.12(158) Graduate of a barber school.

23.12(1) To be considered a graduate, a student shall:

a. Complete the required course and meet the minimum attendance standard.

b. Complete the practical and theoretical curriculum requirements set forth by the school.

c. Pass a final examination upon completion of the course of study.

23.12(2) Students shall be issued a transcript when they have completed all requirements for graduation.

645—23.13(147) Records requirements. Each school shall keep a daily class record of each student, showing the hours devoted to the respective subjects, time devoted by a student to each subject, the total number of hours in attendance, and days present and absent. These records shall be subject to inspection by the board of barbering or a representative of the board and shall be retained for two years after the graduation date.

645—23.14(158) Public notice. A sign shall be clearly displayed in the entrance of the school that indicates in prominent lettering that students perform all services under the supervision of instructors.

645—23.15(158) Apprenticeship. Apprenticeship hours earned in another state may be applied toward the required 2,100 hours of course of study prescribed by Iowa Code section 158.8 at a ratio of 1 hour of credit for each 4 hours of registered apprenticeship completed in the state in which the applicant is licensed or registered as an apprentice.

These rules are intended to implement Iowa Code chapter 158 and section 714.25.

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CHAPTER 24
CONTINUING EDUCATION FOR BARBERS
[Prior to 2/20/02, see 645—Chapter 23]

645—24.1(158) Definitions. For the purpose of these rules, the following definitions shall apply:

"Active license" means a license that is current and has not expired.

"Approved program/activity" means a continuing education program/activity meeting the standards set forth in these rules.

"Audit" means the selection of licensees for verification of satisfactory completion of continuing education requirements during a specified time period.

"Board" means the board of barbering.

"Continuing education" means planned, organized learning acts designed to maintain, improve, or expand a licensee's knowledge and skills in order for the licensee to develop new knowledge and skills relevant to the enhancement of practice, education, or theory development to improve the safety and welfare of the public.

"Hour of continuing education" means at least 50 minutes spent by a licensee in actual attendance at and completion of an approved continuing education activity.

"Inactive license" means a license that has expired because it was not renewed by the end of the grace period. The category of "inactive license" may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

"Independent study" means a subject/program/activity that a person pursues autonomously that meets standards for approval criteria in the rules and includes a posttest.

"License" means license to practice.

"Licensee" means any person licensed to practice as a barber in the state of Iowa.

645—24.2(158) Continuing education requirements.

24.2(1) The biennial continuing education compliance period shall extend for a two-year period beginning on July 1 and ending on June 30 of each even-numbered year. Each biennium, each person who is licensed to practice as a barber in this state shall be required to complete a minimum of eight hours of continuing education that meet the requirements of rule 645—24.3(158,272C). Beginning August 1, 2010, a minimum of one hour of the eight hours shall be in the content areas of Iowa barbering laws and administrative rules and sanitation. A licensee who is a barber instructor shall obtain four hours in teaching methodology in addition to meeting all continuing education requirements for renewal of the barber license.

24.2(2) Requirements of new licensees. Those persons licensed for the first time shall not be required to complete continuing education as a prerequisite for the first renewal of their licenses. Continuing education hours acquired anytime from the initial licensing until the second license renewal may be used. The new licensee will be required to complete a minimum of eight hours of continuing education per biennium for each subsequent license renewal.

24.2(3) Hours of continuing education credit may be obtained by attending and participating in a continuing education activity. These hours must be in accordance with these rules.

24.2(4) No hours of continuing education shall be carried over into the next biennium except as stated for the second renewal. A licensee whose license was reactivated during the current renewal compliance period may use continuing education earned during the compliance period for the first renewal following reactivation.

24.2(5) It is the responsibility of each licensee to finance the cost of continuing education.

[**ARC 7578B**, IAB 2/25/09, effective 4/1/09; **ARC 8349B**, IAB 12/2/09, effective 1/6/10]

645—24.3(158,272C) Standards.

24.3(1) *General criteria.* A continuing education activity which meets all of the following criteria is appropriate for continuing education credit if the continuing education activity:

a. Constitutes an organized program of learning which contributes directly to the professional competency of the licensee;

b. Pertains to subject matters which integrally relate to the practice of the profession;

c. Is conducted by individuals who have specialized education, training and experience by reason of which said individuals should be considered qualified concerning the subject matter of the program. At the time of audit, the board may request the qualifications of presenters;

d. Fulfills stated program goals, objectives, or both; and

e. Provides proof of attendance to licensees in attendance including:

(1) Date(s), location, course title, presenter(s);

(2) Number of program contact hours; and

(3) Certificate of completion or evidence of successful completion of the course provided by the course sponsor.

24.3(2) *Specific criteria.*

a. Continuing education may be obtained by attending programs that meet the criteria in 24.3(1) approved or offered by the following:

(1) National, state or local barber associations.

(2) Barber schools and institutes.

(3) Universities, colleges or community colleges.

b. Continuing education credit offered for cosmetology continuing education credit will be accepted for barber continuing education credit.

c. Beginning August 1, 2010, one hour of continuing education per biennium must be specific to Iowa barbering laws and administrative rules and sanitation.

[**ARC 8349B**, IAB 12/2/09, effective 1/6/10]

645—24.4(158,272C) Audit of continuing education report. Rescinded IAB 2/25/09, effective 4/1/09.

645—24.5(158,272C) Automatic exemption. Rescinded IAB 2/25/09, effective 4/1/09.

645—24.6(158,272C) Continuing education exemption for disability or illness. Rescinded IAB 2/25/09, effective 4/1/09.

645—24.7(158,272C) Grounds for disciplinary action. Rescinded IAB 2/25/09, effective 4/1/09.

645—24.8(158,272C) Continuing education exemption for inactive practitioners. Rescinded IAB 8/17/05, effective 9/21/05.

645—24.9(158,272C) Continuing education exemption for disability or illness. Rescinded IAB 8/17/05, effective 9/21/05.

645—24.10(158,272C) Reinstatement of inactive practitioners. Rescinded IAB 8/17/05, effective 9/21/05.

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◊ Two or more ARCs

RESPIRATORY CARE PRACTITIONERS

CHAPTER 261
LICENSURE OF RESPIRATORY CARE PRACTITIONERS

[Prior to 4/17/02, see 645—Chapter 260]

645—261.1(152B) Definitions. For purposes of these rules, the following definitions shall apply:

"Active license" means a license that is current and has not expired.

"Board" means the board of respiratory care.

"CoARC" means the Commission on Accreditation for Respiratory Care.

"Grace period" means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

"Licensee" means any person licensed to practice as a respiratory care practitioner in the state of Iowa.

"License expiration date" means March 31 of even-numbered years.

"Licensure by endorsement" means the issuance of an Iowa license to practice respiratory care to an applicant who is or has been licensed in another state.

"NBRC" means the National Board of Respiratory Care.

"Reactivate" or *"reactivation"* means the process as outlined in rule 261.14(17A,147,272C) by which an inactive license is restored to active status.

"Reciprocal license" means the issuance of an Iowa license to practice respiratory care to an applicant who is currently licensed in another state that has a mutual agreement with the Iowa board of respiratory care to license persons who have the same or similar qualifications to those required in Iowa.

"Reinstatement" means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

[**ARC 8348B**, IAB 12/2/09, effective 1/6/10]

645—261.2(152B) Requirements for licensure.

261.2(1) The following criteria shall apply to licensure:

a. The applicant shall complete a board-approved application packet. Application forms may be obtained from the board's Web site (http://www.idph.state.ia.us/licensure) or directly from the board office. All applications shall be sent to Board of Respiratory Care, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

b. The applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board until properly completed.

c. Each application shall be accompanied by the appropriate fees specified in 645—subrule 5.17(1).

d. The applicant shall submit two completed sets of the fingerprint packet to facilitate a national criminal history background check. The cost for the evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI) criminal history background checks shall be assessed to the applicant. The board may withhold issuing a license pending receipt of a report from the DCI and FBI.

e. The applicant has satisfactorily completed the certification or registration examination for respiratory therapists administered by the NBRC.

f. Licensees who were issued their licenses within six months prior to the renewal shall not be required to renew their licenses until the renewal month two years later.

261.2(2) Incomplete applications that have been on file in the board office for more than two years shall be considered invalid and shall be destroyed.

645—261.3(152B) Educational qualifications.

261.3(1) The applicant shall have successfully completed a respiratory care education program accredited by, or under a letter of review from, the Commission on Accreditation for Respiratory Care (CoARC).

261.3(2) Foreign-trained respiratory care practitioners shall:

a. Provide an equivalency evaluation of their educational credentials by one of the following: International Educational Research Foundations, Inc., Credentials Evaluation Service, P.O. Box 3665, Culver City, CA 90231-3665, telephone (310)258-9451, Web site www.ierf.org or E-mail at info@ierf.org; or International Credentialing Associates, Inc., 7245 Bryan Dairy Road, Bryan Dairy Business Park II, Largo, FL 33777, telephone (727)549-8555. The professional curriculum must be equivalent to that stated in these rules. A candidate shall bear the expense of the curriculum evaluation.

b. Provide a notarized copy of the certificate or diploma awarded to the applicant from a respiratory care program in the country in which the applicant was educated.

c. Receive a final determination from the board regarding the application for licensure.

[**ARC 8348B**, IAB 12/2/09, effective 1/6/10]

645—261.4(152B) Examination requirements. The examination required by the board shall be the National Board of Respiratory Care Examination or the State Clinical Examination administered by the NBRC.

261.4(1) The applicant shall apply directly to the National Board of Respiratory Care.

261.4(2) Results of the examination must be received by the board of respiratory care by one of the following methods:

a. Scores sent directly from the examination service to the board of respiratory care;

b. A notarized certificate shall be submitted showing proof of the successful completion of the examination for respiratory therapists or respiratory therapy technicians administered by the National Board of Respiratory Care; or

c. A notarized copy of the scores or an electronic Web-based confirmation by the department showing proof of successful completion.

645—261.5(152B) Students.

261.5(1) A student enrolled in an approved respiratory care training program who is employed in an organized health care system may render services defined in Iowa Code sections 152B.2 and 152B.3 under the direct and immediate supervision of a respiratory care practitioner for the duration of the respiratory care practitioner program, not to exceed the duration of the respiratory care program.

261.5(2) Direct and immediate supervision of a respiratory care student means that the licensed respiratory care practitioner shall:

a. Be continuously on site and present in the department or facility where the student is performing care;

b. Be immediately available to assist the person being supervised in the care being performed; and

c. Be responsible for care provided by students.

645—261.6(152B) Licensure by endorsement. An applicant who has been a licensed respiratory care practitioner under the laws of another jurisdiction shall file an application for licensure by endorsement with the board office. The board may receive by endorsement any applicant from the District of Columbia or another state, territory, province or foreign country who:

1. Submits to the board a completed application;

2. Pays the licensure fee specified in rule 645—5.17(147,152B);

3. Submits two completed sets of the fingerprint packet to facilitate a national criminal history background check. The cost for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks shall be assessed to the applicant;

4. Shows evidence of licensure requirements that are similar to those required in Iowa;

5. Provides an equivalency evaluation of foreign educational credentials sent directly from the equivalency service to the board;

6. Provides the examination scores:

- Scores shall be sent directly from the examination service to the board of respiratory care; or
- A notarized certificate shall be submitted showing proof of the successful completion of the examination for respiratory therapists or respiratory therapy technicians administered by the National Board for Respiratory Care; and

7. Provides verification of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification direct from the jurisdiction's board office if the verification provides:

- Licensee's name;
- Date of initial licensure;
- Current licensure status; and
- Any disciplinary action taken against the license.

645—261.7(147) Licensure by reciprocal agreement. Rescinded IAB 11/19/08, effective 1/1/09.

645—261.8(152B) License renewal.

261.8(1) The biennial license renewal period for a license to practice respiratory care shall begin on April 1 of an even-numbered year and end on March 31 of the next even-numbered year. The board shall send a renewal notice by regular mail to each licensee at the address on record at least 60 days prior to the expiration of the license. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive the notice does not relieve the licensee of the responsibility for renewing the license.

261.8(2) An individual who was issued an initial license within six months of the license renewal date will not be required to renew the license until the subsequent renewal two years later.

261.8(3) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—262.2(152B,272C) and the mandatory reporting requirements of subrule 261.8(4). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

b. Submit the completed renewal application and renewal fee before the license expiration date.

261.8(4) Mandatory reporter training requirements.

a. A licensee who, in the scope of professional practice or in the licensee's employment responsibilities, examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph *"e."*

b. A licensee who, in the course of employment, examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of two hours of training in dependent adult abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph *"e."*

c. A licensee who, in the scope of professional practice or in the course of employment, examines, attends, counsels or treats both adults and children in Iowa shall indicate on the renewal application completion of training in abuse identification and reporting for dependent adults and children in the previous five years or condition(s) for waiver of this requirement as identified in paragraph *"e."*

Training may be completed through separate courses as identified in paragraphs *"a"* and *"b"* or in one combined two-hour course that includes curricula for identifying and reporting child abuse and

dependent adult abuse. The course shall be a curriculum approved by the Iowa department of public health abuse education review panel.

d. The licensee shall maintain written documentation for five years after mandatory training as identified in paragraphs *"a"* to *"c,"* including program date(s), content, duration, and proof of participation.

e. The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

(1) Is engaged in active duty in the military service of this state or the United States.

(2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including an exemption of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in 645—Chapter 262.

f. The board may select licensees for audit of compliance with the requirements in paragraphs *"a"* to *"e."*

261.8(5) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license and shall send the licensee a wallet card by regular mail. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

261.8(6) A person licensed to practice as a respiratory care practitioner shall keep the person's license certificate and wallet card displayed in a conspicuous public place at the primary site of practice.

261.8(7) Late renewal. The license shall become late when the license has not been renewed by the expiration date on the wallet card. The licensee shall be assessed a late fee as specified in rule 645—5.17(147,152B). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

261.8(8) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice respiratory care in Iowa until the license is reactivated. A licensee who practices respiratory care in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

645—261.9(272C) Exemptions for inactive practitioners. Rescinded IAB 6/8/05, effective 7/13/05.

645—261.10(272C) Lapsed licenses. Rescinded IAB 6/8/05, effective 7/13/05.

645—261.11(147) Duplicate certificate or wallet card. Rescinded IAB 11/19/08, effective 1/1/09.

645—261.12(147) Reissued certificate or wallet card. Rescinded IAB 11/19/08, effective 1/1/09.

645—261.13(17A,147,272C) License denial. Rescinded IAB 11/19/08, effective 1/1/09.

645—261.14(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

261.14(1) Submit a reactivation application on a form provided by the board.

261.14(2) Pay the reactivation fee specified in rule 645—5.17(147,152B).

261.14(3) If the license has been inactive for two or more years, the licensee shall submit two completed sets of the fingerprint packet to facilitate a national criminal history background check. The cost for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks shall be assessed to the applicant. The board may withhold issuing a license pending receipt of a report from the DCI and FBI.

261.14(4) Provide verification of current competence to practice respiratory care by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 24 hours of continuing education that conforms to standards defined in 645—262.3(152B,272C) within 24 months immediately preceding submission of the application for reactivation.

b. If the license has been on inactive status for more than five years, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 48 hours of continuing education that conforms to standards defined in 645—262.3(152B,272C) within 24 months immediately preceding submission of the application for reactivation.

645—261.15(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 261.14(17A,147,272C) prior to practicing respiratory care in this state.

These rules are intended to implement Iowa Code chapters 17A, 147, 152B and 272C.

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CHAPTER 263
DISCIPLINE FOR RESPIRATORY CARE PRACTITIONERS

[Prior to 4/17/02, see rule 645—260.11(152B,272C)]

645—263.1(152B) Definitions.

"Board" means the board of respiratory care.

"Discipline" means any sanction the board may impose upon licensees.

"Licensee" means a person licensed to practice as a respiratory care practitioner in Iowa.

645—263.2(152B,272C) Grounds for discipline. The board may impose any of the disciplinary sanctions provided in rule 645—263.3(147,272C) when the board determines that the licensee is guilty of any of the following acts or offenses:

263.2(1) Fraud in procuring a license. Fraud in procuring a license includes, but is not limited to, an intentional perversion of the truth in making application for a license to practice in this state, which includes the following:

a. False representations of a material fact, whether by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a license in this state; or

b. Attempting to file or filing with the board or the department of public health any false or forged diploma or certificate or affidavit or identification or qualification in making an application for a license in this state.

263.2(2) Professional incompetency. Professional incompetency includes, but is not limited to:

a. A substantial lack of knowledge or ability to discharge professional obligations within the scope of practice.

b. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other practitioners in the state of Iowa acting in the same or similar circumstances.

c. A failure to exercise the degree of care which is ordinarily exercised by the average practitioner acting in the same or similar circumstances.

d. Failure to conform to the minimal standard of acceptable and prevailing practice of a respiratory care practitioner in this state.

e. Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.

f. Being adjudged mentally incompetent by a court of competent jurisdiction.

263.2(3) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of the profession or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

263.2(4) Practice outside the scope of the profession.

263.2(5) Use of untruthful or improbable statements in advertisements. Use of untruthful or improbable statements in advertisements includes, but is not limited to:

a. An action by a licensee in making information or intention known to the public which is false, deceptive, misleading or promoted through fraud or misrepresentation.

b. Inflated or unjustified expectations of favorable results.

c. Self-laudatory claims that imply that the respiratory care practitioner is skilled in a field or specialty of practice for which the practitioner is not qualified.

d. Extravagant claims or proclaiming extraordinary skills not recognized by the respiratory care profession.

263.2(6) Habitual intoxication or addiction to the use of drugs.

a. The inability of a licensee to practice with reasonable skill and safety by reason of the excessive use of alcohol on a continuing basis.

b. The excessive use of drugs which may impair a licensee's ability to practice with reasonable skill or safety.

263.2(7) Obtaining, possessing, attempting to obtain or possess, or administering controlled substances without lawful authority.

263.2(8) Falsification of client records.

263.2(9) Acceptance of any fee by fraud or misrepresentation.

263.2(10) Negligence by the licensee in the practice of the profession. Negligence by the licensee in the practice of the profession includes a failure to exercise due care including negligent delegation of duties or supervision of employees or other individuals, whether or not injury results; or any conduct, practice or conditions which impair the ability to safely and skillfully practice the profession.

263.2(11) Conviction of a crime related to the profession or occupation of the licensee or the conviction of any crime that would affect the licensee's ability to practice within the profession. A copy of the record of conviction or plea of guilty shall be conclusive evidence.

263.2(12) Violation of a regulation or law of this state, another state, or the United States, which relates to the practice of the profession.

263.2(13) Revocation, suspension, or other disciplinary action taken by a licensing authority of this state, another state, territory, or country; or failure by the licensee to report in writing to the board revocation, suspension, or other disciplinary action taken by a licensing authority within 30 days of the final action. A stay by an appellate court shall not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, the report shall be expunged from the records of the board.

263.2(14) Failure of a licensee or an applicant for licensure in this state to report any voluntary agreements restricting the practice of the profession in another state, district, territory or country.

263.2(15) Failure to notify the board of a criminal conviction within 30 days of the action, regardless of the jurisdiction where it occurred.

263.2(16) Failure to notify the board within 30 days after occurrence of any judgment or settlement of a malpractice claim or action.

263.2(17) Engaging in any conduct that subverts or attempts to subvert a board investigation.

263.2(18) Failure to comply with a subpoena issued by the board, or otherwise fail to cooperate with an investigation of the board.

263.2(19) Failure to comply with the terms of a board order or the terms of a settlement agreement or consent order.

263.2(20) Failure to pay costs assessed in any disciplinary action.

263.2(21) Submission of a false report of continuing education or failure to submit the biennial report of continuing education.

263.2(22) Failure to report another licensee to the board for any violations listed in these rules, pursuant to Iowa Code section 272C.9.

263.2(23) Knowingly aiding, assisting, procuring, or advising a person to unlawfully practice as a respiratory care practitioner.

263.2(24) Failure to report a change of name or address within 30 days after it occurs.

263.2(25) Representing oneself as a respiratory care practitioner when one's license has been suspended or revoked, or when one's license is on inactive status.

263.2(26) Permitting another person to use the licensee's license for any purpose.

263.2(27) Permitting an unlicensed employee or person under the licensee's control to perform activities requiring a license.

263.2(28) Unethical conduct. In accordance with Iowa Code section 147.55(3), behavior (i.e., acts, knowledge, and practices) which constitutes unethical conduct may include, but need not be limited to, the following:

a. Verbally or physically abusing a patient, client or coworker.

b. Improper sexual contact with, or making suggestive, lewd, lascivious or improper remarks or advances to a patient, client or coworker.

c. Betrayal of a professional confidence.

d. Engaging in a professional conflict of interest.

263.2(29) Failure to comply with universal precautions for preventing transmission of infectious diseases as issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

263.2(30) Violation of the terms of an initial agreement with the impaired practitioner review committee or violation of the terms of an impaired practitioner recovery contract with the impaired practitioner review committee.

[**ARC 8348B**, IAB 12/2/09, effective 1/6/10]

645—263.3(147,272C) Method of discipline. The board has the authority to impose the following disciplinary sanctions:

1. Revocation of license.
2. Suspension of license until further order of the board or for a specific period.
3. Prohibit permanently, until further order of the board, or for a specific period the engaging in specified procedures, methods, or acts.
4. Probation.
5. Require additional education or training.
6. Require a reexamination.
7. Order a physical or mental evaluation, or order alcohol and drug screening within a time specified by the board.
8. Impose civil penalties not to exceed $1000.
9. Issue a citation and warning.
10. Such other sanctions allowed by law as may be appropriate.

645—263.4(272C) Discretion of board. The following factors may be considered by the board in determining the nature and severity of the disciplinary sanction to be imposed:

1. The relative serious nature of the violation as it relates to ensuring a high standard of professional care to the citizens of this state;
2. The facts of the particular violation;
3. Any extenuating facts or other countervailing considerations;
4. The number of prior violations or complaints;
5. The seriousness of prior violations or complaints;
6. Whether remedial action has been taken; and
7. Such other factors as may reflect upon the competency, ethical standards, and professional conduct of the licensee.

645—263.5(152B) Order for mental, physical, or clinical competency examination or alcohol or drug screening. Rescinded IAB 11/19/08, effective 1/1/09.

These rules are intended to implement Iowa Code chapters 147, 152B and 272C.

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DENTAL BOARD[650]

[Prior to 5/18/88, Dental Examiners, Board of[320]]

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650—36.1(272D) Definitions. For the purpose of this chapter, the following definitions shall apply.

"Act" means Iowa Code chapter 272D.

"Applicant" means an individual who is seeking the issuance of a license.

"Board" means the Iowa dental board.

"Centralized collection unit" means the centralized collection unit of the Iowa department of revenue.

"Certificate of noncompliance" means a document provided by the centralized collection unit of the department of revenue certifying that the named applicant, licensee, permit holder, or registrant has an outstanding liability placed with the unit and has not entered into an approved payment plan to pay the liability.

"Denial notice" means a board notification denying an application for the issuance or renewal of a license, permit, or registration as required by the Act.

"Revocation or suspension notice" means a board notification suspending a license, registration, or permit for an indefinite or specified period of time or a notification revoking a license, permit, or registration as required by the Act.

"Withdrawal certificate" means a document provided by the centralized collection unit certifying that the certificate of noncompliance is withdrawn and that the board may proceed with issuance, reinstatement, or renewal of a license, permit, or registration.

[**ARC 8329B**, IAB 12/2/09, effective 1/6/10]

650—36.2(272D) Issuance or renewal of a license—denial. The board shall deny the issuance or renewal of a license, permit, or registration upon the receipt of a certificate of noncompliance from the centralized collection unit. This rule shall apply in addition to the procedures set forth in the Act.

36.2(1) *Service of denial notice.* Notice shall be served upon the applicant, licensee, permit holder, or registrant by certified mail, return receipt requested; by personal service; or through authorized counsel.

36.2(2) *Effective date of denial.* The effective date of the denial of the issuance or renewal of a license, permit, or registration, as specified in the denial notice, shall be 60 days following service of the denial notice upon the applicant, licensee, permit holder, or registrant.

36.2(3) *Preparation and service of denial notice.* The executive director of the board is authorized to prepare and serve the denial notice upon the applicant, licensee, permit holder, or registrant.

36.2(4) *Licensees, permit holders, registrants, and applicants responsible to inform board.* Licensees, permit holders, registrants, and applicants shall keep the board informed of all court actions and all centralized collection unit actions taken under or in connection with the Act. Licensees, permit holders, registrants, and applicants shall also provide the board copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to the Act, all court orders entered in such actions, and any withdrawals of certificates issued by the centralized collection unit.

36.2(5) *Reinstatement following denial.* All board fees required for application, renewal, or reinstatement must be paid by applicants, licensees, permit holders, or registrants before a license, permit, or registration will be issued, renewed, or reinstated after the board has denied the issuance or renewal of a license, permit, or registration pursuant to the Act.

36.2(6) *Effect of filing in district court.* In the event an applicant, licensee, permit holder, or registrant files a timely district court action following service of a board denial notice, the board shall continue with the intended action described in the denial notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the board to proceed. For purposes of determining the effective date of the denial of the issuance or renewal of a license, permit, or registration, the board shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

36.2(7) *Final notification.* The board shall notify the applicant, licensee, permit holder, or registrant in writing through regular first-class mail, or such other means as the board determines appropriate in the

circumstances, within ten days of the effective date of the denial of the issuance or renewal of a license, permit, or registration and shall similarly notify the applicant, licensee, permit holder, or registrant if the license, permit, or registration is issued or renewed following the board's receipt of a withdrawal certificate.
[**ARC 8329B**, IAB 12/2/09, effective 1/6/10]

650—36.3(272D) Suspension or revocation of a license. The board shall suspend or revoke a license, permit, or registration upon the receipt of a certificate of noncompliance from the centralized collection unit according to the procedures set forth in the Act. This rule shall apply in addition to the procedures set forth in the Act.

36.3(1) *Service of revocation or suspension notice.* A revocation or suspension notice shall be served upon the licensee, permit holder, or registrant by certified mail, return receipt requested; by personal service; or through authorized counsel.

36.3(2) *Effective date of revocation or suspension.* The effective date of the suspension or revocation of a license, permit, or registration, as specified in the revocation or suspension notice, shall be 60 days following service of the notice upon the licensee, permit holder, or registrant.

36.3(3) *Preparation and service of revocation or suspension notice.* The executive director of the board is authorized to prepare and serve the revocation or suspension notice upon the licensee, permit holder, or registrant and is directed to notify the licensee, permit holder, or registrant that the license, permit, or registration will be suspended, unless the license, permit, or registration is already suspended on other grounds. In the event that the license, permit, or registration is on suspension, the executive director shall notify the licensee, permit holder, or registrant of the board's intention to revoke the license, permit, or registration.

36.3(4) *Responsibility to inform board.* The licensee, permit holder, or registrant shall keep the board informed of all court actions and all centralized collection unit actions taken under or in connection with the Act. Licensees, permit holders, or registrants shall also provide the board copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to the Act, all court orders entered in such actions, and any withdrawal certificates issued by the centralized collection unit.

36.3(5) *Reinstatement following suspension or revocation.* A licensee, permit holder, or registrant shall pay all board fees required for renewal or reinstatement before a license, permit, or registration will be reinstated after the board has suspended or revoked a license, permit, or registration pursuant to the Act.

36.3(6) *Effect of filing in district court.* In the event a licensee, permit holder, or registrant files a timely district court action pursuant to the Act, and following service of a revocation or suspension notice, the board shall continue with the intended action described in the revocation or suspension notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the board to proceed. For purposes of determining the effective date of the suspension or revocation, the board shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

36.3(7) *Final notification.* The board shall notify the licensee, permit holder, or registrant in writing through regular first-class mail, or by such other means as the board determines appropriate in the circumstances, within ten days of the effective date of the suspension or revocation, and shall similarly notify the licensee, permit holder, or registrant if the license, permit, or registration is reinstated following the board's receipt of a withdrawal certificate.
[**ARC 8329B**, IAB 12/2/09, effective 1/6/10]

650—36.4(272D) Sharing of information. Notwithstanding any statutory confidentiality provision, the board may share information with the centralized collection unit of the department of revenue through automated means for the sole purpose of identifying applicants, licensees, permit holders, or registrants subject to enforcement under Iowa Code chapter 272D.
[**ARC 8329B**, IAB 12/2/09, effective 1/6/10]

These rules are intended to implement Iowa Code chapter 272D.

[Filed ARC 8329B (Notice ARC 8042B, IAB 8/12/09), IAB 12/2/09, effective 1/6/10]

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BOARD OF MEDICINE[653]

[Prior to 5/4/88, see Health Department[470], Chs 135 and 136, renamed Medical Examiners Board[653] under the "umbrella" of Public Health Department[641] by 1986 Iowa Acts, ch 1245]
[Prior to 7/4/07, see Medical Examiners Board[653]; renamed by 2007 Iowa Acts, Senate File 74]

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653—12.1(272D) Definitions. For the purpose of this chapter, the following definitions shall apply.

"Act" means Iowa Code sections 272D.1 to 272D.9.

"Applicant" means an individual who is seeking the issuance of a license.

"Board" means the board of medicine.

"Centralized collection unit" means the centralized collection unit of the Iowa department of revenue.

"Certificate of noncompliance" means a document known as a certificate of noncompliance which is provided by the centralized collection unit of the department of revenue certifying that the named applicant or licensee has an outstanding liability placed with the unit and has not entered into an approved payment plan to pay the liability.

"Denial notice" means a board notification denying an application for the issuance or renewal of a license as required by the Act.

"Revocation or suspension notice" means a board notification suspending a license for an indefinite or specified period of time or a notification revoking a license as required by the Act.

"Withdrawal certificate" means a document provided by the centralized collection unit certifying that the certificate of noncompliance is withdrawn and that the board may proceed with issuance, reinstatement, or renewal of a license.

[**ARC 8353B**, IAB 12/2/09, effective 1/6/10]

653—12.2(272D) Issuance or renewal of a license—denial. The board shall deny the issuance or renewal of a license upon the receipt of a certificate of noncompliance from the centralized collection unit. This rule shall apply in addition to the procedures set forth in the Act.

12.2(1) *Service of denial notice.* Notice shall be served upon the applicant or licensee by certified mail, return receipt requested; by personal service; or through authorized counsel.

12.2(2) *Effective date of denial.* The effective date of the denial of the issuance or renewal of a license, as specified in the denial notice, shall be 60 days following service of the denial notice upon the applicant or licensee.

12.2(3) *Preparation and service of denial notice.* The executive director of the board is authorized to prepare and serve the denial notice upon the applicant or licensee.

12.2(4) *Licensees and applicants responsible to inform board.* Licensees and applicants shall keep the board informed of all court actions and all centralized collection unit actions taken under or in connection with the Act. Licensees and applicants shall also provide the board copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to the Act, all court orders entered in such actions, and withdrawals of certificates issued by the centralized collection unit.

12.2(5) *Reinstatement following license denial.* All board fees required for application, license renewal, or license reinstatement must be paid by applicants or licensees before a license will be issued, renewed, or reinstated after the board has denied the issuance or renewal of a license pursuant to the Act.

12.2(6) *Effect of filing in district court.* In the event an applicant or a licensee files a timely district court action following service of a board denial notice, the board shall continue with the intended action described in the denial notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the board to proceed. For purposes of determining the effective date of the denial of the issuance or renewal of a license, the board shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

12.2(7) *Final notification.* The board shall notify the applicant or licensee in writing through regular first-class mail, or such other means as the board determines appropriate in the circumstances, within ten days of the effective date of the denial of the issuance or renewal of a license, and shall similarly notify the applicant or licensee if the license is issued or renewed following the board's receipt of a withdrawal certificate.

[**ARC 8353B**, IAB 12/2/09, effective 1/6/10]

653—12.3(272D) Suspension or revocation of a license. The board shall suspend or revoke a license upon the receipt of a certificate of noncompliance from the centralized collection unit according to the procedures set forth in the Act. This rule shall apply in addition to the procedures set forth in the Act.

12.3(1) *Service of revocation or suspension notice.* A revocation or suspension notice shall be served upon the licensee by certified mail, return receipt requested; by personal service; or through authorized counsel.

12.3(2) *Effective date of revocation or suspension.* The effective date of the suspension or revocation of a license, as specified in the revocation or suspension notice, shall be 60 days following service of the notice upon the licensee.

12.3(3) *Preparation and service of revocation or suspension notice.* The executive director of the board is authorized to prepare and serve the revocation or suspension notice upon the licensee and is directed to notify the licensee that the license will be suspended, unless the license is already suspended on other grounds. In the event that the license is on suspension, the executive director shall notify the licensee of the board's intention to revoke the license.

12.3(4) *Licensee responsible to inform board.* The licensee shall keep the board informed of all court actions and all centralized collection unit actions taken under or in connection with the Act. Licensees shall also provide the board copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to the Act, all court orders entered in such actions, and any withdrawal certificates issued by the centralized collection unit.

12.3(5) *Reinstatement following license suspension or revocation.* A licensee shall pay all board fees required for license renewal or license reinstatement before a license will be reinstated after the board has suspended or revoked a license pursuant to the Act.

12.3(6) *Effect of filing in district court.* In the event a licensee files a timely district court action pursuant to the Act, and following service of a revocation or suspension notice, the board shall continue with the intended action described in the revocation or suspension notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the board to proceed. For purposes of determining the effective date of the license suspension or revocation, the board shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

12.3(7) *Final notification.* The board shall notify the licensee in writing through regular first-class mail, or such other means as the board determines appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of a license, and shall similarly notify the licensee if the license is reinstated following the board's receipt of a withdrawal certificate.

[**ARC 8353B**, IAB 12/2/09, effective 1/6/10]

These rules are intended to implement Iowa Code chapter 272D.

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[Filed ARC 8353B (Notice ARC 8191B, IAB 10/7/09), IAB 12/2/09, effective 1/6/10]

REVENUE DEPARTMENT[701]

Created by 1986 Iowa Acts, Chapter 1245.

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CHAPTER 40
DETERMINATION OF NET INCOME
[Prior to 12/17/86, Revenue Department[730]]

701—40.1(422) Net income defined. Net income for state individual income tax purposes shall mean federal adjusted gross income as properly computed under the Internal Revenue Code and shall include the adjustments in 40.2(422) to 40.9(422). The remaining provisions of this rule and 40.12(422) to 40.72(422) shall also be applicable in determining net income.

This rule is intended to implement Iowa Code section 422.7.

701—40.2(422) Interest and dividends from federal securities. For individual income tax purposes, the state is prohibited by federal law from taxing dividends from corporations owned or sponsored by the federal government, or interest derived from obligations of the United States and its possessions, agencies, and instrumentalities. Therefore, if the federal adjusted gross income of an individual, taxable by Iowa, includes dividends or interest of this type, an adjustment must be made by deducting the amount of the dividend or interest. If the inclusion of an amount of income or the amount of a deduction is based upon federal adjusted gross income and federal adjusted gross income includes dividends from corporations owned or sponsored by the federal government, or interest derived from obligations of the United States and its possessions, agencies, and instrumentalities, a recomputation of the amount of income or deduction must be made excluding dividends or interest of this type from the calculations.

A federal statute exempts stocks and obligations of the United States Government, as well as the interest on the obligations, from state income taxation (see 31 USCS Section 3124(a)).

"Obligations of the United States" are those obligations issued "to secure credit to carry on the necessary functions of government." *Smith v. Davis* (1944) 323 U.S. 111, 119, 89 L.Ed. 107, 113, 65 S.Ct. 157, 161. The exemption is aimed at protecting the "borrowing" and "supremacy" clauses of the United States Constitution. *Society for Savings v. Bowers* (1955) 349 U.S. 143, 144, 99 L.Ed.2d 950, 955, 75 S.Ct. 607, 608; *Hibernia v. City and County of San Francisco* (1906) 200 U.S. 310, 313, 50 L.Ed. 495, 496, 26 S.Ct. 265, 266.

Tax-exempt credit instruments possess the following characteristics:

1. They are written documents,
2. They bear interest,
3. They are binding promises by the United States to pay specified sums at specified dates, and
4. They have Congressional authorization which also pledges the faith and credit of the United States in support of the promise to pay. *Smith v. Davis*, supra.

A governmental obligation that is secondary, indirect, or contingent, such as a guaranty of a nongovernmental obligor's primary obligation to pay the principal amount of and interest on a note, is not an obligation of the type exempted under 31 USCS Section 3124(1). *Rockford Life Ins. Co. v. Department of Revenue*, 107 S.Ct. 2312 (1987).

The following list contains widely held United States Government obligations, but is not intended to be all-inclusive.

This noninclusive listing indicates the position of the department with respect to the income tax status of the listed securities. It is based on current federal law and the interpretation thereof by the department. Federal law or the department's interpretation is subject to change. Federal law precludes all states from imposing an income tax on the interest income from direct obligations of the United States Government. Also, preemptive federal law may preclude state taxation of interest income from the securities of federal government-sponsored enterprises and agencies and from the obligations of U.S. territories. Any profit or gain on the sale or exchange of these securities is taxable.

40.2(1) Federal obligations and obligations of federal instrumentalities the interest on which is exempt from Iowa income tax.

a. United States Government obligations: United States Treasury—Principal and interest from bills, bonds, and notes issued by the United States Treasury exempt under 31 U.S.C. Section 3124[a].

1. Series E, F, G, H, and I bonds

2. United States Treasury bills
3. U.S. Government certificates
4. U.S. Government bonds
5. U.S. Government notes
6. Original issue discount (OID) on a United States Treasury obligation

b. Territorial obligations:

1. Guam—Principal and interest from bonds issued by the Government of Guam (48 USCS Section 1423[a]).

2. Puerto Rico—Principal and interest from bonds issued by the Government of Puerto Rico (48 USCS Section 745).

3. Virgin Islands—Principal and interest from bonds issued by the Government of the Virgin Islands (48 USCS Section 1403).

4. Northern Mariana Islands—Principal and interest from bonds issued by the Government of the Northern Mariana Islands (48 USCS Section 1681(c)).

c. Federal agency obligations:

1. Commodity Credit Corporation—Principal and interest from bonds, notes, debentures, and other similar obligations issued by the Commodity Credit Corporation (15 USCS Section 713a-5).

2. Banks for Cooperatives—Principal and interest from notes, debentures, and other obligations issued by Banks for Cooperatives (12 USCS Section 2134).

3. Farm Credit Banks—Principal and interest from systemwide bonds, notes, debentures, and other obligations issued jointly and severally by Banks of the Federal Farm Credit System (12 USCS Section 2023).

4. Federal Intermediate Credit Banks—Principal and interest from bonds, notes, debentures, and other obligations issued by Federal Intermediate Credit Banks (12 USCS Section 2079).

5. Federal Land Banks—Principal and interest from bonds, notes, debentures, and other obligations issued by Federal Land Banks (12 USCS Section 2055).

6. Federal Land Bank Association—Principal and interest from bonds, notes, debentures, and other obligations issued by the Federal Land Bank Association (12 USCS Section 2098).

7. Financial Assistance Corporation—Principal and interest from notes, bonds, debentures, and other obligations issued by the Financial Assistance Corporation (12 USCS Section 2278b-10[b]).

8. Production Credit Association—Principal and interest from notes, debentures, and other obligations issued by the Production Credit Association (12 USCS Section 2077).

9. Federal Deposit Insurance Corporation (FDIC)— Principal and interest from notes, bonds, debentures, and other such obligations issued by the Federal Deposit Insurance Corporation (12 USCS Section 1825).

10. Federal Financing Bank—Interest from obligations issued by the Federal Financing Bank. Considered to be United States Government obligations (12 USCS Section 2288, 31 USCS Section 3124[a]).

11. Federal Home Loan Bank—Principal and interest from notes, bonds, debentures, and other such obligations issued by any Federal Home Loan Bank and consolidated Federal Home Loan Bank bonds and debentures (12 USCS Section 1433).

12. Federal Savings and Loan Insurance Corporation (FSLIC)—Principal and interest from notes, bonds, debentures, and other such obligations issued by the Federal Savings and Loan Insurance Corporation (12 USCS Section 1725[e]).

13. Federal Financing Corporation—Principal and interest from notes, bonds, debentures, and other such obligations issued by the Federal Financing Corporation (12 USCS Section 2288(b)).

14. Financing Corporation (FICO)—Principal and interest from any obligation of the Financing Corporation (12 USCS Sections 1441[e][7] and 1433).

15. General Services Administration (GSA)—Principal and interest from General Services Administration participation certificates. Considered to be United States Government obligations (31 USCS Section 3124[a]).

16. Housing and Urban Development (HUD).

- Principal and interest from War Housing Insurance debentures (12 USCS Section 1739[d]).
- Principal and interest from Rental Housing Insurance debentures (12 USCS Section 1747g[g]).
- Principal and interest from Armed Services Mortgage Insurance debentures (12 USCS Section 1748b[f]).
- Principal and interest from National Defense Housing Insurance debentures (12 USCS Section 1750c[d]).
- Principal and interest from Mutual Mortgage Insurance Fund debentures (12 USCS Section 1710[d]).

17. National Credit Union Administration Central Liquidity Facility—Income from notes, bonds, debentures, and other obligations issued on behalf of the National Credit Union Administration Central Liquidity Facility (12 USCS Section 1795k[b]).

18. Resolution Funding Corporation—Principal and interest from obligations issued by the Resolution Funding Corporation (12 USCS Sections 1441[f][7] and 1433).

19. Student Loan Marketing Association (Sallie Mae)—Principal and interest from obligations issued by the Student Loan Marketing Association. Considered to be United States Government obligations (20 USCS Section 1087-2[1], 31 USCS Section 3124[a]).

20. Tennessee Valley Authority—Principal and interest from bonds issued by the Tennessee Valley Authority (16 USCS Section 831n-4[d]).

21. United States Postal Service—Principal and interest from obligations issued by the United States Postal Service (39 USCS Section 2005[d][4]).

22. Treasury Investment Growth Receipts.

23. Certificates on Government Receipts.

40.2(2) Taxable securities. There are a number of securities issued under the authority of an Act of Congress which are subject to the Iowa income tax. These securities may be guaranteed by the United States Treasury or supported by the issuing agency's right to borrow from the Treasury. Some may be backed by the pledge of full faith and credit of the United States Government. However, it has been determined that these securities are not direct obligations of the United States Government to pay a specified sum at a specified date, nor are the principal and interest from these securities specifically exempted from taxation by the respective authorizing Acts. Therefore, income from such securities is subject to the Iowa income tax. Examples of securities which fall into this category are those issued by the following agencies and institutions:

a. Federal agency obligations:

1. Federal or State Savings and Loan Associations
2. Export-Import Bank of the United States
3. Building and Loan Associations
4. Interest on federal income tax refunds
5. Postal Savings Account
6. Farmers Home Administration
7. Small Business Administration
8. Federal or State Credit Unions
9. Mortgage Participation Certificates
10. Federal National Mortgage Association
11. Federal Home Loan Mortgage Corporation (Freddie Mac)
12. Federal Housing Administration
13. Federal National Mortgage Association (Fannie Mae)
14. Government National Mortgage Association (Ginnie Mae)
15. Merchant Marine (Maritime Administration)
16. Federal Agricultural Mortgage Corporation (Farmer Mac)

b. Obligations of international institutions:

1. Asian Development Bank
2. Inter-American Development Bank
3. International Bank for Reconstruction and Development (World Bank)

c. Other obligations:

Washington D.C. Metro Area Transit Authority

Interest from repurchase agreements involving federal securities is subject to Iowa income tax. *Nebraska Department of Revenue v. John Loewenstein*, 514 US —, 130 L.Ed.2d 470, 115 S.Ct. — (1994). *Everett v. State Dept. of Revenue and Finance*, 470 N.W.2d 13 (Iowa 1991).

For tax years beginning on or after January 1, 1987, interest from Mortgage Backed Certificate Guaranteed by Government National Mortgage Association ("Ginnie Maes") is subject to Iowa income tax. See *Rockford Life Insurance Company v. Illinois Department of Revenue*, 96 L.Ed.2d 152.

For the treatment of interest or dividends from regulated investment companies (mutual funds) that invest in obligations of the type discussed in this rule, see rule 701—40.52(422).

This rule is intended to implement Iowa Code section 422.7.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—40.3(422) Interest and dividends from foreign securities, and securities of state and their political subdivisions. Interest and dividends from foreign securities and from securities of state and their political subdivisions are to be included in Iowa net income. Certain types of interest and dividends, because of specific exemption, are not includable in income for federal tax purposes. To the extent such income has been excluded for federal income tax purposes, unless the item of income is specifically exempted from state taxation by the laws or constitution of Iowa or of the United States, it must be added to Iowa taxable income.

The following is a noninclusive listing of bonds issued by the state of Iowa and its political subdivisions, interest on which is exempt from both federal and state income taxes.

1. Board of Regents: Bonds issued under Iowa Code sections 262.41, 262.51, 262.60, 262A.8, and 263A.6.
2. Urban Renewal: Bonds issued under Iowa Code section 403.9(2).
3. Municipal Housing Law - Low-income housing: Bonds issued under Iowa Code section 403A.12.
4. Subdistricts of soil conservation districts, revenue bonds: Bonds issued under Iowa Code section 467A.22 (transferred to Iowa Code section 161A.22 in 1993 Iowa Code).
5. Aviation authorities, revenue bonds: Bonds issued under Iowa Code section 330A.16.
6. Rural water districts: Bonds and notes issued under Iowa Code section 357A.15.
7. Iowa Alcoholic Beverage Control Act - Warehouse project: Bonds issued under Iowa Code section 123.159.
8. County Health Center: Bonds issued under Iowa Code section 331.441(2)*"c"*(7).
9. Iowa Finance Authority, Sewage treatment and drinking water facilities financing: Bonds issued under Iowa Code section 220.131(6) (transferred to Iowa Code section 16.131(6) in 1993 Iowa Code).
10. Agricultural Development Authority, Beginning farmer loan program: Bonds issued under Iowa Code section 175.17.
11. Iowa Finance Authority, Iowa comprehensive petroleum underground storage tank fund: Bonds issued under Iowa Code section 455G.6(14).
12. Iowa Finance Authority, E911 Program notes and bonds: Bonds issued under Iowa Code section 477B.20(6). (Transferred to Iowa Code section 34A.20(6) in 1993 Iowa Code.)
13. Quad Cities Interstate Metropolitan Authority Bonds: Bonds issued under Iowa Code section 330B.24. (Transferred to Iowa Code section 28A.24 in 1993 Iowa Code.)
14. Iowa Finance Authority, Municipal Investment Recovery Program: Bonds issued under Iowa Code section 220.173(4). (Transferred to Iowa Code section 16.173(4) in 1993 Iowa Code.)
15. Prison Infrastructure Revenue Bonds: Bonds issued under Iowa Code section 16.177(8).
16. Government Flood Damage Program Bonds: Bonds issued under Iowa Code section 16.183(4).
17. Iowa sewage treatment bonds: Bonds issued under Iowa Code section 16.131(6).
18. Community college residence halls and dormitories bonds: Bonds issued under Iowa Code section 260C.61.

19. Community college bond program bonds: Bonds issued under Iowa Code section 260C.71(6).

20. Regents institutions medical and hospital buildings at University of Iowa bonds: Bonds issued under Iowa Code section 263A.6.

21. Interstate bridges bonds: Bonds issued under Iowa Code section 313A.36.

22. Iowa higher education loan authority: Obligations issued by the authority on or after July 1, 2000, pursuant to either division of Iowa Code chapter 261A as authorized in Iowa Code section 261A.27.

23. Vision Iowa program: Bonds issued on or after July 1, 2000, upon request of the vision Iowa board pursuant to subsection 8 of Iowa Code section 12.71.

24. Honey Creek premier destination park bonds: Bonds issued under Iowa Code Supplement section 463C.12(8).

25. Iowa utilities board and Iowa consumer advocate building project bonds: Bonds issued under 2006 Iowa Acts, chapter 1179, section 70.

Interest from repurchase agreements involving obligations of the type discussed in this rule is subject to Iowa income tax. *Nebraska Department of Revenue v. John Loewenstein*, 514 US —, 130 L.Ed. 2d 470, 115 S.Ct. — (1994). *Everett v. State Dept. of Revenue and Finance*, 470 N.W.2d 13 (Iowa 1991).

For the treatment of interest or dividends from regulated investment companies (mutual funds) that invest in obligations of the type discussed in this rule, see rule 701—40.52(422).

Gains and losses from the sale or other disposition of bonds issued by the state of Iowa or its political subdivisions, as distinguished from interest income, shall be taxable for state income tax purposes.

This rule is intended to implement Iowa Code sections 12.71, 261A.27, and 357A.15; Iowa Code Supplement section 463C.12 as amended by 2006 Iowa Acts, chapter 1004, section 3; and Iowa Code Supplement section 422.7 as amended by 2006 Iowa Acts, chapter 1179, section 71.

701—40.4(422) Certain pensions, annuities and retirement allowances. Rescinded IAB 11/24/04, effective 12/29/04.

701—40.5(422) Military pay.

40.5(1) Rescinded IAB 6/3/98, effective 7/8/98.

40.5(2) For income received for services performed prior to January 1, 1969, and for services performed for tax periods beginning on or after January 1, 1977. An Iowa resident who is on active duty in the armed forces of the United States, as defined in Title 10, United States Code, Section 101, shall include all income received for such service performed prior to January 1, 1969, and for services performed during tax periods beginning on or after January 1, 1977. However, the taxability of this active duty military income shall be terminated for any income received for services performed effective the day after either of the two following conditions:

a. When universal compulsory military service is reinstated by the United States Congress. "Compulsory military service" is defined to be the actual act of drafting individuals into the military service and not just the registration of individuals under the Military Selective Service Act (50 App. U.S.C. 453); or

b. When a state of war is declared to exist by the United States Congress.

Federal active duty does not include a member of the national guard when called for training by order of the governor through order of the adjutant general. These members are in the service of the state and not on active duty of the United States. Federal active duty also does not include members of the various military reserve programs. A taxpayer must be on active federal duty to qualify for exemption. National guard and reservists who undergo voluntary training are not on active duty in a federal status. National guard and reservist pay does not qualify for the military exemption and such pay is taxable by the state of Iowa.

Compensation received from the United States Government by nonresident members of the armed forces who are temporarily present in the state of Iowa pursuant to military orders is exempt from Iowa income tax.

This rule is intended to implement Iowa Code section 422.5.

701—40.6(422) Interest and dividend income. This rule applies to interest and dividends from foreign securities and securities of state and other political subdivisions. Interest and dividends from foreign securities and from securities of state and other political subdivisions are to be included in Iowa taxable income. Certain types of interest and dividends, because of specific exemption, are not included in income for federal tax purposes. To the extent such income has been excluded for federal income tax purposes, unless the term of income is specifically exempted from state taxation by the laws or constitutions of Iowa or of the United States, it must be added to Iowa taxable income.

This rule is intended to implement Iowa Code section 422.7.

701—40.7(422) Current year capital gains and losses. In determining short-term or long-term capital gain or loss the provisions of the Internal Revenue Code are to be followed.

This rule is intended to implement Iowa Code section 422.7.

701—40.8(422) Gains and losses on property acquired before January 1, 1934. When property was acquired prior to January 1, 1934, the basis as of January 1, 1934, for determining capital or other gains or losses is the higher of cost, adjusted for depreciation allowed or allowable to January 1, 1934, or fair market value as of that date.

If, as a result of this provision, a basis is to be used for purposes of Iowa individual income tax which is different from the basis used for purposes of federal income tax, appropriate adjustment must be made and detailed schedules supplied in the computation of Iowa taxable income.

This rule is intended to implement Iowa Code section 422.7.

701—40.9(422) Work opportunity tax credit and alcohol fuel credit. Where an individual claims the work opportunity tax credit under Section 51 of the Internal Revenue Code or the alcohol fuel credit under Section 40 of the Internal Revenue Code, the amount of credit allowable must be used to increase federal taxable income. The amount of credit allowable used to increase federal adjusted gross income is deductible in determining Iowa net income. The work opportunity tax credit applies to eligible individuals who begin work after September 30, 1996, and before September 1, 2011. The adjustment for the alcohol fuel credit is applicable for tax years beginning on or after January 1, 1980.

This rule is intended to implement Iowa Code section 422.7.

701—40.10(422) Exclusion of interest or dividends. Rescinded IAB 11/24/04, effective 12/29/04.

701—40.11(422) Two-earner married couple deduction. Rescinded IAB 11/24/04, effective 12/29/04.

701—40.12(422) Income from partnerships or limited liability companies. Residents engaged in a partnership or limited liability company, even if located or doing business outside the state of Iowa, are taxable upon their distributive share of net income of such partnership or limited liability company, whether distributed or not, and are required to include such distributive share in their return. A nonresident individual who is a member of a partnership or limited liability company doing business in Iowa is taxable on that portion of net income which is applicable to the Iowa business activity whether distributed or not. See 701—Chapter 45.

This rule is intended to implement Iowa Code sections 422.7, 422.8, and 422.15.

701—40.13(422) Subchapter "S" income. Where a corporation elects, under Sections 1371-1379 of the Internal Revenue Code, to distribute the corporation's income to the shareholders, the corporation's income, in its entirety, is subject to individual reporting whether or not actually distributed. Both resident and nonresident shareholders shall report their share of the corporation's net taxable income on their respective Iowa returns. *Isaacson v. Iowa State Tax Commission,* 183 N.W.2d 693, Iowa Supreme Court, February 9, 1971. Residents shall report their distributable share in total while nonresidents shall report only their portion of their distributable share which was earned in Iowa. For tax years beginning on or after January 1, 1996, residents should refer to 701—Chapter 50 to determine if they qualify to

compute Iowa taxable income by allocation and apportionment. See 701—Chapter 54 for allocation and apportionment of corporate income.

This rule is intended to implement Iowa Code sections 422.7, 422.8, 422.15, and 422.36.

701—40.14(422) Contract sales. Interest derived as income from a land contract is intangible personal property and is assignable to the recipient's domicile. Gains received from the sale or assignment of land contracts are considered to be gains from real property in this state and are assignable to this state. As to nonresidents, see 40.16(422).

This rule is intended to implement Iowa Code sections 422.7 and 422.8.

701—40.15(422) Reporting of incomes by married taxpayers who file a joint federal return but elect to file separately for Iowa income tax purposes. Married taxpayers who have separate incomes and have filed jointly for federal income tax purposes can elect to file separate Iowa returns or to file separately on the combined Iowa return form. Where married persons file separately, both must use the optional standard deduction if either elects to use it, or both must claim itemized deductions if either elects to claim itemized deductions. The provisions of Treasury Regulation § 1.63-1 are equally applicable regarding the election to use the standard deduction or itemized deductions for Iowa income tax purposes. The spouses' election to file separately for Iowa income tax purposes is subject to the condition that incomes received by the taxpayers and the deductions for business expenses are allocated between the spouses as the incomes and deductions would have been allocated if the taxpayers had filed separate federal returns. Any Iowa additions to net income and any deductions to net income which pertain to taxpayers filing separately for Iowa income tax purposes must also be allocated accurately between the spouses. Thus, if married taxpayers file a joint federal return and elect to file separate Iowa returns or separately on the combined Iowa return, the taxpayers are required to compute their separate Iowa net incomes as if they had determined their federal adjusted gross incomes on separate federal returns with the Iowa adjustments to net income.

However, the fact that the taxpayers file separately for Iowa income tax purposes does not mean that the spouses will be subject to limitations that would apply if the taxpayers had filed separate federal returns. Instead, tax provisions that are applicable for taxpayers filing joint federal returns are also applicable to the taxpayers when they file separate Iowa returns unless the tax provisions are superseded by specific provisions in Iowa income tax law.

For example, married taxpayers that file separate federal returns cannot take the child and dependent care credit (in most instances) and cannot take the earned income credit. Taxpayers that file a joint federal return and elect to file separately for Iowa income tax purposes can take the child and dependent care credit and the earned income credit on their Iowa returns assuming they meet the qualifications for claiming these credits on the joint federal return.

The following paragraphs and examples are provided to clarify some issues and provide some guidance for taxpayers who filed a joint federal income tax return and elect to file separate Iowa returns or separately on the combined Iowa return form.

1. Election to expense certain depreciable business assets. When married taxpayers who have filed a joint federal return elect to file separate Iowa returns or separately on the combined Iowa return form, the taxpayers may claim the same deduction for the expensing of depreciable business assets as they were allowed on their joint federal return of up to $100,000 (for the tax year beginning on or after January 1, 2003, and which is adjusted annually for inflation for subsequent tax years) as authorized under Section 179 of the Internal Revenue Code. In a situation where one spouse is a wage earner and the second spouse has a small business, the second spouse may claim the same deduction for expensing depreciable assets of up to $100,000 (for the tax year beginning on or after January 1, 2003) that was allowable on the taxpayers' joint federal return. The fact that a spouse elects to file a separate Iowa return or separately on the combined return form after filing a joint federal return does not mean the spouse is limited to the same deduction for expensing of depreciable business assets of up to $50,000 (for the tax year beginning on or after January 1, 2003) that would have applied if the spouse had filed a separate federal return.

In situations where a married couple has ownership of a business, the deduction for the expensing of depreciable assets which is allowable on the spouses' joint federal return should be allocated between the spouses in the same ratio as incomes and losses from the business are reported by the spouses. Subrule 40.15(4) sets out criteria for allocation of incomes and losses of businesses in which married couples have an ownership interest.

2. Capital losses. Except for the Iowa capital gains deduction for limited amounts of net capital gains from certain types of assets described in rule 701—40.38(422), the federal income tax provision for reporting capital gains and losses and for the carryover of capital losses in excess of certain amounts are applicable for Iowa individual income tax purposes. When married taxpayers file a joint federal income tax return and elect to file separate Iowa returns or separately on the combined return form, the spouses must allocate capital gains and losses between them on the basis of the ownership of the assets that were sold or exchanged. That is, the spouses must allocate the capital gains and losses between them on the separate Iowa returns as the capital gains and losses would have been allocated if the taxpayers had filed separate federal returns instead of a joint federal return. However, each spouse is not subject to the $1,500 capital loss limitation on the separate Iowa return which is applicable to a married taxpayer that files a separate federal return. Instead, the spouses are collectively subject to the same $3,000 capital loss limitation for married taxpayers filing joint federal returns which is authorized under Section 1211(b) of the Internal Revenue Code. In circumstances where both spouses have net capital losses, each of the spouses can claim a capital loss of up to $1,500 on the separate Iowa return. In a situation where one spouse has a net capital loss of less than $1,500 and the other spouse has a capital loss greater than $1,500, the first spouse can claim the entire capital loss, while the second spouse can claim the portion of the net capital loss on the joint federal return that was not claimed by the first spouse. In no case can the net capital losses claimed on separate Iowa returns by married taxpayers exceed the $3,000 maximum capital loss that is allowed on the joint federal return. In a circumstance where one spouse has a net capital loss and the other spouse has a net capital gain, the amounts of capital gains and losses claimed by the spouses on their separate Iowa returns must conform with the net capital gain amount or net capital loss amount claimed on the joint federal return for the taxpayers. The following examples illustrate how capital gains and losses are to be allocated between spouses filing separate Iowa returns or separately on the combined Iowa return form for married taxpayers who filed joint federal returns.

EXAMPLE 1. A married couple filed a joint federal return which showed a net capital loss of $3,000. All of the capital loss was attributable to the husband, as the wife had no capital gains or losses. Therefore, when the taxpayers filed separate Iowa returns, the husband's return showed a $3,000 capital loss and the wife's return showed no capital gains or losses.

EXAMPLE 2. A married couple filed a joint federal return showing a net capital loss of $3,000, which was the maximum loss they could claim, although they had aggregate capital losses of $8,000. The husband had a net capital loss of $6,000 and the wife had a net capital loss of $2,000. When the taxpayers filed their separate Iowa returns each spouse claimed a net capital loss of $1,500, since each spouse had a capital loss of up to $1,500. The husband had a net capital loss carryover of $4,500 and the wife had a net capital loss carryover of $500.

EXAMPLE 3. A married couple filed a joint federal return showing a net capital loss of $2,500. The husband had a net capital gain of $7,500 and the wife had a net capital loss of $10,000. The wife claimed a net capital loss of $10,000 on her separate Iowa return, while the husband reported a net capital gain of $7,500 on his separate Iowa return.

EXAMPLE 4. A married couple filed a joint federal return showing a net capital loss of $3,000. The wife had a net capital loss of $800 and the husband had a net capital loss of $2,500. The wife claimed a $800 net capital loss on her separate Iowa return. The husband claimed a net capital loss on his separate Iowa return of $2,200 which was the portion of the net capital loss claimed on the joint federal return that was not claimed by the wife. The husband had a net capital loss carryover of $300.

3. Unemployment compensation benefits. When a husband and wife have filed a joint federal return and elect to file separate Iowa returns or separately on the Iowa combined return form, the spouses are to report the same amount of unemployment compensation benefits on their Iowa returns as was reported for federal income tax purposes as provided in Section 85 of the Internal Revenue Code.

When unemployment compensation benefits are received in the tax year the benefits are to be reported by the spouse or spouses who received the benefits as a result of employment of the spouse or spouses. Nonresidents of Iowa, including nonresidents covered by the reciprocal agreement with Illinois, are to report unemployment compensation benefits on the Iowa income tax return as Iowa source income to the extent the benefits pertain to the individual's employment in Iowa. In a situation where the unemployment compensation benefits are the result of employment in Iowa and in one or more other states, the unemployment compensation benefits should be allocated to Iowa on the basis of the individual's Iowa salaries and wages for the employer to the total salaries and wages for the employer. However, to the extent that unemployment compensation benefits pertain to a person's employment in Iowa for a railroad and the benefits are paid by the railroad retirement board, the benefits are totally exempt from Iowa income tax pursuant to 45 U.S.C. Section 352(e).

40.15(1) *Income from property in which only one spouse has an ownership interest but which is not used in business.* If ownership of property not used in a business is in the name of only one spouse and each files a separate state return, income derived from such property may not be divided between husband and wife but must be reported by only that spouse possessing the ownership interest.

40.15(2) *Income from property in which both husband and wife have an ownership interest but which is not used in a business.* A husband and wife who file a joint federal return and elect to file separate Iowa returns must each report the share of income from jointly or commonly owned real estate, stocks, bonds, bank accounts, and other property not used in a business in the same manner as if their federal adjusted gross incomes had been determined separately. The rules for determining the manner of reporting this income depend upon the nature of the ownership interest and, in general, may be summarized as follows:

a. Joint tenants. A husband and wife owning property as joint tenants with the right of survivorship, a common example of which is a joint savings account, should each report on separate returns one-half of the income from the savings account held by them in joint tenancy.

b. Tenants in common. Income from property held by husband and wife as tenants in common is reportable by them in proportion to their legally enforceable ownership interests in the property.

40.15(3) *Salary and wages derived from personal or professional services performed in the course of employment.* A husband and wife who file a joint federal return and elect to file separate Iowa returns must report on each spouse's state return the salary and wages which are attributable to services performed pursuant to each individual's employment. The income must be reported on Iowa separate returns in the same manner as if their federal adjusted gross incomes had been determined separately. The manner of reporting wages and salaries by spouses is dependent upon the nature of the employment relationship and is subject to the following rules:

a. Interspousal employment—salary or wages paid by one spouse to the other. Wages or compensation paid for services or labor performed by one spouse with respect to property or business owned by the other spouse may be reported on a separate return if the amount of the payment is reasonable for the services or labor actually performed. It is presumed that the compensation or wages paid by one spouse to the other is not reasonable nor allowable for purposes of reporting the income separately unless a bona fide employer-employee relationship exists. For example, unless actual services are rendered, payments are actually made, working hours and standards are set and adhered to, unemployment compensation and workers' compensation requirements are met, the payments may not be separately reported by the salaried spouse.

b. Wages and salaries received by a husband or wife pursuant to an employment agreement with an employer other than a spouse. Wages or compensation paid for services or labor performed by a husband or wife pursuant to an employment agreement with some other employer is presumed income of only that spouse that is employed and must be reported separately only by that spouse.

40.15(4) *Income from a business in which both husband and wife have an ownership interest.* Income derived from a business the ownership of which is in both spouses' names, as evidenced by record title or by the existence of a bona fide partnership agreement or by other recognized method of establishing legal ownership, may be allocated between spouses and reported on separate individual state income tax returns provided that the interest of each spouse is allocated according to the capital interest of each, the management and control exercised by each, and the services performed

by each with respect to such business. Compliance with the conditions contained in paragraphs *"a"* or *"b"* of this subrule and consideration of paragraphs *"c," "d,"* and *"e"* of this subrule must be made in allocating income from a business in which both husband and wife have an ownership interest.

a. Allocation of partnership income. Allocation of partnership income between spouses is presumed valid only if partnership information returns, as required for income tax purposes, have currently been filed with respect to the federal self-employment tax law. An oral understanding does not constitute a bona fide partnership implied merely from a common ownership of property.

b. Allocation of income derived from a business other than a partnership in which both husband and wife claim an ownership interest. In the case of a business owned by a husband and wife who filed a joint federal income tax return in which one of them claimed all of the income therefrom for federal self-employment tax purposes, it will be presumed for purposes of administering the state income tax law, unless expressly shown to the contrary by the taxpayer, that the spouse who claimed that income for federal self-employment tax purposes did, thereby, with the consent of the other spouse, claim all right to such income and that therefore such income must be included in the state income tax return of the spouse who claimed it for federal self-employment tax purposes if the husband and wife file separate state income tax returns.

c. Capital contribution. In determining the weight to be attributed to the capital contribution of each spouse to a business, consideration may be given only to that invested capital which is legally traceable to each individual spouse. Capital existing under the right, dominion, and control of one spouse which is invested in the business is presumed to be a capital contribution of that spouse. Sham transactions which do not affect real changes of ownership in capital between spouses in that such transactions do not legally disturb the right, dominion, and control of the assignor or the donor over the capital must be disregarded in determining capital contribution of the recipient spouse.

d. Management and control. Participation in the control and management of a business must be distinguished from the regular performance of nonmanagerial services. Contribution of management and control with respect to the business must be of a substantial nature in order to accord it weight in making an allocation of income. Substantial participation in management does not necessarily involve continuous or even frequent presence at the place of business, but it does involve genuine consultation with respect to at least major business decisions, and it presupposes substantial acquaintance with an interest in the operations, problems, and policies of the business, along with sufficient maturity and background of education or experience to indicate an ability to grasp business problems that are appreciably commensurate with the demands of the enterprise concerned. Vague or general statements as to family discussions at home or elsewhere will not be accepted as a sufficient showing of actual consultation.

e. Services performed. The amount of services performed by each spouse is a factor to be considered in determining proper allocation of income from a business in which each spouse has an ownership interest. In order to accord weight to services performed by an individual spouse, the services must be of a beneficial nature in that they make a direct contribution to the business. For example, for a business operation, whether it is a retail sales enterprise, farming operation or otherwise, in which both husband and wife have an ownership interest, the services contributed by the spouses must be directly connected with the business operation. Services for the family such as planting and maintaining family gardens, domestic housework, cooking family meals, and routine errands and shopping, are not considered to be services performed or rendered as an incident of or a contribution to the particular business; such activities by a spouse must be disregarded in determining the allocable income attributable to that spouse.

This rule is intended to implement Iowa Code section 422.7.

[**ARC 8356B**, IAB 12/2/09, effective 1/6/10]

701—40.16(422) Income of nonresidents. Except as otherwise provided in this rule all income of nonresidents derived from sources within Iowa is subject to Iowa income tax.

Net income received by a nonresident taxpayer from a business, trade, profession, or occupation in Iowa must be reported.

Income from the sale of property, located in Iowa, including property used in connection with the trade, profession, business or occupation of the nonresident, is taxable to Iowa even though the sale is consummated outside of Iowa, and provided that the property was sold before subsequent use outside of Iowa. Any income from the property prior to its sale is also Iowa taxable income.

Income received from a trust or an estate, where the income is from Iowa sources, is taxable, regardless of the situs of the estate or trust. Dividends received in lieu of, or in partial or full payment of, an amount of wages or salary due for services performed in Iowa by a nonresident shall be considered taxable Iowa income. Annuities, interest on bank deposits and interest-bearing obligations, and dividends are not allocated to Iowa except to the extent to which they are derived from a business, trade, profession, or occupation carried on within the state of Iowa by the nonresident.

Interest received from the sale of property, on an installment contract even though the gain from the sale of the property is subject to Iowa taxation, is not allocable to Iowa if the property is not part of the nonresident's trade, profession, business or occupation. As to residents, see 40.14(422).

40.16(1) *Nonresidents exempt from paying tax.* See 701—subrules 39.5(10) and 39.5(11) for the net income exemption amounts for nonresidents.

These provisions for reducing tax in 701—subrule 39.5(10), paragraph *"c,"* and 701—subrule 39.5(11), paragraph *"b,"* do not apply to the Iowa minimum tax which must be paid irrespective of the amount of Iowa income that an individual has.

40.16(2) *Compensation for personal services of nonresidents.* The Iowa income of a nonresident must include compensation for personal services rendered within the state of Iowa. The salary or other compensation of an employee or corporate officer who performs services related to businesses located in Iowa, or has an office in Iowa, are not subject to Iowa tax, if the services are performed while the taxpayer is outside of Iowa. However, the salary earned while the nonresident employee or officer is located within the state of Iowa would be subject to Iowa taxation. The Iowa taxable income of the nonresident shall include that portion of the total compensation received from the employer for personal services for the tax year which the total number of working days that the individual was employed within the state of Iowa bears to the total number of working days within and without the state of Iowa.

Compensation paid by an Iowa employer for services performed wholly outside of Iowa by a nonresident is not taxable income to the state of Iowa. However, all services performed within Iowa, either part-time or full-time, would be taxable to the nonresident and must be reported to this state.

Compensation received from the United States Government by a nonresident member of the armed forces is explained in 40.5(422).

Income from commissions earned by a nonresident traveling salesperson, agent or other employee for services performed or sales made and whose compensation depends directly on the volume of business transacted by the nonresident will include that proportion of the compensation received which the volume of business transacted by the employee within the state of Iowa bears to the total volume of business transacted by the employee within and without the state. Allowable deductions will be apportioned on the same basis. However, where separate accounting records are maintained by a nonresident or the employer of the business transacted in Iowa, then the amount of Iowa compensation can be reported based upon separate accounting.

Nonresident actors, singers, performers, entertainers, wrestlers, boxers (and similar performers), must include as Iowa income the gross amount received for performances within this state.

Nonresident attorneys, physicians, engineers, architects (and other similar professions), even though not regularly employed in this state, must include as Iowa income the entire amount of fees or compensation received for services performed in this state.

If nonresidents are employed in this state at intervals throughout the year, as would be the case if employed in operating trains, planes, motor buses, or trucks and similar modes of transportation, between this state and other states and foreign countries, and who are paid on a daily, weekly or monthly basis, the gross income from sources within this state is that portion of the total compensation for personal services which the total number of working days employed within the state bears to the total number of working days both within and without the state. If paid on a mileage basis, the gross income from sources within this state is that portion of the total compensation for services which the number of miles traveled in Iowa

bears to the total number of miles traveled both within and without the state. If paid on some other basis, the total compensation for personal services must be apportioned between this state and other states and foreign countries in such a manner as to allocate to Iowa that portion of the total compensation which is reasonably attributable to personal services performed in this state. Any alternative method of allocation is subject to review and change by the director. However, pursuant to federal law, nonresidents who earn compensation in Iowa and one or more other states for a railway company, an airline company, a merchant marine company, or a motor carrier are only subject to the income tax laws of their state of residence, and the compensation would not be considered gross income from sources within Iowa.

40.16(3) *Income from business sources within and without the state.* When income is derived from any business, trade, profession, or occupation carried on partly within and partly without the state only such income as is fairly and equitably attributable to that portion of the business, trade, profession, or occupation carried on in this state, or to services rendered within the state shall be included in the gross income of a nonresident taxpayer. In any event, the entire amount of such income both within and without the state is to be shown on the nonresident's return.

40.16(4) *Apportionment of business income from business carried on both within and without the state.*

a. If a nonresident, or a partnership or trust with a nonresident member, transacts business both within and without the state, the net income must be so apportioned as to allocate to Iowa a portion of the income on a fair and equitable basis, in accordance with approved methods of accounting.

b. The amount of net income attributable to the manufacture or sale of tangible personal property shall be that portion which the gross sales made within the state bears to the total gross sales. The gross sales of tangible personal property are in the state if the property is delivered or shipped to a purchaser within this state, regardless of the F.O.B. point or other conditions of the sale.

c. Income derived from business other than the manufacture or sale of tangible personal property shall be attributed to Iowa in that portion which the Iowa gross receipts bear to the total gross receipts. Gross receipts are attributable to this state in the portion which the recipient of the service receives benefit of the service in this state.

d. If the taxpayer believes that the gross sales or gross receipts methods subjects the taxpayer to taxation on a greater portion of net income than is reasonably attributable to the business within this state the taxpayer may request the use of separate accounting or another alternative method which the taxpayer believes to be proper under the circumstances. In any event, the entire income received by the taxpayer and the basis for a special method of allocation shall be disclosed in the taxpayer's return.

40.16(5) *Income from intangible personal property.* Business income of nonresidents from rentals or royalties for the use of, or the privilege of using in this state, patents, copyrights, secret processes and formulas, goodwill, trademarks, franchises, and other like property is income from sources within the state.

Income of nonresidents from intangible personal property such as shares of stock in corporations, bonds, notes, bank deposits and other indebtedness is not taxable as income from sources within this state except where such income is derived from a business, trade, profession, or occupation carried on within this state by the nonresident. If a nonresident buys or sells stocks, bonds, or other such property, so regularly, systematically and continuously as to constitute doing business in this state, the profit or gain derived from such activity is taxable as income from a business carried on within Iowa.

Following are examples to illustrate when intangible income may or may not be subject to the allocation provisions of Iowa Code section 422.8 and rules 701—40.15(422) and 701—42.3(422):

EXAMPLE A - An Illinois resident is a laborer at a factory in Davenport. A $50 payroll deduction is made each week from the laborer's paycheck to the company's credit union. The Illinois resident will earn $600 in interest income from the Iowa credit union account in 1983. The interest income would not be included in the net income allocated to Iowa since the interest income is not derived from the taxpayer's business or utilized for business purposes.

EXAMPLE B - A Nebraska resident is a self-employed plumber, who has a plumbing business in Council Bluffs. The plumber has an interest-bearing checking account in an Iowa bank which the plumber uses to pay bills for the plumbing business. The plumber will earn $200 in interest income

from the checking account in 1982. The plumber will have a net income of $25,000 from the plumbing business which will be reported on the plumber's 1982 Iowa return. The interest income earned by this nonresident would be taxable to Iowa since it is derived from the business and is utilized in the business.

EXAMPLE C - An Illinois resident has a farm in Illinois. The Illinois resident has an account in an Iowa savings and loan association and invests earnings from the Illinois farm in the Iowa savings and loan account. In 1982, the Illinois farmer will earn $1,000 in interest income from the account in the Iowa savings and loan. The interest income is not included in the net income allocable to Iowa since the interest income is not derived from the taxpayer's trade or business.

EXAMPLE D - An Illinois resident has Iowa farms. The Illinois resident invests the profits from the farms in a savings account in an Iowa bank. Several times a year, the taxpayer transfers part of the funds from the savings account to the taxpayer's checking account to purchase machinery to be used in the farming operations. The interest income would not be included in income allocated to Iowa since the interest income is not derived from the taxpayer's trade or business nor is the savings account utilized as a business account.

EXAMPLE E - An Illinois resident is a physician, whose practice is in Iowa. The physician has a business checking account in an Iowa bank that is used to pay the bills relating to the physician's practice. In the same bank, the physician has a personal savings account where all the physician's receipts for a given month are deposited. On the first working day of the month, funds are transferred from the savings account to the checking account to pay the bills that have accrued during the month. The interest income from the savings account would be included in net income allocated to Iowa since it is derived from and utilized in the business.

EXAMPLE F - A nonresident has a farm in Iowa which is the nonresident's principal business, although this person is an Illinois resident. The nonresident has an interest-bearing checking account in an Iowa bank. This checking account is used to pay personal expenditures as well as to pay expenses incurred in operation of the farm. In 1982, the taxpayer will earn $550 in interest from the checking account. The interest would be included in net income allocated to Iowa since the interest is derived from the business, generated from a business account, and utilized in the business.

Income of a nonresident beneficiary from an estate or trust, distributed or distributable to the beneficiary out of income from intangible personal property of the estate or trust, is not income from sources in this state and is not taxable to the nonresident beneficiary unless the property is so used by the estate or trust as to create a business, trade, profession, or occupation in this state.

Whether or not the executor or administrator of an estate or the trustee of a trust is a resident of this state is immaterial, insofar as the taxation of income of beneficiaries from the estate or trust are concerned.

EXAMPLE G - A nonresident is a partner in a family partnership in which the other partners are members of the same family. The other partners are residents of Iowa. The partnership invests in mutual funds, interest-bearing securities and stocks which produce interest, dividend and capital gain income for the partnership. The partners who are Iowa residents make the decisions in Iowa on what investments should be made by the partnership. The distributive share of interest, dividend and capital gain income reported by the nonresident would be included in net income allocated to Iowa since it was derived from a business carried on within the state. *Jensen, Herman A. & Vineta L.*, Docket No. 88-20-1-0014, Letter of Findings (1992).

40.16(6) *Distributive shares of nonresident partners.* When a partnership derives income from sources within this state as determined in 40.16(3) to 40.16(5), the nonresident members of the partnership are taxable only upon that portion of their distributive share of the partnership income which is derived from sources within this state.

40.16(7) *Interest and dividends from government securities.* Interest and dividends from federal securities subject to the federal income tax under the Internal Revenue Code are not to be included in determining the Iowa net income of a nonresident, but any interest and dividends from securities and from securities of state and other political subdivisions exempt for federal income tax under the Internal Revenue Code are to be included in the Iowa net income of a nonresident to the extent that same are

derived from a business, trade, profession, or occupation carried on within the state of Iowa by the nonresident.

40.16(8) *Gains or losses from sales or exchanges of real property and tangible personal property by a nonresident of Iowa.* If a nonresident realizes any gains or losses from sales or exchanges of real property or tangible personal property within the state of Iowa, such gains or losses are subject to the Iowa income tax and shall be reported to this state by the nonresident. Gains or losses attributable to Iowa will be determined as follows:

1. Gains or losses from sales or exchanges of real property located in this state are allocable to this state.

2. Capital gains and losses from sales or exchanges of tangible personal property are allocable to this state if the property had a situs in this state at the time of the sale.

In determining whether a short-term or long-term capital gain or a capital loss is involved in a sale or exchange, and determining the amount of a gain from the sale of real or tangible property in Iowa, the provisions of the Internal Revenue Code are to be followed.

40.16(9) *Capital gains or losses from sales or exchanges of ownership interests in Iowa business entities by nonresidents of Iowa.* Nonresidents of Iowa who sell or exchange ownership interests in various Iowa business entities will be subject to Iowa income tax on capital gains and capital losses from those transactions for different entities as described in the following paragraphs:

a. Capital gains from sales or exchanges of stock in C corporations and S corporations. When a nonresident of Iowa sells or exchanges stock in a C corporation or an S corporation, that shareholder is selling or exchanging the stock, which is intangible personal property. The capital gain received by a nonresident of Iowa from the sale or exchange of capital stock of a C corporation or an S corporation is taxable to the state of the personal domicile or residence of the owner of the capital stock unless the stock attains an independent business situs apart from the personal domicile of the individual who sold the capital stock. The stock may acquire an independent business situs in Iowa if the stock had been used as an integral part of some business activity occurring in Iowa in the year in which the sale or exchange of the stock had taken place. Whether the stock has attained an independent business status is determined on a factual basis.

For example, a situation in which capital stock owned by a nonresident of Iowa was used as collateral to secure a loan to remodel a retail store in Iowa, regardless of the ownership of the store, would meet the test for the stock being used as an integral part of some business activity in Iowa.

Assuming that the gain from the sale or exchange of stock is attributable to Iowa, the next step is to determine how much of the gain is attributable to Iowa. This is computed on the basis of the Iowa allocation and apportionment rules applicable to the separate business the stock has become an integral part of for the year in which the sale or exchange occurred. For example, if the business was subject to Iowa income tax on 40 percent of its income in the year of the sale or exchange, then 40 percent of the capital gain would be attributable or taxable by Iowa.

However, the fact that the gain from the sale or exchange of stock is taxable or partially taxable to Iowa does not mean that the dividends received by the nonresident in the year of sale are taxable to Iowa. Dividends from stock used in an Iowa specific business activity would not be taxable to Iowa except under special circumstances. An illustration of these special circumstances would be when the dividends are from capital stock from a business where the purchase and sale of stock constitute a regular business in Iowa. In this situation the dividends would be taxable to Iowa. See subrule 40.16(5).

b. Capital gains from sales or exchanges of interests in partnerships. When a nonresident of Iowa sells or exchanges the individual's interest in a partnership, the nonresident is actually selling an intangible since the partnership can continue without the nonresident partner and the assets used by the partnership are legally owned by the partnership and an individual retains only an equitable interest in the assets of the partnership by virtue of the partner's ownership interest in the partnership. However, because of the unique attributes of partnerships, the owner's interest in a partnership is considered to be localized or "sourced" at the situs of the partnership's activities as a matter of law. *Arizona Tractor Co. v. Arizona State Tax Com'n.,* 566 P.2d 1348, 1350 (Ariz. App. 1997); Iowa Code chapter 486 (unique attributes of a partnership defined). Therefore, if a partnership conducts all of its business in Iowa, 100

percent of the gain on the sale or exchange of a partnership interest would be attributable to Iowa. On the other hand, if the partnership conducts 100 percent of its business outside of Iowa, none of the gain would be attributable to Iowa for purposes of the Iowa income tax. In the situation where a partnership conducts business both in and out of Iowa, the capital gain from the sale or exchange of an interest in the partnership would be allocated or apportioned in and out of Iowa based upon the partnership's activities in and out of Iowa in the year of the sale or exchange.

Note that if a partnership is a publicly traded partnership and is taxed as a corporation for federal income tax purposes, any capital gains realized on the sale or exchange of a nonresident partner's interest in the partnership will receive the same tax treatment as the capital gain from the sale or exchange of an interest in a C corporation or an S corporation as specified in paragraph *"a"* of this subrule.

c. Capital gains from sales or exchanges of sole proprietorships. When a nonresident sells or exchanges the individual's interest in a sole proprietorship, the nonresident is actually selling or exchanging tangible and intangible personal property used in this business because the sole proprietor is the legal and equitable owner of all such assets. Therefore, the general source or situs rules governing the gain from the sale or exchange of tangible property and intangible property by a nonresident individual control. Thus, if the sole proprietorship is located in Iowa, the gain from the sale or exchange of the proprietorship by a nonresident would be taxable to Iowa.

d. Capital gains from sales or exchanges of interests in limited liability companies. Limited liability companies are hybrid business entities containing elements of both a partnership and a corporation. If a limited liability company properly elected to file or would have been required to file a federal partnership tax return, a capital gain from the sale or exchange of an ownership interest in the limited liability company by a nonresident member of the company would be taxable to Iowa to the same extent as if the individual were selling a similar interest in a partnership as described in paragraph *"b"* of this subrule. However, if the limited liability company properly elected or would have been required to file a federal corporation tax return, a nonresident member who sells or exchanges an ownership interest in the limited liability company would be treated the same as if the nonresident were selling a similar interest in a C corporation or an S corporation as described in paragraph *"a"* of this subrule.

e. Taxation of corporate liquidations. As a matter of Iowa law, the proceeds from corporate liquidating distributions are not considered to be the proceeds from the sale or exchange of corporate stock. Rather, such proceeds represent the transfer back to the shareholder of that shareholder's pro-rata share of the actual assets of the corporation in which each shareholder held only an equitable ownership interest prior to the dissolution. *Lynch v. State Board of Assessment and Review,* 228 Iowa 1000, 1003-1004, 291 N.W. 161 (1940). The amount of such gain is calculated by subtracting the distribution realized from the shareholder's basis in the stock. Id. Thus, any gain realized by the shareholder upon such distribution is considered a capital gain from a sale or exchange of the assets by the shareholder for purposes of sourcing the shareholder's liquidating distribution gain. Consequently, the gain, whether it is from a distribution of cash or other property, is controlled by the general source or situs rules in subrule 40.16(8) governing the taxation of the sale or exchange of tangible personal property by a nonresident and subrule 40.16(10) governing the sale or exchange of intangible personal property by a nonresident.

f. Capital losses realized by a nonresident of Iowa from the sale or exchange of an ownership interest in an Iowa business entity. In a situation where a nonresident of Iowa sells the ownership interest in an Iowa business entity and has a capital loss from the transaction, the nonresident can claim the loss on the Iowa income tax return under the same circumstances that a capital gain would have been reported as described in paragraphs *"a"* through *"e"* of this subrule. The federal income tax provisions for netting Iowa source capital gains and losses are applicable as well as the federal provisions for limiting the net capital loss in the tax year to $3,000, with the carryover of the portion of net capital losses that exceed $3,000.

40.16(10) *Capital gains and losses from sales or exchanges of intangible personal property other than ownership interests in business entities.* Capital gains and losses realized by a nonresident of Iowa from the sale or exchange of intangible personal property (other than interests in business entities) are taxable to Iowa if the intangible property was an integral part of some business activity occurring

regularly in Iowa prior to the sale or exchange. In the case of an intangible asset which was an integral part of a business activity of a business entity occurring regularly within and without Iowa, a capital gain or loss from the sale or exchange of the intangible asset by a nonresident of Iowa would be reported to Iowa in the ratio of the Iowa business activity to the total business activity for the year of the sale.

This rule is intended to implement Iowa Code sections 422.5, 422.7, and 422.8.

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701—40.17(422) Income of part-year residents. A taxpayer who was a resident of Iowa for only a portion of the taxable year is subject to the following rules of taxation:

1. For that portion of the taxable year for which the taxpayer was a nonresident, the taxpayer shall allocate to Iowa only the income derived from sources within Iowa.
2. For that portion of the taxable year for which the taxpayer was an Iowa resident, the taxpayer shall allocate to Iowa all income earned or received whether from sources within or without Iowa.

A taxpayer moving into Iowa may adjust the Iowa-source gross income on Schedule IA 126 by the amount of the moving expense to the extent allowed by Section 217 of the Internal Revenue Code. Any reimbursement of moving expense shall be included in Iowa-source gross income. A taxpayer moving from Iowa to another state or country may not adjust the Iowa-source gross income by the amount of moving expense, nor should any reimbursement of moving expense be allocated to Iowa.

This rule is intended to implement Iowa Code sections 422.5, 422.7, and 422.8.

701—40.18(422) Net operating loss carrybacks and carryovers. Net operating losses shall be allowed or allowable for Iowa individual income tax purposes and will be computed using a method similar to the method used to compute losses allowed or allowable for federal income tax purposes. In determining the applicable amount of Iowa loss carrybacks and carryovers, the adjustments to net income set forth in Iowa Code section 422.7 and the deductions from net income set forth in Iowa Code section 422.9 must be considered.

40.18(1) *Treatment of federal income taxes.*

a. Refund of federal income taxes due to net operating loss carrybacks or carryovers shall be reflected in the following manner:

(1) Accrual basis taxpayers shall accrue refunds of federal income taxes to the year in which the net operating loss occurs.

(2) Cash basis taxpayers shall reflect refunds of federal income taxes in the return for the year in which the refunds are received.

(3) Refunds reported in the year in which the net operating loss occurs which contain both business and nonbusiness components shall be analyzed and separated accordingly. The amount of refund attributable to business income shall be that amount of federal taxes paid on business income which are being refunded.

b. Federal income taxes paid in the year of the loss which contain both business and nonbusiness components shall be analyzed and separated accordingly. Federal income taxes paid in the year of the loss shall be reflected as a deduction to business income to the extent that the federal income tax was the result of the taxpayer's trade or business. Federal income taxes paid which are not attributable to a taxpayer's trade or business shall also be allowed as a deduction but will be limited to the amount of gross income which is not derived from a trade or business.

40.18(2) *Nonresidents doing business within and without Iowa.* If a nonresident does business both within and without Iowa, the nonresident shall make adjustments reflecting the apportionment of the operating loss on the basis of business done within and without the state of Iowa, according to rule 40.16(422). The apportioned income or loss shall be added or deducted, as the case may be, to any amount of other income attributable to Iowa for that year.

40.18(3) *Loss carryback and carryforward.* The net operating loss attributable to Iowa as determined in rule 40.18(422) shall be subject to the federal 2-year carryback and 20-year carryover provisions if the net operating loss was for a tax year beginning after August 5, 1997, or subject to the federal 3-year carryback and the 15-year carryforward provisions if the net operating loss was for

a tax year beginning prior to August 6, 1997. However, in the case of a casualty or theft loss for an individual taxpayer or for a net operating loss in a presidentially declared disaster area incurred by a taxpayer engaged in a small business or in the trade or business of farming, the net operating loss is to be carried back 3 taxable years and forward 20 taxable years if the loss is for a tax year beginning after August 5, 1997. The net operating loss or casualty or theft loss shall be carried back or over to the applicable year as a reduction or part of a reduction of the taxable income attributable to Iowa for that year. However, a net operating loss shall not be carried back to a year in which the taxpayer was not doing business in Iowa. If the election under Section 172(b)(3) of the Internal Revenue Code is made, the Iowa net operating loss shall be carried forward 20 taxable years if the net operating loss is for a tax year beginning after August 5, 1997, or the net operating loss shall be carried forward 15 taxable years if the loss is for a tax year beginning before August 6, 1997. A copy of the federal election made under Section 172(b)(3) of the Internal Revenue Code must be attached to the Iowa individual return filed with the department.

40.18(4) *Loss not applicable.* No part of a net loss for a year for which an individual was not subject to the imposition of Iowa individual income tax shall be included in the Iowa net operating loss deduction applicable to any year prior to or subsequent to the year of the loss.

40.18(5) *Special adjustments applicable to net operating losses.* Section 172(d) of the Internal Revenue Code provides for certain modifications when computing a net operating loss. These modifications refer to, but are not limited to, such things as considerations of other net operating loss deductions, treatment of capital gains and losses, and the limitation of nonbusiness deductions. Where applicable, the modifications set forth in Section 172 of the Internal Revenue Code shall be considered when computing the net operating loss carryover or carryback for Iowa income tax purposes.

40.18(6) *Distinguishing business or nonbusiness items.* In computing a net operating loss, nonbusiness deductions may be claimed only to the extent of nonbusiness income. Therefore, it is necessary to distinguish between business and nonbusiness income and expenses. For Iowa net operating loss purposes, an item will retain the same business or nonbusiness identity which would be applicable for federal income tax purposes.

40.18(7) *Examples.* The computation of a net operating loss deduction for Iowa income tax purposes is illustrated in the following examples:

a. Individual A had the following items of income for the taxable year:

Gross income from retail sales business		$125,000
Interest income from federal securities		2,000
Salary from part-time job		12,500
Individual A's federal return showed the following deductions:		
Business deductions (retail sales)		$150,000
Itemized (nonbusiness) deductions:		
Interest	$400	
Real estate tax	600	
Iowa income tax	800	$ 1,800

Individual A paid $3,000 federal income tax during the year which consisted of $2,500 federal withholding (business) and a $500 payment (nonbusiness) which was for the balance of the prior year's federal tax liability.

The federal computations are as follows:

	Per Return	Computed NOL
Income:		
Retail Sales	$125,000	$125,000
Interest income-federal securities	2,000	2,000
Salary	12,500	12,500
Subtotal	$139,500	$139,500
Deductions:		
Business	$150,000	$150,000
Itemized deductions	1,800	1,800
(Loss) per federal	($ 12,300)	
Computed net operating loss		($ 12,300)

Since the nonbusiness deductions do not exceed the nonbusiness income, the loss per the federal return and the computed net operating loss are the same.

The Iowa computations are as follows:

	Per Return	Computed NOL
Income:		
Retail sales	$125,000	$125,000
Salary	12,500	12,500
Subtotal	$137,500	$137,500
Deductions:		
Business	$150,000	$150,000
Federal tax deductions	3,000	2,500
Itemized deductions	1,000	-
(Loss) per return	($ 16,500)	
Computed Iowa NOL		($ 15,000)

NOTE: Itemized (nonbusiness deductions) are eliminated due to the lack of nonbusiness income. The only nonbusiness income, interest from federal securities, is not taxable for Iowa income tax purposes under Iowa Code section 422.7. The only federal tax deduction allowable is that related to business activity.

b. Individual B had the following items of income for the taxable year:

Gross income from restaurant business	$300,000
Wages	12,000
Business long-term capital gain @100%	1,000
Municipal bond interest (nonbusiness)	1,000
Federal tax refund of prior year taxes	500
Iowa tax refund of prior year taxes	100
Individual B's federal return showed the following deductions:	
Business deductions from restaurant	$333,000
Itemized deductions:	

Interest (nonbusiness)	$590	
Real estate tax (nonbusiness)	780	
Iowa income tax*	520	
Alimony (nonbusiness)	600	
Union dues (business)	100	2,590

*Iowa estimated payments totaled $220 of which $70 related to nonbusiness income and $150 related to business capital gains and business profits. $300 in Iowa tax was withheld from his wages.

Individual B paid $2,000 in federal income taxes during the tax year. $1,500 of this amount was withholding on wages and $500 was a federal estimated payment based on capital gains and projected business profits.

In the previous year 75 percent of B's income was from business sources and 25 percent was from nonbusiness sources.

The federal computations are as follows:

	Per Return	Computed NOL
Income:		
Retail sales	$300,000	$300,000
Wages	12,000	12,000
Capital gains	500(a)	1,000(a)
Iowa refund	100	100
Subtotal	$312,600	$313,100
Deductions:		
Business	$333,000	$333,000
Itemized deductions	2,590	575(b)
(Loss) per federal	($ 22,990)	
Computed net operating loss		($ 20,475)

(a) Capital gains are reduced by 50 percent in computing adjusted gross income, but must be reported in full in computing a net operating loss.

(b) Itemized deductions are limited to business deductions consisting of $100 for union dues, $450 for Iowa tax on business income, and nonbusiness deductions to the extent of nonbusiness income which amounts to $25. The only nonbusiness income is 25 percent of the $100 Iowa refund.

The Iowa computations are as follows:

	Per Return	Computed NOL
Income:		
Retail sales	$300,000	$300,000
Wages	12,000	12,000
Capital gains	500	1,000
Municipal bond interest	1,000	1,000
Federal refund	500	500
Subtotal	$314,000	$314,500

Deductions:		
Business	$333,000	$333,000
Federal tax	2,000	2,000
Itemized deductions	2,070(c)	1,225(d)
(Loss) per return	($ 23,070)	
Computed Iowa NOL		($ 21,725)

(c) Iowa income tax is not an itemized deduction for Iowa income tax purposes.

(d) Itemized deductions are limited to business deductions of $100 for union dues and nonbusiness deductions to the extent of nonbusiness income of $1,125. Nonbusiness income includes $1,000 of municipal bond interest and 25 percent ($125) of the federal tax refund.

40.18(8) *Net operating losses for nonresidents and part-year residents for tax years beginning on or after January 1, 1982.* For tax years beginning on or after January 1, 1982, nonresidents and part-year residents may carryback/carryforward only those net operating losses from Iowa sources. Nonresidents and part-year residents may not carryback/carryforward net operating losses which are from all sources.

Before the Iowa net operating loss of a nonresident or part-year resident is available for carryback/carryforward to another tax year, the loss must be decreased or increased by a number of possible adjustments depending on which adjustments are applicable to the taxpayer for the year of the loss. Iowa Net Operating Loss (NOL) Worksheet (41-123) may be used to make the adjustments to the net operating loss and compute the net operating loss deduction available for carryback/carryforward.

If the net operating loss was increased by an adjustment for an individual retirement account or H.R.10 retirement plan, the net operating loss should be decreased by the amount of the adjustment. The net operating loss should also be decreased by the amount of any capital loss or by the capital gain deduction to the extent the capital loss or capital gain deduction was from the sale or exchange of an asset from an Iowa source.

In a situation where the nonresident or part-year resident taxpayer received a federal income tax refund in the year of the NOL, the refund should reduce the loss in the ratio of the Iowa source income to the all source income for the tax year in which the refund was generated.

The net operating loss should be increased by any federal income tax paid in the loss year for a prior year in the ratio of the Iowa income for the prior year to the all source income for the prior year. Federal income tax withheld from wages or other compensation received in the loss year may be used to increase the Iowa net operating loss to the extent the tax is withheld from wages or other compensation earned in Iowa.

Federal estimate tax payments would be allocated to Iowa and increase the net operating loss on the basis of the Iowa income not subject to withholding to total income not subject to withholding. In any case where this method of allocation of federal estimate payments to Iowa is not considered to be equitable, the taxpayer may allocate the payments using another method as long as this method is disclosed on the taxpayer's Iowa individual income tax return for the year of the loss. However, the burden of proof is on the taxpayer to show that an alternate method of allocation is equitable.

Nonbusiness deductions included in the itemized deductions paid during the year of the net operating loss may be used to increase the NOL to the extent of nonbusiness income which is reported to Iowa in computation of the net operating loss. In most instances of net operating losses for nonresidents, no itemized deductions will be allowed in computing the net operating loss deduction. This is because most nonresidents will have no nonbusiness income reported to Iowa. Business deductions included in the federal itemized deductions may be used to increase the net operating loss deduction to the extent the deductions pertain to a business, trade, occupation or profession conducted in Iowa.

EXAMPLE A. A nonresident taxpayer had the following all source income and Iowa source income for 1982:

Category	All Source Income	Iowa Source Income
Wages	$20,000	$20,000
Interest	5,000	0
Rental income	5,000	5,000
Business loss	(50,000)	(10,000)
Iowa net income (loss)	($20,000)	$15,000

The nonresident taxpayer did not have an Iowa net operating loss available for carryback/carryforward for Iowa income tax purposes because the taxpayer's Iowa source income was not negative. The taxpayer's all source loss of ($20,000) does not qualify for carryback/carryforward on the Iowa return. However, since the taxpayer's all source income is negative, the taxpayer will not have an Iowa income tax liability for the year of the all source loss.

EXAMPLE B. A nonresident taxpayer received a federal refund of $1,000 in 1983. The refund was from the taxpayer's 1981 federal return where the taxpayer's Iowa income was 20% of the total income. $2,000 of federal income tax was withheld from the taxpayer's Iowa wages in 1982. The taxpayer had $10,000 in itemized deductions in 1982. However, the taxpayer had no Iowa nonbusiness income in 1982. In addition, no Iowa business deductions were included in the itemized deductions available on the federal return. The individual had the following all source income and Iowa source income in 1982:

Category	All Source Income	Iowa Source Income
Wages	$60,000	$10,000
Interest	3,000	0
Rental income	5,000	5,000
Farm income loss	(30,000)	(30,000)
Capital gain	2,000	2,000
Total incomes	$40,000	($13,000)

The taxpayer's Iowa source loss of ($13,000) was decreased by $200 of the federal refund since 20% of the refund was considered to be from Iowa income. The loss was decreased by $3,000 which was the capital gain deduction of the Iowa source asset sold in 1982. The loss was increased by the federal income tax withheld of $2,000 from Iowa wages. Because there is no Iowa source nonbusiness income nor Iowa source business deductions, the taxpayer's itemized deductions will not affect the net operating loss deduction.

Shown below is a recap of the net operating loss deduction for the nonresident taxpayer.

Iowa source net loss	($13,000)
Iowa portion of federal refund	200
Federal tax withheld on Iowa wages	(2,000)
Capital gain deduction	3,000
Total	($11,800)

The taxpayer's net operating loss deduction available for carryback/carryforward to another tax year is ($11,800).

After all adjustments are made to the Iowa net operating loss to compute the net operating loss deduction available for carryback/carryforward, the NOL deduction is applied to the carryback/carryforward tax year as described in paragraph *"a"* and paragraph *"b"* below:

a. Application of net operating losses to tax years beginning prior to January 1, 1982. In cases where a net operating loss deduction for a nonresident or part-year resident for a tax year beginning on

or after January 1, 1982, is applied to a tax year beginning prior to January 1, 1982, the net operating loss deduction is applied to the taxable income for the carryback/carryforward year unless the NOL deduction is greater than the taxable income. If the NOL deduction is greater than the taxable income, the taxable income is increased by any Iowa source capital loss or any Iowa source capital gain deduction before the NOL deduction is applied against the taxable income.

EXAMPLE 1. A nonresident taxpayer has an Iowa net operating loss deduction of ($15,000) from the taxpayer's 1982 Iowa return. The taxpayer is carrying the NOL deduction back to 1979 where taxpayer's Iowa taxable income was $14,000. The taxpayer had a net capital loss of $3,000 in 1979. Because the taxpayer's 1979 taxable income of $14,000 was $1,000 less than the NOL deduction, the taxable income was increased by $1,000 of the net capital loss so there would be no carryover of the NOL to 1980. However, since the NOL deduction erased all the taxable income for 1979, the taxpayer would be granted a refund of all the Iowa income tax paid for the carryback year of 1979, plus applicable interest.

b. Application of net operating losses to tax years beginning on or after January 1, 1982. In situations where a net operating loss of a nonresident or part-year resident for a tax year beginning on or after January 1, 1982, is carried back/carried forward for application to a tax year beginning on or after January 1, 1982, the net operating loss deduction is applied to the Iowa source income of the taxpayer for the carryback/carryforward year. The Iowa source income is the income on line 25 of Section B of Schedule IA-126 for the 1982 and 1983 Iowa returns and line 26 of Section B of Schedule IA-126 for the 1984 Iowa return and the incomes on similar corresponding lines of Section B of Schedule IA-126 for tax years after 1984. In situations where the net operating loss deductions are larger than the Iowa source incomes, the Iowa source incomes are increased by any Iowa source capital gains or capital losses that are applicable, not to exceed the NOL deduction.

The Iowa source net income after reduction by the NOL deduction is divided by the all source income for the taxpayer. The resulting percentage is the adjusted Iowa income percentage. This percentage is subtracted from 100 percent to arrive at the revised nonresident/part-year resident credit for the taxpayer. The taxpayer's overpayment as a result of the net operating loss is the amount by which the revised nonresident/part-year credit exceeds the nonresident/part-year credit prior to application of the net operating loss deduction.

EXAMPLE 1. A nonresident taxpayer had a net operating loss deduction of $11,800 for the 1996 tax year. When the 1996 Iowa return was filed, the taxpayer elected to carry the loss forward to the 1997 tax year. The taxpayer's all source net income and Iowa source net income for 1997 were as shown below. The net operating loss carryforward from 1996 is deducted only from the Iowa source income for 1997:

Category	All Source Income	Iowa Source Income
Wages	$ 60,000	$ 20,000
Interest	3,000	0
Rental income	10,000	3,000
Farm income	25,000	25,000
Capital gain	2,000	2,000
Net operating loss carryforward	—	(11,800)
Iowa net income	$100,000	$ 38,200

The Iowa source income of $38,200 after reduction by the NOL carryforward is divided by the all source income of $100,000 which results in an Iowa income percentage of 38.2. This percentage is subtracted from 100 percent to arrive at the nonresident/part-year resident credit percentage of 61.8. When the tax after credit amount of $7,364 is multiplied by the nonresident/part-year credit percentage of 61.8, this results in a credit of $4,551. This credit is $869 greater than the nonresident/part-year credit of $3,682 would have been for 1997 without application of the net operating loss deduction which was carried forward from 1996.

40.18(9) *Net operating loss carryback for a taxpayer engaged in the business of farming.* Notwithstanding the net operating loss carryback periods described in subrule 40.18(3), a taxpayer who is engaged in the trade or business of farming as defined in Section 263A(e)(4) of the Internal Revenue Code and has a loss from farming as defined in Section 172(b)(1)(F) of the Internal Revenue Code for a tax year beginning on or after January 1, 1998, this loss from farming is a net operating loss which the taxpayer may carry back five taxable years prior to the year of the loss. Therefore, if a taxpayer has a net operating loss from the trade or business of farming for the 1998 tax year, the net operating loss from farming can be carried back to the taxpayer's 1993 Iowa return and can be applied to the income shown on that return. The farming loss is the lesser of (1) the amount that would be the net operating loss for the tax year if only income and deductions from the farming business were taken into account, or (2) the amount of the taxpayer's net operating loss for the tax year. Thus, if a taxpayer has a $10,000 loss from a grain farming business and the taxpayer had wages in the tax year of $7,000, the taxpayer's loss for the year is only $3,000. Therefore, the taxpayer has a net operating loss from farming of $3,000 that may be carried back five years.

However, if a taxpayer has a net operating loss from the trade or business of farming for a taxable year beginning in 1998 or for a taxable year after 1998 and makes a valid election for federal income tax purposes to carry back the net operating loss two years, or three years if the loss was in a presidentially declared disaster area or related to a casualty or theft loss, the net operating loss must be carried back two years or three years for Iowa income tax purposes. A copy of the federal election made under Section 172(i)(3) for the two-year or three-year carryback in lieu of the five-year carryback may be attached to the Iowa return or the amended Iowa return to show why the carryback was two years or three years instead of five years.

This rule is intended to implement Iowa Code sections 422.5 and 422.7 and Iowa Code Supplement section 422.9(3).

701—40.19(422) Casualty losses. Casualty losses may be treated in the same manner as net operating losses and may be carried back three years and forward seven years in the event said casualty losses exceed income in the loss year.

This rule is intended to implement Iowa Code section 422.7.

701—40.20(422) Adjustments to prior years. When Iowa requests for refunds are filed, they shall be allowed only if filed within three years after the tax payment upon which a refund or credit became due, or one year after the tax payment was made, whichever time is the later. Even though a refund may be barred by the statute of limitations, a loss shall be carried back and applied against income on a previous year to determine the correct amount of loss carryforward.

This rule is intended to implement Iowa Code section 422.73.

701—40.21(422) Additional deduction for wages paid or accrued for work done in Iowa by certain individuals. For tax years beginning on or after January 1, 1984, but before January 1, 1989, a taxpayer who operates a business which is considered to be a small business as defined in subrule 40.21(2) is allowed an additional deduction for 50 percent of the first 12 months of wages paid or accrued during the tax years for work done in Iowa by employees first hired on or after January 1, 1984, or after July 1, 1984, where the taxpayer first qualifies as a small business under the expanded definition of a small business effective July 1, 1984, and meets one of the following criteria.

A handicapped individual domiciled in this state at the time of hiring.

An individual domiciled in this state at the time of hiring who meets any of the following conditions:

1. Has been convicted of a felony in this or any other state or the District of Columbia.
2. Is on parole pursuant to Iowa Code chapter 906.
3. Is on probation pursuant to Iowa Code chapter 907 for an offense other than a simple misdemeanor.
4. Is in a work release program pursuant to Iowa Code chapter 247A.

An individual, whether or not domiciled in this state at the time of the hiring, who is on parole or probation and to whom the interstate probation and parole compact under Iowa Code section 913.40 applies.

For tax years beginning on or after January 1, 1989, the additional deduction for wages paid or accrued for work done in Iowa by certain individuals is 65 percent of the wages paid for the first 12 months of employment of the individuals, not to exceed $20,000 per individual. Individuals must meet the same criteria to qualify their employers for this deduction for tax years beginning on or after January 1, 1989, as for tax years beginning before January 1, 1989.

For tax years ending after July 1, 1990, a taxpayer who operates a business which does not qualify as a small business specified in subrule 40.21(2) may claim an additional deduction for wages paid or accrued for work done in Iowa by certain convicted felons provided the felons are described in the four numbered paragraphs above and the following unnumbered paragraph and provided the felons are first hired on or after July 1, 1990. The additional deduction is 65 percent not to exceed $20,000 for the first 12 months of wages paid for work done in Iowa.

The qualifications mentioned in subrules 40.21(1), 40.21(4), 40.21(5) and 40.21(6) and in subrule 40.21(3), paragraphs *"f"* and *"g,"* apply to the additional deduction for work done in Iowa by a convicted felon in situations where the taxpayer is not a small business as well as in situations where the taxpayer is a small business.

The additional deduction applies to any individual hired on or after July 1, 2001, whether or not domiciled in Iowa at the time of hiring, who is on parole or probation and to whom either the interstate probation and parole compact under Iowa Code section 907A.1 or the compact for adult offenders under Iowa Code chapter 907B applies. The amount of additional deduction for hiring this individual is equal to 65 percent of the wages paid, but the additional deduction is not to exceed $20,000 for the first 12 months of wages paid for work done in Iowa.

40.21(1) The additional deduction shall not be allowed for wages paid to an individual who was hired to replace an individual whose employment was terminated within the 12-month period preceding the date of first employment. However, if the individual being replaced left employment voluntarily without good cause attributable to the employer or if the individual was discharged for misconduct in connection with the individual's employment as determined by the department of workforce development, the additional deduction shall be allowed.

The determination of whether an individual left employment voluntarily without good cause attributable to the employer or if the individual was discharged for misconduct is a factual determination which must be made on a case-by-case basis.

40.21(2) The term "small business" means a business entity organized for profit including but not limited to an individual proprietorship, partnership, joint venture, association or cooperative. It includes the operation of a farm, but not the practice of a profession. The following conditions apply to a business entity which is a small business for purposes of the additional deduction for wages:

a. The small business shall not have had more than 20 full-time equivalent employee positions during each of the 26 consecutive weeks within the 52-week period immediately preceding the date on which an individual for whom an additional deduction for wages is taken was hired. Full-time equivalent position means any of the following:

1. An employment position requiring an average work week of 40 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 positions which equal one full-time position. For purposes of this subrule each part-time position shall be categorized with regard to the average number of hours worked each week as a one-quarter, half, three-quarter, 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)

b. The small business shall not have more than $1 million in annual gross revenues, or after July 1, 1984, $3 million in annual gross revenues or as the average of the three preceding tax years. "Annual gross revenues" means total sales, before deducting returns and allowances but after deducting corrections and trade discounts, sales taxes and excise taxes based on sales, as determined in accordance with generally accepted accounting principles.

c. The small business shall not be an affiliate or subsidiary of a business which is dominant in its field of operation. "Dominant in its field of operation" means having more than 20 full-time equivalent employees and more than $1 million of annual gross revenues, or after July 1, 1984, $3 million of annual gross revenues or as the average of the three preceding tax years. "Affiliate or subsidiary of a business dominant in its field of operations" means a business which is at least 20 percent owned by a business dominant in its field of operation, or by partners, officers, directors, majority stockholders, or their equivalent, of a business dominant in that field of operation.

d. "Operation of a farm" means the cultivation of land for the production of agricultural crops, the raising of poultry, the production of eggs, the production of milk, the production of fruit or other horticultural crops, grazing or the production of livestock. Operation of a farm shall not include the production of timber, forest products, nursery products, or sod and operation of a farm shall not include a contract where a processor or distributor of farm products or supplies provides spraying, harvesting or other farm services.

e. "The practice of a profession" means a vocation requiring specialized knowledge and preparation including but not limited to the following: medicine and surgery, podiatry, osteopathy, osteopathic medicine and surgery, psychology, psychiatry, chiropractic, nursing, dentistry, dental hygiene, optometry, speech pathology, audiology, pharmacy, physical therapy, occupational therapy, mortuary science, law, architecture, engineering and surveying, and accounting.

40.21(3) Definitions.

a. The term *"handicapped person"* means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

The term handicapped does not include any person who is an alcoholic or drug abuser whose current use of alcohol or drugs prevents the person from performing the duties of employment or whose employment, by reason of current use of alcohol or drugs, would constitute a direct threat to the property or the safety of others.

b. The term *"physical or mental impairment"* means any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin and endocrine; or any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

c. The term *"major life activities"* means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

d. The term *"has a record of such impairment"* means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

e. The term *"is regarded as having such an impairment"* means:

1. Has a physical or mental impairment that does not substantially limit major life activities but that is perceived as constituting such a limitation;

2. Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or

3. Has none of the impairments defined as physical or mental impairments, but is perceived as having such an impairment.

f. The term *"successfully completing a probationary period"* includes those instances where the employee quits without good cause attributable to the employer during the probationary period or was discharged for misconduct during the probationary period.

g. The term *"probationary period"* means the period of probation for newly hired employees, if the employer has a written probationary policy. If the employer has no written probationary policy for newly hired employees, the probationary period shall be considered to be six months from the date of hire.

40.21(4) If a newly hired employee has been certified as either a vocational rehabilitation referral or an economically disadvantaged ex-convict for purposes of qualification for the work opportunity tax credit under Section 51 of the Internal Revenue Code, that employee shall be considered to have met the qualifications for the additional wage deduction.

A vocational rehabilitation referral is any individual certified by a state employment agency as having a physical or mental disability which, for the individual constitutes or results in a substantial handicap to employment. In addition, the individual must have been referred to the employer after completion or while receiving rehabilitation services pursuant to either a state or federal approved vocational rehabilitation program.

For all other newly hired employees, the employer has the burden of proof to show that the employees meet the qualifications for the additional wage deduction.

40.21(5) The taxpayer shall include a schedule with the filing of its tax return showing the name, address, social security number, date of hiring and wages paid of each employee for which the taxpayer claims the additional deduction for wages.

40.21(6) If the employee for which an additional deduction for wages was allowed fails to successfully complete a probationary period and the taxpayer has already filed an Iowa individual income tax return taking the additional deduction for wages, the taxpayer shall file an amended return adding back the additional deduction for wages. The amended return shall state the name and social security number of the employee who failed to successfully complete a probationary period.

This rule is intended to implement Iowa Code section 422.7 as amended by 2001 Iowa Acts, House Files 287 and 759.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—40.22(422) Disability income exclusion.

40.22(1) Effective for tax years beginning on or after January 1, 1984, a taxpayer who is permanently and totally disabled and has not attained age 65 by the end of the tax year or reached mandatory retirement age can exclude a maximum of $100 per week of payments received in lieu of wages. In order for the payments to qualify for the exclusion, the payments must be made under a plan providing payment of such amounts to an employee for a period during which the employee is absent from work on account of permanent and total disability.

40.22(2) In the case of a married couple where both spouses meet the qualifications for the disability exclusion, each spouse may exclude $5,200 of income received on account of disability.

40.22(3) There is a reduction in the exclusion, dollar for dollar, to the extent that a taxpayer's federal adjusted gross income (determined without this exclusion and without the deduction for the two-earner married couple) exceeds $15,000. In the case of a married couple, both spouses' incomes must be considered for purposes of determining if the disability income exclusion is to be reduced for income that exceeds $15,000. The taxpayers' disability income exclusion is eliminated when the taxpayers' federal adjusted gross income is equal to or exceeds $20,200. The deduction of the taxpayers' disability income exclusion because the taxpayers' federal adjusted gross income is greater than $15,000 is illustrated in the following example:

A married couple is filing their 1984 Iowa return. The husband retired during the year and received $8,000 in disability income during the 40-week period in 1984 that he was retired. The husband's other income in 1984 was $2,500 and the wife's income was $7,500.

Of the $8,000 in disability payments received by the husband in the 40-week period he was retired in 1984, only $4,000 is eligible for the exclusion. This is because the maximum amount that can be excluded on a weekly basis as a result of the disability exclusion is $100.

However, the $4,000 that qualifies for the exclusion must be reduced to the extent that the taxpayer's federal adjusted gross income exceeds $15,000. In this example, the taxpayer's federal adjusted gross income is $18,000, which exceeds $15,000 by $3,000. Therefore, the amount eligible for exclusion of $4,000 must be reduced by $3,000. This gives the taxpayers an exclusion of $1,000.

40.22(4) For purposes of the disability income exclusion, "permanent and total disability" means the individual is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which (a) can be expected to last for a continuous period of 12 months or more or (b) can be expected to result in death. A certificate from a qualified physician must be attached to the individual's tax return attesting to the taxpayer's permanent and total disability as of the date the individual claims to have retired on disability. The certificate must include the name and address of the physician and contain an acknowledgment that the certificate will be used by the taxpayer to claim the exclusion. In an instance where an individual has been certified as permanently and totally disabled by the Veterans Administration, Form 6004 may be attached to the return instead of the physician's certificate. Form 6004 must be signed by a physician on the VA disability rating board.

40.22(5) Mandatory retirement age is the age at which the taxpayer would have been required to retire under the employer's retirement program.

40.22(6) The disability income exclusion is not applicable to federal income tax for tax years beginning after 1983. There are many revenue rulings, court cases and other provisions which were relevant to the disability income exclusion for the tax periods when the exclusion was available on federal returns. These provisions, court cases and revenue rulings concerning the disability income exclusion are equally applicable to the disability income exclusion on Iowa returns for tax years beginning on or after January 1, 1984.

This rule is intended to implement Iowa Code section 422.7.

701—40.23(422) Social security benefits. For tax years beginning on or after January 1, 1984, but before January 1, 2014, social security benefits received are taxable on the Iowa return. Although Tier 1 railroad retirement benefits were taxed similarly as social security benefits for federal income tax purposes beginning on or after January 1, 1984, these benefits are not subject to Iowa income tax. 45 U.S.C. Section 231m prohibits taxation of railroad retirement benefits by the states.

The following subrules specify how social security benefits are taxed for Iowa individual income tax purposes for tax years beginning on or after January 1, 1984, but prior to January 1, 1994; for tax years beginning on or after January 1, 1994, but prior to January 1, 2007; and for tax years beginning on or after January 1, 2007, but prior to January 1, 2014:

40.23(1) *Taxation of social security benefits for tax years beginning on or after January 1, 1984, but prior to January 1, 1994.* For tax years beginning on or after January 1, 1984, but prior to January 1, 1994, social security benefits are taxable on the Iowa return to the same extent as the benefits are taxable for federal income tax purposes. When both spouses of a married couple receive social security benefits and file a joint federal income tax return but separate returns or separately on the combined return form, the taxable portion of the benefits must be allocated between the spouses. The following formula should be used to compute the amount of social security benefits to be reported by each spouse on the Iowa return:

$$\text{Taxable Social Security Benefits on the Federal Return} \times \frac{\text{Total Social Security Benefit Received by Husband (or Wife)}}{\text{Total Social Security Benefits Received by Both Spouses}}$$

The example shown below illustrates how taxable social security benefits are allocated between spouses:

A married couple filed a joint federal income tax return for 1984. They filed separately on the combined return form for Iowa income tax purposes. During the tax year the husband received $6,000 in social security benefits and the wife received $3,000 in social security benefits. $2,000 of the social security benefits was taxable on the federal return.

The $2,000 in taxable social security benefits is allocated to the spouses on the following basis:

Husband

$$\$2{,}000 \times \frac{\$6{,}000}{\$9{,}000} = \$1{,}333.40$$

Wife

$$\$2{,}000 \times \frac{\$3{,}000}{\$9{,}000} = \$666.60$$

In situations where taxpayers have received both social security benefits and Tier 1 railroad retirement benefits and are taxable on a portion of those benefits, the formula which follows should be used to determine the social security benefits to be included in net income:

$$\text{Taxable Social Security Benefits and Railroad Retirement Benefits on Federal Return} \times \frac{\text{Total Social Security Benefit Received}}{\text{Total Social Security Benefits and Railroad Retirement Benefits Received}}$$

40.23(2) *Taxation of social security benefits for tax years beginning on or after January 1, 1994, but prior to January 1, 2007.* For tax years beginning on or after January 1, 1994, but prior to January 1, 2007, although up to 85 percent of social security benefits received may be taxable for federal income tax purposes, no more than 50 percent of social security benefits will be taxable for state individual income tax purposes. Thus, in the case of Iowa income tax returns for 1994 through 2006, social security benefits will be taxed as the benefits were taxed from 1984 through 1993 as described in subrule 40.23(1).

The amount of social security benefits that is subject to tax is the lesser of one-half of the annual benefits received in the tax year or one-half of the taxpayer's provisional income over a specified base amount. The provisional income is the taxpayer's modified adjusted gross income plus one-half of the social security benefits and one-half of the railroad retirement benefits received. Although railroad benefits are not taxable, one-half of the railroad retirement benefits received may be used to determine the amount of social security benefits that is taxable for state income tax purposes. Modified adjusted gross income is the taxpayer's federal adjusted gross income, plus interest that is tax-exempt on the federal return, plus any of the following incomes:

1. Savings bond proceeds used to pay expenses of higher education excluded from income under Section 135 of the Internal Revenue Code.
2. Foreign source income excluded from income under Section 911 of the Internal Revenue Code.
3. Income from Guam, American Samoa, and the Northern Mariana Islands excluded under section 931 of the Internal Revenue Code.
4. Income from Puerto Rico excluded under Section 933 of the Internal Revenue Code.

A taxpayer's base amount is: *(a)* $32,000 if married and a joint federal return was filed, *(b)* $0 if married and separate federal returns were filed by the spouses and *(c)* $25,000 for individuals who filed federal returns and used a filing status other than noted in *(a)* and *(b)*.

The IA 1040 booklet and instructions for 1994 through 2006 will include a worksheet to compute the amount of social security benefits that is taxable for Iowa income tax purposes. An example of the social security worksheet follows. Similar worksheets will be used for computing the amount of social security benefits that is taxable for years 1995 through 2006. An example of the social security worksheet follows:

1. Enter amount(s) from box 5 of all of Form(s) SSA-1099. If a joint return was filed, enter totals from box 5 of Form(s) SSA-1099 for both spouses. Do not include railroad retirement benefits from RRB-1099 here. See line 3.	1. _____
2. Divide line 1 amount above by 2.	2. _____
*3. Add amounts of the following incomes from Form 1040: wages, taxable interest income, dividend income, taxable state and local income tax refunds, alimony, business income or loss, capital gain or loss, capital gain distributions, other gains, taxable IRA distributions, taxable pensions and annuities, incomes from Schedule E, farm income or loss, unemployment compensation, other income and 1/2 of railroad retirement benefits from RRB 1099.	3. _____
4. Enter amount from Form 1040, line 8b for interest that is federally tax-exempt.	4. _____
5. Add lines 2, 3 and 4.	5. _____
6. Enter total adjustment to income from Form 1040.	6. _____
7. Subtract line 6 from line 5.	7. _____
8. Enter on line 8 one of the following amounts based on the filing status used on Form 1040: Single, Head of Household, or Qualifying Widow(er), enter $25,000. Married filing jointly, enter $32,000. Married filing separately, enter $0 ($25,000 if you did not live with spouse any time in 1994).	8. _____
9. Subtract line 8 from line 7. If zero or less enter 0. If line 9 is zero, none of the social security benefits are taxable. If line 9 is more than zero, go to line 10.	9. _____
10. Divide line 9 amount above by 2.	10. _____
11. Taxable social security benefits enter smaller of line 2 or line 10 here and on line 14 IA 1040.	11. _____

*If applicable, include on line 3 the following incomes excluded from federal adjusted gross income: foreign earned income, income excluded by residents of Puerto Rico, American Samoa, and Guam and proceeds from savings bonds used for higher education.

Married taxpayers who filed a joint federal return and are filing separate Iowa returns or separately on the combined return form can allocate taxable social security benefits between them with the following formula.

$$\text{Taxable Social Security Benefits From Worksheet} \times \frac{\text{Total Social Security Benefit Received by Husband (or Wife)}}{\text{Total Social Security Benefits Received by Both Spouses}}$$

40.23(3) *Taxation of social security benefits for tax years beginning on or after January 1, 2007, but prior to January 1, 2014.* For tax years beginning on or after January 1, 2007, but prior to January 1, 2014, the amount of social security benefits subject to Iowa income tax will be computed as described in subrule 40.23(2), but will be further reduced by the following percentages:

Calendar years 2007 and 2008	32%
Calendar year 2009	43%
Calendar year 2010	55%
Calendar year 2011	67%
Calendar year 2012	77%
Calendar year 2013	89%

The Iowa individual income tax booklet and instructions for 2007 through 2013 will include a worksheet to compute the amount of social security benefits that is taxable for Iowa income tax purposes. An example of the social security worksheet follows:

1. Enter amount(s) from box 5 of Form(s) SSA-1099. If a joint return was filed, enter totals from box 5 of Form(s) SSA-1099 for both spouses. Do not include railroad retirement benefits from RRB-1099 here. See line 3.	1. _____
2. Divide line 1 amount above by 2.	2. _____
*3. Add amounts of the following incomes from Form 1040: wages, taxable interest income, dividend income, taxable state and local income tax refunds, alimony, business income or loss, capital gain or loss, capital gain distributions, other gains, taxable IRA distributions, taxable pensions and annuities, incomes from Schedule E, farm income or loss, unemployment compensation, other income and 1/2 of railroad retirement benefits from RRB 1099.	3. _____
4. Enter amount from Form 1040, line 8b for interest that is federally tax-exempt.	4. _____
5. Add lines 2, 3 and 4.	5. _____
6. Enter total adjustment to income from Form 1040.	6. _____
7. Subtract line 6 from line 5.	7. _____
8. Enter on line 8 one of the following amounts based on the filing status used on Form 1040: Single, Head of Household, or Qualifying Widow(er), enter $25,000. Married filing jointly, enter $32,000. Married filing separately, enter $0 ($25,000 if you did not live with spouse anytime during the year).	8. _____
9. Subtract line 8 from line 7. If zero or less enter 0. If line 9 is zero, none of the social security benefits are taxable. If line 9 is more than zero, go to line 10.	9. _____
10. Divide line 9 amount above by 2.	10. _____
11. Taxable social security benefits before phase-out exclusion. Enter smaller of line 2 or line 10.	11. _____
12. Multiply line 11 by applicable exclusion percentage.	12. _____
13. Taxable social security benefits. Subtract line 12 from line 11.	13. _____

*If applicable, include on line 3 the following incomes excluded from federal adjusted gross income: foreign earned income, income excluded by residents of Puerto Rico, American Samoa, and Guam and proceeds from savings bonds used for higher education and employer-provided adoption benefits.

Married taxpayers who filed a joint federal return and are filing separate Iowa returns or separately on the combined return form can allocate taxable social security benefits between them with the following formula.

$$\text{Taxable Social Security Benefits From Worksheet} \times \frac{\text{Total Social Security Benefit Received by Spouse 1 (or Spouse 2)}}{\text{Total Social Security Benefits Received by Both Spouses}}$$

The amount on line 12 of this worksheet is the phase-out exclusion of social security benefits which must be included in net income in determining whether an Iowa return must be filed in accordance with rules 701—39.1(422) and 701—39.5(422), and this amount must also be included in net income in calculating the special tax computation in accordance with rule 701—39.15(422).

40.23(4) *Taxation of social security benefits for tax years beginning on or after January 1, 2014.* For tax years beginning on or after January 1, 2014, no social security benefits are taxable on the Iowa return. However, the 100 percent phase-out exclusion of social security benefits must still be included in net income in determining whether an Iowa return must be filed in accordance with rules 701—39.1(422) and

701—39.5(422), and the 100 percent phase-out exclusion of social security benefits must also be included in net income in calculating the special tax computation in accordance with rule 701—39.15(422).

This rule is intended to implement Iowa Code section 422.7 as amended by 2006 Iowa Acts, Senate File 2408.

701—40.24(99E) Lottery prizes. Prizes awarded under the Iowa Lottery Act are Iowa earned income. Therefore, individuals who win lottery prizes are subject to Iowa income tax in the aggregate amount of prizes received in the tax year, even if the individuals were not residents of Iowa at the time they received the prizes.

This rule is intended to implement Iowa Code section 99E.19.

701—40.25(422) Certain unemployment benefits received in 1979. Rescinded IAB 11/24/04, effective 12/29/04.

701—40.26(422) Contributions to the judicial retirement system. Rescinded IAB 11/24/04, effective 12/29/04.

701—40.27(422) Incomes from distressed sales of qualifying taxpayers. For tax years beginning on or after January 1, 1986, taxpayers with gains from sales, exchanges, or transfers of property must exclude those gains from net income, if the gains are considered to be distressed sale transactions.

40.27(1) *Qualifications that must be met for transactions to be considered distressed sales.* There are a number of qualifications that must be met before a transaction can be considered to be a distressed sale. The transaction must involve forfeiture of an installment real estate contract, the transfer of real or personal property securing a debt to a creditor in cancellation of that debt, or from the sale or exchange of property as a result of actual notice of foreclosure. The following three additional qualifications need to have been met.

a. The forfeiture, transfer, or sale or exchange was done for the purpose of establishing a positive cash flow.

b. Immediately before the forfeiture, transfer, or sale or exchange, the taxpayer's debt-to-asset ratio exceeded 90 percent as computed under generally accepted accounting principles.

c. The taxpayer's net worth at the end of the tax year was less than $75,000.

In determining the taxpayer's debt-to-asset ratio immediately before the forfeiture, transfer, or sale or exchange and at the end of the tax year, the taxpayer must include any asset transferred within 120 days prior to the transaction or within 120 days prior to the end of the tax year without adequate and full consideration in money or money's worth.

Proof of forfeiture of the installment real estate contract, proof of transfer of property to a creditor in cancellation of a debt, or a copy of the notice of foreclosure constitutes documentation of the distressed sale and must be made a part of the return. Balance sheets showing the taxpayer's debt-to-asset ratio immediately before the distressed sale transaction and the taxpayer's net worth at the end of the tax year must also be included with the income tax return. The balance sheets supporting the debt-to-asset ratio and the net worth must list the taxpayer's personal assets and liabilities as well as the assets and liabilities of the taxpayer's farm or other business.

For purposes of this provision, in the case of married taxpayers, except in the instance when the husband and wife live apart at all times during the tax year, the assets and liabilities of both spouses must be considered in determining the taxpayers' net worth or the taxpayers' debt-to-asset ratio.

40.27(2) *Losses from distressed sale transactions of qualifying taxpayers.* Losses from distressed sale transactions meeting the qualifications described above were disallowed prior to the time that the provision for disallowing these losses was repealed in the 1990 session of the General Assembly. Taxpayers whose Iowa income tax liabilities were increased because of disallowance of losses from distressed sales transactions may file refund claims with the department to get refunds of the taxes paid due to disallowance of the losses. Refund claims will be honored by the department to the extent that

the taxpayers provide verification of the distressed sale losses and the claims are filed within the statute of limitations for refund given in Iowa Code subsection 422.73(2).

This rule is intended to implement Iowa Code section 422.7.

701—40.28(422) Losses from passive farming activities. Rescinded IAB 2/18/04, effective 3/24/04.

701—40.29(422) Intangible drilling costs. For tax years beginning on or after January 1, 1986, but before January 1, 1987, intangible drilling and development costs which pertain to any well for the production of oil, gas, or geothermal energy, and which are incurred after the commencement of the installation of the production casing for the well, are not allowed as an expense in the tax year when the costs were paid or incurred and must be added to net income. Instead of expensing the intangible drilling and development costs which are incurred after the commencement of the installation of the production casing for a well, the expenses must be amortized over a 26-month period, beginning in the month in which the costs are paid or incurred if the costs were incurred for a well which is located in the United States, the District of Columbia, and those continental shelf areas which are adjacent to United States territorial waters and over which the United States has exclusive rights with respect to the exploration and exploitation of natural resources as provided in Section 638 of the Internal Revenue Code.

In the case of intangible drilling and development costs which are incurred for oil or gas wells outside the United States, those costs must be recovered over a ten-year straight-line amortization period beginning in the year the costs are paid or incurred. However, in lieu of amortization of the costs, the taxpayer may elect to add these costs to the basis of the property for cost depletion purposes.

For tax years beginning on or after January 1, 1987, the intangible drilling costs, which are an addition to income subject to amortization, are the intangible drilling costs described in Section 57(a)(2) of the Internal Revenue Code. These intangible drilling costs are an item of tax preference for federal minimum tax purposes for tax years beginning after December 31, 1986.

This rule is intended to implement Iowa Code section 422.7.

701—40.30(422) Percentage depletion. For tax years beginning on or after January 1, 1987, the percentage depletion that is an addition to net income is the depletion described in Section 57(a)(1) of the Internal Revenue Code only to the extent the depletion applies to an oil, gas, or geothermal well. This depletion is an item of tax preference for federal minimum tax purposes for tax years beginning after December 31, 1986.

This rule is intended to implement Iowa Code section 422.7.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—40.31(422) Away-from-home expenses of state legislators. For tax years beginning on or after January 1, 1987, state legislators whose personal residences in their legislative districts are more than 50 miles from the state capitol may claim the same deductions for away-from-home expenses as are allowed on their federal income tax returns under Section 162(h)(1)(B) of the Internal Revenue Code. These individuals may claim deductions for meals and lodging per "legislative day" in the amount of per diem allowance for federal employees in effect for the tax year. The portion of this per diem allowance which is equal to the daily expense allowance authorized for state legislators in Iowa Code section 2.10 may be claimed as an adjustment to income. The balance of the per diem allowance for federal employees must be allocated between lodging expenses and meal expenses and is deductible as a miscellaneous itemized deduction. However, only 50 percent of the amount attributable to meal expenses may be deducted for tax years beginning on or after January 1, 1994.

State legislators whose personal residences in their legislative districts are 50 miles or less from the state capitol may claim a deduction for meals and lodging of $50 per "legislative day." However, in lieu of either of the deduction methods previously described in this rule, any state legislator may elect to itemize adjustments to income for amounts incurred for meals and lodging for the "legislative days" of the state legislator.

This rule is intended to implement Iowa Code section 422.7.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—40.32(422) Interest and dividends from regulated investment companies which are exempt from federal income tax. For tax years beginning on or after January 1, 1987, interest and dividends from regulated investment companies which are exempt from federal income tax under the Internal Revenue Code are subject to Iowa income tax. See rule 701—40.52(422) for a discussion of the Iowa income tax exemption of some interest and dividends from regulated investment companies that invest in certain obligations of the state of Iowa and its political subdivisions the interest from which is exempt from Iowa income tax. To the extent that a loss on the sale or exchange of stock in a regulated investment company was disallowed on an individual's federal income tax return pursuant to Section 852(b)(4)(B) of the Internal Revenue Code because the taxpayer held the stock six months or less and because the regulated investment company had invested in federal tax-exempt securities, the loss is allowed for purposes of computation of net income.

This rule is intended to implement Iowa Code section 422.7.

701—40.33(422) Partial exclusion of pensions and annuities for retired and disabled public employees. Rescinded IAB 11/24/04, effective 12/29/04.

701—40.34(422) Exemption of restitution payments for persons of Japanese ancestry. For tax years beginning on or after January 1, 1988, restitution payments authorized by P.L. 100-383 to individuals of Japanese ancestry who were interned during World War II are exempt from Iowa income tax to the extent the payments are included in federal adjusted gross income. P.L. 100-383 provides for a payment of $20,000 for each qualifying individual who was alive on August 10, 1988. In cases where the qualifying individuals have died prior to the time that the restitution payments were received, the restitution payments received by the survivors of the interned individuals are also exempt from Iowa income tax.

This rule is intended to implement Iowa Code section 422.7.

701—40.35(422) Exemption of Agent Orange settlement proceeds received by disabled veterans or beneficiaries of disabled veterans. For tax years beginning on or after January 1, 1989, proceeds from settlement of a lawsuit against the manufacturer or distributor of a Vietnam herbicide received by a disabled veteran or the beneficiary of a disabled veteran for damages from exposure to the herbicide are exempt from Iowa income tax to the extent the proceeds are included in federal adjusted gross income. For purposes of this rule, Vietnam herbicide means a herbicide, defoliant, or other causative agent containing a dioxin, including, but not limited to, Agent Orange used in the Vietnam conflict beginning December 22, 1961, and ending May 7, 1975.

This rule is intended to implement Iowa Code section 422.7.

701—40.36(422) Exemption of interest earned on bonds issued to finance beginning farmer loan program. Interest earned on or after July 1, 1989, from bonds or notes issued by the agricultural development authority to finance the beginning farmer loan program is exempt from the state income tax.

This rule is intended to implement Iowa Code sections 175.17 and 422.7.

701—40.37(422) Exemption of interest from bonds issued by the Iowa comprehensive petroleum underground storage tank fund board. Interest received from bonds issued by the Iowa comprehensive petroleum underground storage tank fund board is exempt from state individual income tax. This is effective for interest received from these bonds on or after May 5, 1989, but before July 1, 2009.

This rule is intended to implement Iowa Code section 455G.6.

701—40.38(422) Capital gains deduction or exclusion for certain types of net capital gains. Effective for tax years beginning on or after January 1, 1990, but prior to January 1, 1998, a deduction is allowed in computing net income for 45 percent of the net capital gains described in subrules 40.38(1) to 40.38(4). See subrules 40.38(6) through 40.38(14) for the capital gain deduction or

exclusion which is applicable for net capital gains received in tax years beginning on or after January 1, 1998. However, the aggregate net capital gains from subrules 40.38(1) through 40.38(4) which are to be considered for the tax year for the capital gain deduction cannot exceed $17,500 for all individual taxpayers except married taxpayers filing separate state returns. In the case of married taxpayers filing separate returns, the aggregate net capital gains to be considered for the deduction cannot exceed $8,750 per spouse. Married taxpayers filing separately on the combined return form shall prorate the $17,500 capital gain deduction limitation between the spouses in the ratio of each spouse's net capital gains from subrules 40.38(1) through 40.38(4) to the total net capital gains of both spouses from subrules 40.38(1) through 40.38(4). Effective for tax years beginning on or after January 1, 1994, the capital gain deduction is not allowed for purposes of computation of a net operating loss for the tax year and for purposes of computing the income for a tax year to which a net operating loss is carried. Subrule 40.38(5) includes information on how the capital gain deduction is treated in a tax year with a net operating loss and in a tax year with the capital gain deduction where a net operating loss deduction is carried.

40.38(1) Net capital gains from sales or exchanges of real property, tangible personal property, or other assets of a business owned by the taxpayer for a minimum of ten years and in which the taxpayer has materially participated for a minimum of ten years. Net capital gains from the sales or exchanges of real property, tangible personal property, or other assets from a business the taxpayer has owned for ten years and in which the taxpayer materially participated as defined in Section 469(h) of the Internal Revenue Code for ten years qualify for the capital gain deduction. In the case of installment sales of real property, tangible personal property, or other assets of a business, where the selling price of the business assets is paid to the seller in one or more years after the year in which the sales transaction occurred, all installments received on or after January l, 1990, qualify for the capital gains deduction, assuming the taxpayers had met the ownership and material participation requirements at the time the sales transactions occurred. *Herbert Clausen and Sylvia Clausen v. the Iowa Department of Revenue and Finance,* Law No. 32313, Crawford County District Court, May 24, 1995. For example, if a taxpayer received an installment payment in 1996 from the sale of the taxpayer's farmland in 1988, the installment received in 1996 would qualify for the 45 percent capital gain deduction if the taxpayer had owned the farmland at least ten years at the time of the sale and the taxpayer had materially participated in the farm business for a minimum of ten years at the time of the sale. The following terms and definitions clarify which sales and exchanges of assets of a business qualify for the capital gain deduction authorized in rule 701—40.38(422).

a. Business. A business includes any activity engaged in by a person with the object of gain, benefit, or advantage, either direct or indirect. In addition, a business for purposes of the capital gains deduction in rule 40.38(422) must have been owned by the taxpayer for at least ten years and the taxpayer must have materially participated in the business for at least ten years.

b. Assets of a business. Those assets of a business which may qualify for capital gain treatment under rule 40.38(422) if the assets are sold or exchanged under the conditions described in this rule are real property, tangible personal property, or other assets of a business which were held by the business more than one year at the time the assets were sold or exchanged. However, for purposes of this subrule, tangible personal property of a business does not include cattle or horses described in subrule 40.38(2), other livestock described in subrule 40.38(3), or timber which is described in subrule 40.38(4).

c. Material participation in a business if the taxpayer has been involved in the operation of the business on a regular, continuous, and substantial basis for ten or more years at the time assets of the business are sold or exchanged. If the taxpayer has involvement in a business which meets the criteria for material participation in an activity under Section 469(h) of the Internal Revenue Code and the Treasury rules for material participation in §1.469-5 and §1.469-5T, for ten years or more immediately before the sale or exchange of the assets of a business, the taxpayer shall be considered to have satisfied the material participation requirement for this subrule. In determining whether or not a particular taxpayer has material participation in a business, participation of the taxpayer's spouse in a business must also be taken into account. The spouse's participation in the business must be taken into account even if the spouse does not file a joint state return with the taxpayer, or if the spouse has no ownership interest in

the business. A taxpayer is most likely to have material participation in a business if that business is the taxpayer's principal business. However, it is possible for a taxpayer to have had material participation in more than one business in a tax year for purposes of this subrule.

A highly relevant factor in material participation in a business is how regularly the taxpayer is present at the place where the principal operations of a business are carried on. In addition, a taxpayer is likely to have material participation in a business if the taxpayer performs all functions of the business.

The fact that the taxpayer utilizes employees or contracts services to perform daily functions in a business will not prevent the taxpayer from qualifying as materially participating in the business.

Generally, an individual will be considered as materially participating in a tax year if the taxpayer satisfies or meets any of the following tests:

1. The individual participates in the business for more than 500 hours in the taxable year.

EXAMPLE. Joe and Sam Smith are brothers who formed a computer software business in 1981 in Altoona, Iowa. In 1991, Joe spent approximately 550 hours selling software for the business and Sam spent about 600 hours developing new software programs for the business. Both Joe and Sam would be considered to have materially participated in the computer software business in 1991.

2. The individuals' participation in the business constitutes substantially all of the participation in the business for the tax year.

EXAMPLE. Roger McKee is a teacher in a small town in southwest Iowa. He owns a truck with a snowplow blade. He contracts with some of his neighbors to plow driveways. He maintains and drives the truck. In the winter of 1991, there was little snow so Mr. McKee spent only 20 hours in 1991 in clearing driveways. Roger McKee is deemed to have materially participated in the snowplowing business in 1991.

3. The individual participates in the business for more than 100 hours in the tax year and no other individual spends more time in the business activity than the taxpayer.

4. The individual participates in two or more businesses, excluding rental businesses, in the tax year and participates for more than 500 hours in all of the businesses and more than 100 hours in each of the businesses. Thus, the taxpayer is regarded as materially participating in each of the business activities.

EXAMPLE. Frank Evans is a full-time CPA. He owns a restaurant and a record store. In 1992, Mr. Evans spent 400 hours in working at the restaurant and 150 hours at the record store. Mr. Evans is treated as a material participant in each of the businesses in 1992.

5. An individual who has materially participated (by meeting any of the tests in numbered paragraphs "1" through "4" above) in a business for five of the past ten years will be deemed a material participant in the current year.

EXAMPLE. Joe Bernard is the co-owner of a plumbing business. He retired in 1988 after 35 years in the business. Since Joe's retirement, he has retained his interest in the business. Joe is considered to be materially participating in the business for the years through 1993 or for the five years after the year of retirement. Thus, if the plumbing business is sold before the end of 1993, the sale will qualify for the Iowa capital gain on Joe's 1993 Iowa return because he was considered to be a material participant in the business according to the federal rules for material participation.

6. An individual who has materially participated in a personal service activity for at least three years will be treated as a material participant for life. A personal service activity involves the performance of personal services in the fields of health, law, engineering, architecture, accounting, actuarial science, performing arts, consulting or any other trade or business in which capital is not a material income-producing factor.

EXAMPLE. Gerald Williams is a retired attorney, but retains an interest in the law firm he was involved in for over 40 years. Because the law firm is a personal services activity, Mr. Williams is considered to be a material participant in the law firm even after his retirement from the firm.

7. An individual who participates in the business activity for more than 100 hours may be treated as materially participating in the activity if, based on all the facts and circumstances, the individual participates on a regular, continuous, and substantial basis. The following paragraphs provide clarification regarding the facts and circumstances test:

- A retired or disabled farmer is treated as materially participating in a farming activity for the current year if the farmer materially participated in the activity for five of the last eight years before the farmer's retirement or disability. That is, the farmer must have been subject to self-employment tax in five of the eight years before retirement or disability and had to have been either actively farming so the income was reported on Schedule F or materially participating in a crop-share activity for five of those eight last years prior to retirement or disability.

EXAMPLE. Fred Smith was 80 years old in 1991 when he sold 200 acres of farmland he had owned since 1951. Mr. Smith retired in 1981. In the last eight years before retirement, Mr. Smith was paying self-employment tax on his farm income which was reported on Schedule F for each of those eight years. In the years before he sold the farmland, Mr. Smith was leasing the farmland on a cash-rent basis, whereby Mr. Smith would not be considered to be materially participating in the farming activity. Because Mr. Smith had material participation in the farmland in the eight years before retirement, Mr. Smith was considered to have met the material participation requirement, so the capital gain qualified for the Iowa capital gain deduction.

- A surviving spouse of a farmer is treated as materially participating in the farming activity for the current tax year if the farmer met the material participation requirements at the time of death and the spouse actively participates in the farming business activity. That is, the spouse participates in the making of management decisions relating to the farming activity or arranges for others to provide services (such as repairs, plowing, and planting).
- Management activities of a taxpayer are not considered for purposes of determining if there was material participation if either of the following apply: Anybody other than the taxpayer is compensated for management services; or somebody provides more hours of management services than the taxpayer.

Material participation by individuals in specific types of activities. The following are individuals in specific types of activities that may have unique problems or circumstances related to material participation in a business:

1. Limited partners of a limited partnership. The limited partners will not be treated as materially participating in any activity of a limited partnership except in a situation where the limited partner would be treated as materially participating under the material participation tests in paragraphs "1," "5" and "6" above as if the taxpayer were not a limited partner for the tax year.
2. Work not customarily done by owners. Work done in connection with an activity shall not be treated as participation in the activity if both of the following apply:

Such work is not of a type that is customarily done by an owner of such activity; and

One of the principal purposes for the performance of such work is to avoid the disallowance of any loss or credit from such activity.

3. Participation in a business by an investor. Work done by an individual in the individual's capacity as an investor in an activity is not considered to be material participation in the business or activity unless the investor is directly involved in the day-to-day management or operations of the activity or business.
4. Cash farm lease. A farmer who rents farmland on a cash basis will not generally be considered to be materially participating in the farming activity. The burden is on the landlord to show there was material participation in the cash-rent farm activity.
5. Farm landlord involved in crop-share arrangement. A farm landlord is subject to self-employment tax on net income from a crop-share arrangement with a tenant. The landlord is considered to be materially participating with the tenant in the crop-share activity if the landlord meets one of the four following tests:

TEST 1. The landlord does any three of the following: (1) Pay or be obligated to pay for at least half the direct costs of producing the crop; (2) Furnish at least half the tools, equipment, and livestock used in producing the crop; (3) Consult with the tenant; and (4) Inspect the production activities periodically.

TEST 2. The landlord regularly and frequently makes, or takes part in making, management decisions substantially contributing to or affecting the success of the enterprise.

TEST 3. The landlord worked 100 hours or more spread over a period of five weeks or more in activities connected with crop production.

TEST 4. The landlord has done tasks or performed duties which, considered in their total effect, show that the landlord was materially and significantly involved in the production of the farm commodities.

6. Conservation reserve payments. Farmers entering into long-term contracts providing for less intensive use of highly erodible or other specified cropland can receive compensation for conversion of such land in the form of an "annualized rental payment." Although the CRP payments are referred to as "rental payments," the payments are considered to be receipts from farm operations and not rental payments from real estate.

If an individual is receiving CRP payments and is not considered to be retired from farming, the CRP payments are subject to self-employment tax. If individuals actively manage farmland placed in the CRP program by directly participating in seeding, mowing, and planting the farmland or by overseeing these activities, the owner will be considered to have had material participation in the farming activity.

7. Rental activities or businesses. For purposes of subrules 40.38(1) and 40.38(7), the general rule is that a taxpayer who actively participates in a rental activity or business which would be considered to have been material participation in another business or activity would be deemed to have had material participation in the rental activity unless covered by a specific exception in this subrule (for example, the exceptions for farm rental activities in numbered paragraphs "4," "5," and "6" immediately above). Rental activity or rental business is as the term is used in Section 469(c) of the Internal Revenue Code.

EXAMPLE. Ryan Stanley is an attorney who has owned two duplex units since 1991 and has received rental income from these duplexes since 1991. Mr. Stanley is responsible for the maintenance of the duplexes and may hire other individuals to perform repairs and other upkeep on the duplexes. However, no person spends more time in maintaining the duplexes than Mr. Stanley. The duplexes are sold in 2004, resulting in a capital gain. Mr. Stanley can claim the capital gain deduction on the 2004 Iowa return since he met the material participation requirements for this rental activity.

40.38(2) Net capital gains from sales of cattle or horses used for certain purposes which were held for 24 months by taxpayers who received more than one-half of their gross incomes from farming or ranching. Net capital gains from the sales of cattle or horses held 24 months or more for breeding, dairy, or sporting purposes qualify for the capital gains deduction on limited capital gains provided in rule 40.38(422) if more than 50 percent of the taxpayer's gross income in the tax year is from farming or ranching operations. Proper records should be kept showing purchase and birth dates of cattle and horses. The absence of records may make it impossible for the owner to show that the owner has held a particular animal for the necessary holding period. Whether cattle or horses are held for draft, breeding, sporting, or dairy purposes depends on all the facts and circumstances of each case.

Whether or not cattle or horses sold by the taxpayer after the taxpayer has held them 24 months or more were held for draft, breeding, dairy, or sporting purposes may be determined from federal court cases on such sales and the standards and examples included in Treasury Regulations §1.1231-2.

A taxpayer's gross income from farming or ranching includes amounts the individual has received in the tax year from cultivating the soil or raising or harvesting any agricultural commodities. This includes the income from the operation of a stock, dairy, poultry, fish, bee, fruit, or truck farm, plantation, ranch, nursery, range, orchard, or oyster bed, as well as income in the form of crop shares received from the use of the taxpayer's land. It also includes total gains from sales of draft, breeding, dairy, or sporting livestock. In the case of individual income tax returns for the 1988 tax year gross income from farming includes the total of the amounts from line 12 or line 52 of Schedule F and line 8 of Form 4835, (Farm Rental Income and Expenses), plus the share of partnership income from farming, the share of distributable net taxable income from farming of an estate or trust, and total gains from the sale of livestock held for draft, breeding, sport, or dairy purposes, as shown on Form 4797 (Sale of Business Property). In the case of an individual's returns for tax years beginning after 1988, equivalent lines from returns and supplementary forms would be used to determine a taxpayer's gross income from farming or ranching for those years.

To make the calculation as to whether more than half of the taxpayer's gross income in the tax year is from farming or ranching operations, the gross income from farming or ranching as determined in the previous paragraph is divided by the taxpayer's total gross income. If the resulting percentage is greater

than 50 percent, the taxpayer's capital gains from sales of cattle and horses described previously in this subrule will be considered for the capital gain deduction provided in rule 40.38(422).

In instances where married taxpayers file a joint return, the gross income from farming or ranching of both spouses will be considered for the purpose of determining whether or not the taxpayers received more than half of their gross income from farming or ranching.

However, in situations where married taxpayers file separate Iowa returns or separately on the combined return form, each spouse must separately determine whether or not that spouse has more than 50 percent of gross income from farming or ranching operations.

40.38(3) Net capital gains from sale of breeding livestock, other than cattle or horses, held 12 or more months by taxpayers who received more than one-half of gross incomes from farming or ranching. Net capital gains from the sale of breeding livestock, other than cattle or horses, held 12 or more months from the date of acquisition qualify for the capital gain deduction in rule 40.38(422), if more than one-half of the taxpayer's gross income is from farming or ranching. For the purposes of this subrule, "livestock" has a broad meaning and includes hogs, mules, donkeys, sheep, goats, fur-bearing mammals, and other mammals. Livestock does not include poultry, chickens, turkeys, pigeons, geese, other birds, fish, frogs, reptiles, etc. If livestock other than cattle or horses is considered to have been held for breeding purposes under the criteria established in Treasury Regulation §1.1231-2, the livestock will also be deemed to have been breeding livestock for this subrule. In addition, for the purposes of this subrule livestock does not include cattle and horses held for 24 or more months for draft, breeding, dairy, or sporting purposes which were described in subrule 40.38(2).

The procedure in subrule 40.38(2) for determining whether or not more than 50 percent of a taxpayer's gross income is from farming or ranching operations is also applicable for this subrule.

40.38(4) Net capital gains from sales of timber held by the taxpayer more than one year. Effective for tax years beginning on or after January 1, 1990, capital gains from qualifying sales of timber held by the taxpayer for more than one year are eligible for the capital gains deduction described in rule 40.38(422). In all of the following examples of circumstances where gains from sales of timber qualify for capital gains treatment, it is assumed that the timber sold was held by the owner for more than one year at the time the timber was sold. The owner of the timber can be the owner of the land on which the timber was cut or the holder of a contract to cut the timber. In the case where a taxpayer sells standing timber the taxpayer held for investment, any gain from the sale is a capital gain. Timber includes standing trees usable for lumber, pulpwood, veneer, poles, pilings, crossties, and other wood products. It does not apply to sales of pulpwood cut by a contractor from the tops and limbs of felled trees. Under the general rule, the cutting of timber results in no gain or loss, and it is not until the sale or exchange that gain or loss is realized. But if a taxpayer owned, or had a contractual right to cut timber, the taxpayer may make an election to treat the cutting of timber as a sale or exchange in the year the timber is cut. Gain or loss on the cutting of the timber is determined by subtracting the adjusted basis for depletion of the timber from the fair market value of the timber on the first day of the tax year in which the timber is cut. For example, the gain on this type of transaction is computed as follows:

Fair market value of timber on January 1, 1990	$400,000
Minus: Adjusted basis for depletion	100,000
Capital gain on cutting of timber	$300,000

The fair market value shown above of $400,000 is the basis of the timber. A later sale of the cut timber, including treetops and stumps would result in ordinary income for the taxpayer and not a capital gain.

Evergreen trees, such as those used as Christmas trees, that are more than six years old at the time they are severed from their roots and sold for ornamental purposes, are included in the definition of timber for purposes of this subrule. The term "evergreen trees" is used in its commonly accepted sense and includes pine, spruce, fir, hemlock, cedar, and other coniferous trees. Where customers of the taxpayer cut down the Christmas tree of their choice on the taxpayer's farm, there is no sale until the tree is cut. However, "evergreen trees" sold in a live state do not qualify for capital gain treatment.

Capital gains or losses also are received from sales of timber by a taxpayer who has a contract which gives the taxpayer an economic interest in the timber. The date of disposal of the timber shall be the day the timber is cut, unless payment for the timber is received before the timber is cut. Under this circumstance, the taxpayer may treat the date of the payment as the date of disposal of the timber.

Additional information about gains and losses from the sale of timber is included under Treasury Regulations §1.631-1 and §1.631-2.

40.38(5) Treatment of capital gain deduction for tax years with net operating losses and for tax years to which net operating losses are carried. The following paragraphs describe the tax treatment of the capital gain deduction in a tax year with a net operating loss and the tax treatment of a capital gain deduction in a tax year to which a net operating loss was carried:

a. For tax years beginning on or after January 1, 1994, the capital gain deduction otherwise allowable on a return is not allowed for purposes of computing a net operating loss from the return which can be carried to another tax year and applied against the income for the other tax year.

EXAMPLE. Joe Jones filed a 1994 return showing a net loss of $12,000. On this return Mr. Jones claimed a capital gain deduction of $3,000 from sale of breeding stock, other than cattle or horses, held 12 months or more which was considered in computing the loss of $12,000. However, the $3,000 capital gain deduction is not allowed in the computation of the net operating loss deduction for 1994 for purposes of carrying the net operating loss deduction to another tax year. Thus, the net operating loss deduction for 1994 is $9,000.

b. In the case of net operating losses for tax years beginning on or after January 1, 1994, which are carried back to a tax year prior to 1994 where the taxpayer has claimed the capital gains deduction described above, the capital gains deduction is not allowed for purposes of computing the income to which the net operating loss deduction is applied.

EXAMPLE. John Brown had a net operating loss of $20,000 on the Iowa return he filed for 1994. Mr. Brown elected to carry back the net operating loss to his 1991 Iowa return. The 1991 return showed a taxable income of $27,000 which included a capital gain deduction of $3,000. For purposes of computing the income in the carryback year to which the net operating loss would be applied, the income was increased by $3,000 to disallow the capital gain deduction properly allowed in computing taxable income for the carryback year. Therefore, the net operating loss deduction from 1994 was applied to an income of $30,000 for the carryback year.

40.38(6) Exclusion of net capital gains from the sales of real property, from the sales of assets of a business entity, from the sales of certain livestock of a business, from the sales of timber, from liquidation of assets of certain corporations, and from certain stock sales which are treated as acquisition of assets of the corporation. For tax years beginning on or after January 1, 1998, net capital gains from the sale of the assets of a business described in subrules 40.38(7) to 40.38(13) are excluded in the computation of net income for qualified individual taxpayers. Net capital gains means capital gains net of capital losses because Iowa's starting point for computing net income is federal adjusted gross income. Subrule 40.38(14) describes situations in which the capital gain deduction otherwise allowed is not allowed for purposes of computation of a net operating loss or for computation of the taxable income for a tax year to which a net operating loss is carried.

40.38(7) Net capital gains from the sale of real property used in a business. Net capital gains from the sale of real property used in a business are excluded from net income on the Iowa return of the owner of a business to the extent the owner had held the real property in the business for ten or more years and the owner had materially participated in the business for at least ten years. For purposes of this provision, material participation is defined in Section 469(h) of the Internal Revenue Code and described in detail in subrule 40.38(1), paragraph *"c."*

For capital gains reported for tax years ending prior to January 1, 2006, the term "held" is defined as "owned." See Decision of the Administrative Law Judge in James and Linda Bell, Docket No. 01DORF013, January 15, 2002. Therefore, the real property had to be owned by the taxpayer for ten or more years to meet the ownership requirement for the capital gain deduction for tax years ending prior to January 1, 2006. For capital gains reported for tax years ending on or after January 1, 2006, the term "held" is determined using the holding period provisions set forth in Section 1223 of the Internal

Revenue Code and the federal regulations which adopt Section 1223. Therefore, as long as the holding period used to compute the capital gain is ten years or more, the ownership requirement for the capital gain deduction will be met for tax years ending on or after January 1, 2006.

Note that for purposes of taxation of capital gains from the sales of real property of a business by a taxpayer, there is no waiver of the ten-year material participation requirement when the property is sold to a lineal descendant of the taxpayer as there is for capital gains from sales of businesses described in subrule 40.38(8).

In situations in which real property was sold by a partnership, subchapter S corporation, limited liability company, estate, or trust and the capital gain from the sale of the real property flows through to the owners of the business entity for federal income tax purposes, the owners can exclude the capital gain from their net incomes if the real property was owned for ten or more years and the owners had materially participated in the business for ten years prior to the date of sale of the real property, irrespective of whether the type of business entity changed during the ten-year period prior to the date of sale. That is, if the owner of the business had owned and materially participated in the business in the entire ten-year period before the sale, the fact that the business changed from one type of entity to another during the period does not disqualify the owner from excluding capital gains from the sale of real estate owned by the business during that whole ten-year period.

Capital gains from the sale of real property by a C corporation do not qualify for the capital gain exclusion except under the specific circumstances of a liquidation described in subrule 40.38(12).

Capital gains from the sale of real property held for ten or more years for speculation but not used in a business also do not qualify for the capital gain exclusion.

EXAMPLE 1. ABC Company, an S corporation, owned 1,000 acres of land. John Doe is the sole shareholder of ABC Company and had materially participated in ABC Company and owned ABC Company for more than ten years at the time 500 acres of the land were sold for a capital gain of $100,000 in 1998. The capital gain recognized in 1998 by ABC Company and which passed to John Doe as the shareholder of ABC Company is exempt from Iowa income tax because Mr. Doe met the material participation and ownership time requirements.

EXAMPLE 2. John Smith and Sam Smith both owned 50 percent of the stock in Smith and Company which was an S corporation that held 1,000 acres of farmland. Sam Smith had managed all the farming operations for the corporation from the time the corporation was formed in 1980. John Smith was an attorney who lived and practiced law in Denver, Colorado. John Smith was the father of Sam Smith. In 1998, Smith and Company sold 200 acres of the farmland for a $50,000 gain. $25,000 of the gain passed through to John Smith and $25,000 of the gain passed through to Sam Smith. The farmland was sold to Jerry Smith, who was another son of John Smith. Both John Smith and Sam Smith had owned the corporation for at least ten years at the time the land was sold, but only Sam Smith had materially participated in the corporation for the last ten years. Sam Smith could exclude the $25,000 capital gain from the land sale because he had met the time of ownership and time of material participation requirements. John Smith could not exclude the $25,000 gain since although he had met the time of ownership requirement, he did not meet the material participation requirement. Although the land sold by the corporation was sold to John Smith's son, a lineal descendant of John Smith, the capital gain John Smith realized from the land sale does not qualify for exemption for state income tax purposes. There is no waiver of the ten-year material participation requirement for taxpayer's sales of real estate from a business to a lineal descendant of the taxpayer as is described for sales of business assets in subrule 40.38(8).

EXAMPLE 3. Jerry Jones had owned and had materially participated in a farming business for 15 years and raised row crops in the business. There were 500 acres of land in the farming business; 300 acres had been held for 15 years, and 200 acres had been held for 5 years. If Mr. Jones sold the 200 acres of land that had been held only 5 years, any capital gain from the sale of this land would not be excludable since the land was part of the farming business but had been owned for less than 10 years. If the 300 acres of land that had been held for 15 years had been sold, the capital gain from that sale would qualify for exclusion.

EXAMPLE 4. John Pike owned a farming business for more than ten years. In this business, Mr. Pike farmed a neighbor's land on a crop-share basis throughout the period. Mr. Pike bought 80 acres of land in 1992 and farmed that land until the land was sold in 1998 for a capital gain of $20,000. The capital gain was taxable on Mr. Pike's Iowa return since the farmland had been held for less than ten years although the business had been operated by Mr. Pike for more than ten years.

EXAMPLE 5. Joe and John Perry were brothers in a partnership for six years which owned 80 acres of land. The brothers dissolved the partnership in 1993, formed an S corporation, and included the land in the assets of the S corporation. The land was sold in 1998 to Brian Perry, who was the grandson of John Perry. The Perry brothers realized a capital gain of $15,000 from the land sale which was divided equally between the brothers. Joe Perry was able to exclude the capital gain he had received from the sale as he had owned the land and had materially participated in the business for at least ten years at the time the land was sold. John Perry was unable to exclude the capital gain because although he had owned the land for ten years, he had not materially participated in the business for ten years when the land was sold. The fact that the land was sold to a lineal descendant of John Perry is not relevant because the sale involved only real property held in a business and not the sale of all, or substantially all, of the tangible personal property and intangible property of the business.

EXAMPLE 6. Todd Myers had a farming business which he had owned and which he had materially participated in for 20 years. There were two tracts of farmland in the farming business. In 1998, he sold one tract of farmland in the farming business that he had owned for more than 10 years for a $50,000 capital gain. The farmland was sold to a person who was not a lineal descendant. During the same year, Mr. Myers had $30,000 in long-term capital losses from sales of stock. In this situation, on Mr. Myers' 1998 Iowa return, the capital gains would not be applied against the capital losses. Because the capital losses are unrelated to the farming business, Mr. Myers does not have to reduce the Iowa capital gain deduction by the capital losses from the sales of stock.

EXAMPLE 7. Jim Casey had owned farmland in Greene County, Iowa, since 1987, and had materially participated in the farming business. In 1998, Mr. Casey entered into a like-kind exchange under Section 1031 of the Internal Revenue Code for farmland located in Carroll County, Iowa. Mr. Casey continued to materially participate in the farming business in Carroll County. The farmland in Carroll County was sold in 2005, resulting in a capital gain. For federal tax purposes, the holding period for the capital gain starts in 1987 under Section 1223 of the Internal Revenue Code. Because Mr. Casey owned the farmland in Carroll County for less than ten years, based on Iowa law at the time of the sale, the capital gain from the sale does not qualify for the Iowa capital gain exclusion. The exclusion is not allowed even though the holding period for federal tax purposes is longer than ten years because the capital gain was reported for a tax year ending prior to January 1, 2006. If the farmland was sold in 2006, the gain would qualify for the capital gain exclusion since the capital gain would have been reported for a tax year ending on or after January 1, 2006.

EXAMPLE 8. Jane and Ralph Murphy, a married couple, owned farmland in Iowa since 1975. Ralph died in 1994 and, under his will, Jane acquired a life interest in the farm. The farmland was managed by their son, Joseph, after Ralph's death. Jane died in 1998, and Joseph continued to materially participate and manage the farm operation. Joseph sold the farmland in 2006 and reported a capital gain. For federal tax purposes, the holding period for the capital gain starts in 1994, when Ralph died, under Section 1223 of the Internal Revenue Code. Because the holding period for the capital gain was ten years or more under Section 1223 of the Internal Revenue Code, Joseph is entitled to the capital gain exclusion under Iowa law since he materially participated for ten years or more and the capital gain was reported for a tax year ending on or after January 1, 2006.

40.38(8) Net capital gains from the sale of assets of a business by an individual that had owned the business ten years and had materially participated in the business for ten years. Net capital gains from the sale of the assets of a business are excluded from an individual's net income to the extent the individual had owned the business for ten or more years and the individual had materially participated in the business for ten or more years. In addition to the ownership and material participation qualifications for the capital gain exclusion, the owner of the business must have sold substantially all of the tangible personal property or the service of the business in order for the capital gains to be excluded from taxation.

For purposes of this rule, the term "substantially all of the tangible property or service of the business" means that the sale of the assets of a business during the tax year must represent at least 90 percent of the fair market value of all of the tangible personal property and service of the business on the date of sale of the business assets. Thus, if the fair market value of a business's tangible personal property and service was $400,000, the business must sell tangible personal property and service of the business that had a fair market value of 90 percent of the total value of those assets to achieve the 90 percent or more standard. However, this does not mean that the amount raised from the sale of the assets must be $360,000 in order for the 90 percent standard to be met, only that the assets involved in the sale of the business must represent 90 percent of the total value of the business assets.

Note that if the 90 percent of assets test is met, capital gains from other assets of the business can also be excluded. Some of these assets include, but are not limited to, stock of another corporation, bonds, including municipal bonds, and interests in other businesses. Note also that if the 90 percent test has been met, all of the individual assets of the business do not have to have been held for ten years on the date of sale for the capital gains from the sale of these assets to be excluded in computing the taxpayer's net income. This statement is made with the assumption that the taxpayer has owned the business and materially participated in the business for ten years prior to the sale of the assets of the business.

In most instances, the sale of merchandise or inventory of a business will not result in capital gains for the seller of a business, so the proceeds from the sale of these items would not be excluded from taxation.

For the purposes of this rule, the term "service of the business" means intangible assets used in the business or for the production of business income which, if sold for a gain, would result in a capital gain for federal income tax purposes. Intangible assets that are used in the business or for the production of income include, but are not limited to, the following items: (1) goodwill, (2) going concern value, (3) information base, (4) patent, copyright, formula, design, or similar item, (5) client lists, and (6) any franchise, trademark, or trade name. The type of business that owns the intangible asset is immaterial, whether the business is a manufacturing business, retail business, or a service business, such as a law or accounting firm.

However, when the business owned by the taxpayer for a minimum of ten years is sold to an individual or individuals who are all lineal descendants of the taxpayer, the taxpayer does not need to have materially participated in the business for ten years prior to the sale of the business in order for the capital gain to be excluded in the computation of net income.

For purposes of these rules, the term "lineal descendant" means children of the taxpayer, including legally adopted children and biological children, stepchildren, grandchildren, great-grandchildren, and any other lineal descendants of the taxpayer.

In situations in which substantially all the tangible personal property or service was sold by a partnership, subchapter S corporation, limited liability company, estate, or trust and the capital gains from the sale of the assets flow through to the owners of the business entity for federal income tax purposes, the owners can exclude the capital gains from their net incomes if the owners had owned the business for ten or more years and the owners had materially participated in the business for ten years prior to the date of sale of the tangible personal property or service, irrespective of whether the type of business entity changed during the ten-year period prior to the sale.

Note that additional information on sales of business assets which may qualify for the exclusion and criteria for material participation in a business may be found in subrule 40.38(1).

Installments received in the tax year from installment sales of businesses are eligible for the exclusion if all relevant criteria were met at the time of the installment sale which would make the capital gains from the sale exempt from taxation if the installment sale of the business had occurred on or after January 1, 1998.

Sale of capital stock of an Iowa corporation or an Iowa farm corporation to a lineal descendant or to another individual does not constitute the sale of a business for purposes of the capital gain exclusion, whether the corporation is a C corporation or an S corporation.

Capital gains from the sale of an ownership interest in a partnership, limited liability company or other entity are not eligible for the capital gain exclusion. *Ranniger v. Iowa Department of Revenue and Finance*, Iowa Supreme Court, No. 11, 06-0761, March 21, 2008.

Note that the sale of one activity of a business or one distinct part of a business may not constitute the sale of a business for purposes of this rule unless the activity or distinct part is a separate business entity such as a partnership or sole proprietorship which is owned by the "business" or unless it represents the sale of at least 90 percent of the fair market value of the tangible personal property or service of the business.

In order to determine whether the sale of the business assets constitutes the sale of a business for purposes of excluding capital gains recognized from the sale, refer to 701—subrule 54.2(1) relating to a unitary business. If activities or locations comprise a unitary business, then 90 percent or more of that unitary business must be sold to meet the requirement for capital gains from the sale to be excluded from taxation. If the activity or location constitutes a separate, distinct, non-unitary business, then 90 percent of the assets of that location or activity must be sold to qualify for the exemption of the capital gain. The burden of proof is on the taxpayer to show that a sale of assets of a business meets the 90 percent standard.

EXAMPLE 1. Joe Rich is the sole owner of Eagle Company, which is an S corporation. In 1998, Mr. Rich sold all the stock of Eagle Company to his son, Mark Rich, and recognized a $100,000 gain on the sale of the stock. This capital gain would be taxable on Joe Rich's 1998 Iowa return since the sale of stock of a corporation did not constitute the sale of the tangible personal property and service of a business.

EXAMPLE 2. Randall Insurance Agency, a sole proprietorship, is owned solely by Peter Randall. In 1998, Peter Randall received capital gains from the sale of all tangible assets of the insurance agency. In addition, Mr. Randall had capital gains from the sale of client lists and goodwill to the new owners of the business. Since Mr. Randall had owned the insurance agency for more than ten years and had materially participated in the insurance agency for more than ten years at the time of the sale of the tangible property and intangible property of the business, Mr. Randall can exclude the capital gains from the sale of the tangible assets and the intangible assets in computing net income on his 1998 Iowa return.

EXAMPLE 3. Joe Brown owned and materially participated in a sole proprietorship for more than ten years. During the 1998 tax year, Mr. Brown sold two delivery trucks and had capital gains from the sale of the trucks. The trucks were valued at $30,000 at the time of sale which was about 10 percent of the tangible personal property of the business. Mr. Brown could not exclude the capital gains from the sale of the trucks on his 1998 Iowa return as the sale of those assets did not involve the sale of substantially all of the tangible personal property and service of Mr. Brown's business.

EXAMPLE 4. Rich Bennet owned a restaurant and a gift shop in the same building that were part of a sole proprietorship owned only by Mr. Bennet, who had owned and materially participated in both business activities for over ten years. Mr. Bennet sold the gift shop in 1998 for $100,000 and had a capital gain of $40,000 from the sale. The total fair market value of all tangible personal property and intangible assets in the proprietorship at the time the gift shop was sold was $250,000. Mr. Bennet could not exclude the capital gain on his 1998 Iowa return because he had not sold at least 90 percent of the tangible and intangible assets of the business.

EXAMPLE 5. Joe and Ray Johnson were partners in a farm partnership that they had owned for 12 years in 1998 when the assets of the partnership were sold to Ray's son Charles. Joe Johnson had materially participated in the partnership for the whole time that the business was in operation, so he could exclude the capital gain he had received from the sale of the partnership assets. Although Ray Johnson had not materially participated in the farm business, he could exclude the capital gain he received from the sale of the assets of the partnership because the sale of the partnership assets was to his son, a lineal descendant.

EXAMPLE 6. Kevin and Ron Barker owned a partnership which held a chain of six gas stations in an Iowa city. In 1998, the Barkers sold 100 percent of the property of two of the gas stations and received a capital gain from the sale of $30,000. Separate business records were kept for each of the gas stations. Since the partnership was considered to be a unitary business and the Barkers sold less than 90 percent of

the fair market value of the business, the Barkers could not exclude the capital gain from the sale of the gas stations from the incomes reported on their 1998 Iowa returns. However, any gain from the sale of the real property may qualify for exclusion, assuming the ten-year ownership and material participation qualifications are met.

EXAMPLE 7. Rudy Stern owned a cafe in one Iowa city and a fast-food restaurant in another Iowa city. Mr. Stern had owned both businesses and had materially participated in the operation of both businesses for ten years. Each business was operated with a separate manager and kept separate business records. In 1998, Mr. Stern sold all the tangible and intangible assets associated with the cafe and received a capital gain from the sale of the cafe. Mr. Stern can exclude the capital gain from his net income for 1998 because the cafe and fast-food restaurant were considered to be separate and distinct non-unitary businesses.

EXAMPLE 8. Doug Jackson is a shareholder in an S corporation, Jackson Products Corporation. Mr. Jackson has a 75 percent ownership interest in the S corporation, and he has materially participated in the operations of the S corporation since its incorporation in 1980. In 2002, Mr. Jackson transfers 10 percent of his ownership interest in the S corporation to Doug Jackson Irrevocable Trust. The income from the irrevocable trust is reported on Mr. Jackson's individual income tax return. In 2005, the assets of Jackson Products Corporation are sold, resulting in a capital gain. Mr. Jackson can claim the capital gain deduction on both his 65 percent ownership held in his name and the 10 percent irrevocable trust ownership since the capital gain from the irrevocable trust flows through to Mr. Jackson's income tax return, and Mr. Jackson retained a 75 percent interest in the S corporation for more than ten years.

40.38(9) Net capital gains from the sales of cattle or horses held for two years and used for certain purposes. Net capital gains from the sales of certain cattle or horses held for 24 months or more before the sale and which were owned by taxpayers who received more than one-half of their gross incomes in the tax year from farming or ranching operations are excluded from taxation. The cattle or horses must have been held the required two-year period for breeding, dairy, or sporting purposes in order for the capital gain from the sale of the horses and cattle to qualify for exclusion. These are the same sales of horses and cattle that are eligible for capital gain treatment for federal income tax purposes under Section 1231 of the Internal Revenue Code.

In situations where the qualifying cattle or horses are sold by the taxpayer to a lineal descendant of the taxpayer, the taxpayer does not need to have had more than 50 percent of gross income in the tax year from farming or ranching activities in order for the capital gain to be excluded.

Capital gains from sales of qualifying cattle or horses by an S corporation, partnership, or limited liability company, where the capital gains flow through to the individual owners for federal income tax purposes are eligible for the exclusion only in situations in which the individual owners have more than 50 percent of their gross incomes in the tax year from farming or ranching activities, or where the sale of the qualifying cattle or horses was to lineal descendants of the owners reporting the capital gains from the sales of the qualifying cattle or horses.

However, capital gains from sales of qualifying cattle or horses by a C corporation are not eligible for the capital gain exclusion.

Information about whether cattle or horses were held for draft, breeding, dairy, or sporting purposes is described in detail in subrule 40.38(2). The same subrule includes criteria for determining if more than 50 percent of a taxpayer's gross income in a tax year was from farming or ranching. Note that this standard for determining a taxpayer's qualification for the capital gain deduction or exclusion is if the taxpayer's gross income from farming or ranching, not net income from those activities, is greater than 50 percent of the taxpayer's total gross income and not total net income.

EXAMPLE. Bob Deen had a cattle operation that held black angus cattle in the operation for breeding purposes. In 1998, Mr. Deen sold 40 head of cattle that had been held for breeding purposes for two years. Mr. Deen's total gross income from farming was $125,000, but he had a $10,000 loss from his farming operation. Mr. Deen also had wages of $25,000 from a job at a local farming cooperative. Because Mr. Deen had more than 50 percent of his gross income in 1998 from farming operations, he could exclude the capital gain from the sale of the breeding cattle. Although Mr. Deen had a loss from

his farming activities, he still had more than 50 percent of his gross income in the tax year from those activities.

40.38(10) Net capital gains from sales of certain livestock other than horses and cattle. Net capital gains from sale of breeding livestock, other than cattle or horses held 12 or more months by taxpayers who have more than 50 percent of their gross incomes in the tax year from farming or ranching operations, are excluded from taxation. These are the same sales of breeding livestock other than cattle or horses that are eligible for capital gain treatment for federal income tax purposes under Section 1231 of the Internal Revenue Code. In an instance in which a taxpayer sells breeding livestock other than cattle or horses which have been held 12 or more months, and the sale of the livestock is to a lineal descendant of the taxpayer, the taxpayer does not need to have more than 50 percent of the gross income in the tax year from farming or ranching operations to be eligible for the capital gain exclusion.

Capital gains from sales of qualifying livestock other than cattle or horses by an S corporation, partnership, or limited liability company, where the capital gains flow through to the owners of the respective business entity for federal income tax purposes, qualify for the exclusion to the extent the owners receiving the capital gains meet the qualifications for the exclusion on the basis of having more than 50 percent of the gross income in the tax year from farming or ranching activities.

Capital gains from the sale of qualifying livestock other than cattle or horses by a C corporation are not eligible for the exclusion.

Animals that are considered livestock other than cattle or horses for purposes of this rule are listed in subrule 40.38(3). Criteria for determining whether more than 50 percent of a taxpayer's gross income in the tax year is from farming or ranching are defined in subrule 40.38(2).

40.38(11) Capital gains from the sales of timber held by the taxpayer more than one year. These sales of timber are sales that would qualify for capital gain treatment for federal income tax purposes under Section 1231 of the Internal Revenue Code. Thus, if the sale of timber products meets the criteria for capital gain treatment for federal income tax purposes, the capital gain will qualify for exclusion on the Iowa income tax return.

Subrule 40.38(4) includes information on which tree products are considered to be timber for purposes of this rule as well as which sales of timber qualify for the capital gain exclusion. Additional information about gains and losses from the sale of timber products is found in Treasury Regulations §1.631-1 and §1.631-2.

Capital gains from the sale of qualifying timber by an S corporation, partnership, or limited liability company, which flow to the owners of the respective business entity for federal individual income tax purposes, are eligible for the capital gain exclusion.

Capital gains from the sale of timber by a C corporation do not qualify for the capital gain exclusion.

40.38(12) Capital gains from the liquidation of assets of corporations which are recognized as sales of assets for federal income tax purposes. Capital gains realized from liquidations of corporations which are recognized as sales of assets for federal income tax purposes under Section 331 of the Internal Revenue Code may be eligible for the capital gain exclusion. To the extent the capital gains are reported by the shareholders of the corporations for federal income tax purposes and the shareholders are individuals, the shareholders are eligible for the capital gain deduction if the shareholders meet the qualifications for time of ownership and time of material participation in the corporation being liquidated. The burden of proof is on the shareholders to show they meet these time of ownership and material participation requirements.

40.38(13) Capital gains from certain stock sales which are treated as acquisitions of assets of the corporation for federal income tax purposes. Capital gains received by individuals from a sale of stock of a target corporation which is treated as an acquisition of the assets of the corporation under Section 338 of the Internal Revenue Code may be excluded if the individuals receiving the capital gains had owned an interest in the target corporation and had materially participated in the corporation for ten years prior to the date of the sale of the corporation. Note that the burden of proof is on the taxpayer to show eligibility to exclude the capital gains from these transactions in the computation of net income for Iowa individual income tax purposes.

40.38(14) Net capital gain deduction or exclusion not allowed for purposes of computation of a net operating loss or for computation of income for a tax year to which a net operating loss is carried. Although the net capital gain deduction or exclusion in this rule is allowed for the purposes of computation of a taxpayer's net income for a tax year, the deduction or exclusion is not allowed for the purposes of the computation of a net operating loss in the tax year. In addition, if a net operating loss for a tax year beginning on or after January 1, 1998, is carried forward to a subsequent tax year or is carried back to a prior tax year, the net capital gain deduction or exclusion is not allowed for the purposes of computing the income for the tax year to which the net operating loss was carried.

This rule is intended to implement Iowa Code section 422.7.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—40.39(422) Exemption of interest from bonds or notes issued to fund the E911 emergency telephone system. Interest received on or after May 4, 1990, from bonds or notes issued by the Iowa finance authority to fund the E911 emergency telephone system is exempt from the state income tax.

This rule is intended to implement Iowa Code sections 422.7 and 477B.20.

701—40.40(422) Exemption of active-duty military pay of national guard personnel and armed forces reserve personnel received for services related to operation desert shield. For tax years ending on or after August 2, 1990, military pay received by persons in the national guard and persons in the armed forces military reserve is exempt from state income tax to the extent the military pay is not otherwise excluded from taxation and the military pay is for active-duty military service on or after August 2, 1990, pursuant to military orders related to Operation Desert Shield. The exemption applies to individuals called to active duty in Iowa to replace other persons who were in military units who were called to serve on active duty outside Iowa provided the military orders specify that the active duty assignment in Iowa pertains to Operation Desert Shield.

Persons filing original returns or amended returns on Form IA 1040X for tax years where the exempt income was received should print the notation, "Operation Desert Shield" at the top of the original return form or amended return form. A copy of the military orders showing the person was called to active duty and was called in support of Operation Desert Shield should be attached to the original return form or amended return form to support the exemption of the active duty military pay.

This rule is intended to implement Iowa Code section 422.7.

701—40.41(422) Disallowance of private club expenses. Rescinded IAB 11/24/04, effective 12/29/04.

701—40.42(422) Depreciation of speculative shell buildings.

40.42(1) For tax years beginning on or after January 1, 1992, speculative shell buildings constructed or reconstructed after that date may be depreciated as 15-year property under the accelerated cost recovery system of the Internal Revenue Code. If the taxpayer has deducted depreciation on the speculative shell building on the taxpayer's federal income tax return, that amount of depreciation must be added to the federal adjusted gross income in order to deduct depreciation computed under this rule.

40.42(2) On sale or other disposition of the speculative building, the taxpayer must report on the taxpayer's Iowa individual income tax return the same gain or loss as is reported on the taxpayer's federal individual income tax return. If, while owned by the taxpayer, the building is converted from a speculative shell building to another use, the taxpayer must deduct the same amount of depreciation on the taxpayer's Iowa tax return as is deducted on the taxpayer's federal tax return.

40.42(3) For the purposes of this rule, the term "speculative shell building" means a building as defined in Iowa Code section 427.1(27)*"c."*

This rule is intended to implement Iowa Code section 422.7.

701—40.43(422) Retroactive exemption for payments received for providing unskilled in-home health care services to a relative. Retroactive to January 1, 1988, for tax years beginning on or after that date, supplemental assistance payments authorized under Iowa Code section 249.3(2)*"a"*(2) which are received by an individual providing unskilled in-home health care services to a member of the caregiver's

family are exempt from state income tax to the extent that the individual caregiver is not a licensed health care professional designated in Iowa Code section 147.13, subsections 1to 10.

Taxpayers who paid state income tax on the supplemental assistance payments on individual income tax returns for tax years beginning in the 1988 calendar year and who are eligible for the exemption may claim refunds of state income tax paid on the assistance payments, if the refund claims are filed with the department of revenue on or before April 30, 1993.

This rule is intended to implement Iowa Code section 422.7.
[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—40.44(422,541A) Individual development accounts. Individual development accounts are authorized for low-income taxpayers for tax years beginning on or after January 1, 1994. Additions to the accounts are described in the following subrule:

40.44(1) *Exemption of additions to individual development accounts.* The following additions to individual development accounts are exempt from the state income tax of the owners of the accounts to the extent the additions were subject to federal income tax:

a. The amount of contributions made in the tax year to an account by persons and entities other than the owner of the account.

b. The amount of any savings refund or state match payments made in the tax year to an account as authorized for contributions made to the accounts by the owner of the account.

c. Earnings on the account in the tax year or interest earned on the account.

40.44(2) *Additions to net income for withdrawals from individual development accounts.* Rescinded IAB 9/11/96, effective 10/16/96.

This rule is intended to implement Iowa Code sections 422.7, 541A.2 and 541A.3 as amended by 2008 Iowa Acts, Senate File 2430.

701—40.45(422) Exemption for distributions from pensions, annuities, individual retirement accounts, or deferred compensation plans received by nonresidents of Iowa. For tax years beginning on or after January 1, 1994, a distribution from a pension plan, annuity, individual retirement account, or deferred compensation plan which is received by a nonresident of Iowa is exempt from Iowa income tax to the extent the distribution is directly related to the documented retirement of the pensioner, annuitant, owner of individual retirement account, or participant in a deferred compensation arrangement. For tax years beginning on or after January 1, 1996, distributions of nonqualified retirement benefits which are paid by a partnership to its retired partners and which are received by a nonresident of Iowa are exempt from Iowa income tax to the extent the distribution is directly related to the documented retirement of the partner. In a situation where the pensioner, annuitant, owner of the individual retirement account, or participant of a deferred compensation arrangement dies before the date of documented retirement, any distribution from the pension, annuity, individual retirement account, or deferred compensation arrangement will not be taxable to the beneficiary receiving the distributions if the beneficiary is a nonresident of Iowa. If the pensioner, annuitant, owner of the individual retirement account, or participant of a deferred compensation arrangement dies after the date of documented retirement, any distributions from the pension, annuity, individual retirement account, or deferred compensation arrangement will not be taxable to a beneficiary receiving distributions if the beneficiary is a nonresident of Iowa.

For purposes of this rule, the distributions from the pensions, annuities and deferred compensation arrangements were from pensions, annuities, and deferred compensation earned entirely or at least partially from employment or self-employment in Iowa. For purposes of this rule, distributions from individual retirement arrangements were from individual retirement arrangements that were funded by contributions from the arrangements that were deductible or partially deductible on the Iowa income tax return of the owner of the individual retirement accounts.

The following subrules include definitions and examples which clarify when distributions from pensions, annuities, individual retirement accounts, and deferred compensation arrangements are exempt from Iowa income tax, when the distributions are received by nonresidents of Iowa:

40.45(1) *Definitions.*

a. The word "beneficiary" means an individual who receives a distribution from a pension or annuity plan, individual retirement arrangement, or deferred compensation plan as a result of either the death or divorce of the pensioner, annuitant, participant of a deferred compensation arrangement, or owner of an individual retirement account.

b. The term "individual's documented retirement" means any evidence that the individual can provide to the department of revenue which would establish that the individual or the individual's beneficiary is receiving distributions from the pension, annuity, individual retirement account, or the deferred compensation arrangement due to the retirement of the individual.

Examples of documents that would establish an individual's retirement may include: copies of birth certificates or driver's licenses to establish an individual's age; copies of excerpts from an employer's personnel manual or letter from employer to establish retirement or early retirement policies; a copy of a statement from a physician to establish an individual's disability which could have contributed to a person's retirement.

c. The term "nonresident" applies only to individuals and includes all individuals other than those individuals domiciled in Iowa and those individuals who maintain a permanent place of abode in Iowa. See 701—subrule 38.17(2) for the definition of domicile.

40.45(2) *Examples:*

a. John Jones had worked for the same Iowa employer for 32 years when he retired at age 62 and moved to Arkansas in March of 1994. Mr. Jones started receiving distributions from the pension plan from his former employer starting in May 1994. Because Mr. Jones was able to establish that he was receiving the distributions from the pension plan due to his retirement from his employment, Mr. Jones was not subject to Iowa income tax on the distributions from the pension plan. Note that Mr. Jones had sold his Iowa residence in March and established his domicile in Arkansas at the time of his move to Arkansas.

b. Wanda Smith was the daughter of John Smith who died in February 1994 after 25 years of employment with a company in Urbandale, Iowa. Wanda Smith was the sole beneficiary of John and started receiving distributions from John's pension in April 1994. Wanda Smith was a bona fide resident of Oakland, California, when she received distributions from her father's pension. Wanda was not subject to Iowa income tax on the distributions since she was a nonresident of Iowa at the time the distributions were received.

c. Martha Graham was 55 years old when she quit her job with a firm in Des Moines to take a similar position with a firm in Dallas, Texas. Ms. Graham had worked for the Des Moines business for 22 years before she resigned from the job in May 1994. Starting in July 1994, Ms. Graham received monthly distributions from the pension from her former Iowa employer. Although Ms. Graham was a nonresident of Iowa, she was subject to Iowa income tax on the pension distribution since the taxpayer didn't have a documented retirement.

d. William Moore was 58 years old when he quit his job with a bank in Mason City in February 1994 after 30 years of employment with the bank. By the time Mr. Moore started receiving pension payments from his employment with the bank, he had moved permanently to New Mexico. Shortly after he arrived in New Mexico, Mr. Moore secured part-time employment. The pension payments were not taxable to Iowa as Mr. Moore was retired notwithstanding his part-time employment in New Mexico.

e. Joe Brown had worked for an Iowa employer for 25 years when he retired in June 1992 at the age of 65. Mr. Brown started receiving monthly pension payments in July 1992. Mr. Brown resided in Iowa until August 1994, when he moved permanently to Nevada to be near his daughter. Mr. Brown was not taxable to Iowa on the pension payments he received after his move to Nevada. Mr. Brown's retirement occurred in June 1992 when he resigned from full-time employment.

This rule is intended to implement Iowa Code section 422.8.

701—40.46(422) Taxation of compensation of nonresident members of professional athletic teams. Effective for tax years beginning on or after January 1, 1995, the Iowa source income of a nonresident individual who is a member of a professional athletic team includes the portion of the

individual's total compensation for services provided for the athletic team that is in the ratio that the number of duty days spent in Iowa rendering services for the team during the tax year bears to the total number of duty days spent both within and without Iowa in the tax year. Thus, if a nonresident member of a professional athletic team has $50,000 in total compensation from the team in 1995 and the athlete has 20 Iowa duty days and 180 total duty days for the team in 1995, $5,556 of the compensation would be taxable to Iowa ($50,000 × 20/180 = $5,556).

The following subrules include definitions, examples, and other information which clarify Iowa's taxation of nonresident members of professional athletic teams:

40.46(1) *Definitions.*

a. The term "professional athletic team" includes, but is not limited to, any professional baseball, basketball, football, soccer, or hockey team.

b. The term "member of a professional athletic team" includes those employees who are active players, players on the disabled list, and any other persons required to travel and who travel with and perform services on behalf of a professional athletic team on a regular basis. This includes, but is not limited to, coaches, managers, and trainers.

c. The term "total compensation for services rendered as a member of a professional athletic team" means the total compensation received during the taxable year for services rendered. "Total compensation" includes, but is not limited to, salaries, wages, bonuses (as described in subparagraph (1) of this paragraph), and any other type of compensation paid during the taxable year to a member of a professional athletic team for services performed in that year. Such compensation does not include strike benefits, severance pay, termination pay, contract or option year buy-out payments, expansion or relocation payments, and any other payments not related to services rendered for the team.

For purposes of this paragraph, "bonuses" included in "total compensation for services rendered as a member of a professional athletic team" subject to the allocation described in this rule are:

(1) Bonuses earned as a result of play (i.e., performance bonuses) during the season, including bonuses paid for championship, playoff, or "bowl" games played by a team, or for the member's selection to all-star, league, or other honorary positions; and

(2) Bonuses paid for signing a contract, unless all of the following conditions are met:

1. The payment of the signing bonus is not conditional upon the signee playing any games for the team, or performing any subsequent services for the team, or even making the team;
2. The signing bonus is payable separately from the salary and any other compensation; and
3. The signing bonus is nonrefundable.

d. Except as provided in subparagraphs (4) and (5) of this paragraph, the term "duty days" means all days during the taxable year from the beginning of the professional athletic team's official preseason training period through the last game in which the team competes or is scheduled to compete. Duty days are included in the allocation described in this rule for the tax year in which they occur, including where a team's official preseason training period through the last game in which the team competes, or is scheduled to compete, occurs during more than one tax year.

(1) Duty days also includes days on which a member of a professional athletic team renders a service for a team on a date which does not fall within the previously mentioned period (e.g., participation in instructional leagues, the "Pro Bowl" or promotional "caravans"). Rendering a service includes conducting training and rehabilitation activities, but only if conducted at the facilities of the team.

(2) Included within duty days are game days, practice days, days spent at team meetings, promotional caravans and preseason training camps, and days served with the team through all postseason games in which the team competes or is scheduled to compete.

(3) Duty days for any person who joins a team during the period from the beginning of the professional athletic team's official preseason training period through the last game in which the team competes, or is scheduled to compete, begins on the day the person joins the team. Conversely, duty days for any person who leaves a team during such period ends on the day the person leaves the team. When a person switches teams during a taxable year, separate duty day calculations are to be made for the period the person was with each team.

(4) Days for which a member of a professional athletic team is not compensated and is not rendering services for the team in any manner, including days when the member of a professional athletic team has been suspended without pay and prohibited from performing any services for the team, are not to be treated as duty days.

(5) Days for which a member of a professional athletic team is on the disabled list and does not conduct rehabilitation activities at facilities of the team and is not otherwise rendering services for the team in Iowa, are not to be considered duty days spent in Iowa. However, all days on the disability list are considered to be included in total duty days spent both within and outside the state of Iowa.

(6) Total duty days for members of a professional athletic team that are not professional athletes are the number of days in the year that the members are employed by the professional athletic team. Thus, in the case of a coach of a professional athletic team who was coach for the entire year of 1995, the coach's total duty days for 1995 would be 365.

(7) Travel days in Iowa by a team member that do not involve a game, practice, team meeting, all-star game, or other personal service for the team are not considered to be duty days in Iowa. However, to the extent these days fall within the period from the team's preseason training period through the team's final game, these Iowa travel days will be considered in the total duty days spent within and outside Iowa, for team members who are professional athletes.

(8) Duty days in Iowa do not include days a team member performs personal services for the professional athletic team in Iowa on those days that the team member is a bona fide resident of a state with which Iowa has a reciprocal tax agreement. See rule 701—38.13(422).

40.46(2) *Filing composite Iowa returns for nonresident members of professional athletic teams.* Professional athletic teams may file composite Iowa returns on behalf of team members who are nonresidents of Iowa and who have compensation that is taxable to Iowa from duty days in Iowa for the athletic team. However, the athletic team may include on the composite return only those team members who are nonresidents of Iowa and who have no Iowa source incomes other than the incomes from duty days in Iowa for the team. The athletic team may exclude from the composite return any team member who is a nonresident of Iowa and whose income from duty days in Iowa is less than $1,000. See rule 701—48.1(422) about filing Iowa composite returns.

40.46(3) *Examples of taxation of nonresident members of professional athletic teams.*

a. Player A, a member of a professional athletic team, is a nonresident of Iowa. Player A's contract for the team requires A to report to such team's training camp and to participate in all exhibition, regular season, and playoff games. Player A has a contract which covers seasons that occur during year 1/year 2 and year 2/year 3. Player A's contract provides that A is to receive $500,000 for the year 1/year 2 season and $600,000 for the year 2/year 3 season. Assuming player A receives $550,000 from the contract during taxable year 2 ($250,000 for one-half the year 1/year 2 season and $300,000 for one-half the year 2/year 3 season), the portion of compensation received by player A for taxable year 2, attributable to Iowa, is determined by multiplying the compensation player A receives during the taxable year ($550,000) by a fraction, the numerator of which is the total number of duty days player A spends rendering services for the team in Iowa during taxable year 2 (attributable to both the year 1/year 2 season and the year 2/year 3 season) and the denominator of which is the total number of player A's duty days spent both within and outside Iowa for the entire taxable year.

b. Player B, a member of a professional athletic team, is a nonresident of Iowa. During the season, B is injured and is unable to render services for B's team. While B is undergoing medical treatment at a clinic, which is not a facility of the team, but is located in Iowa, B's team travels to Iowa for a game. The number of days B's team spends in Iowa for practice, games, meetings, for example, while B is present at the clinic, are not to be considered duty days spent in Iowa for player B for that taxable year for purposes of this rule, but these days are considered to be included within total duty days spent both within and outside Iowa.

c. Player C, a member of a professional athletic team, is a nonresident of Iowa. During the season, C is injured and is unable to render services for C's team. C performs rehabilitation exercises at the facilities of C's team in Iowa as well as at personal facilities in Iowa. The days C performs rehabilitation exercise in the facilities of C's team are considered duty days spent in Iowa for player C for that taxable

year for purposes of this rule. However, days player C spends at personal facilities in Iowa are not to be considered duty days spent in Iowa for player C for that taxable year for purposes of this rule, but the days are considered to be included within total duty days spent both within and outside Iowa.

d. Player D, a member of a professional athletic team, is a nonresident of Iowa. During the season, D travels to Iowa to participate in the annual all-star game as a representative of D's team. The number of days D spends in Iowa for practice, the game, meetings, for example, are considered to be duty days spent in Iowa for player D for that taxable year for purposes of this rule, as well as included within total duty days spent both within and outside Iowa.

e. Assume the same facts as given in paragraph *"d,"* except that player D is not participating in the all-star game and is not rendering services for D's team in any manner. Player D is instead traveling to and attending this game solely as a spectator. The number of days player D spends in Iowa for the game is not to be considered to be duty days spent in Iowa for purposes of this rule. However, the days are considered to be included within total duty days spent both within and outside Iowa.

40.46(4) *Use of an alternative method to compute taxable portion of a nonresident's compensation as a member of a professional athletic team.* If a nonresident member of a professional athletic team believes that the method provided in this rule for allocation of the member's compensation to Iowa is not equitable, the nonresident member may propose the use of an alternative method for the allocation of the compensation to Iowa. The request for an alternative method for allocation must be filed no later than 60 days before the due date of the return, considering that the due date may be extended for up to 6 months after the original due date if at least 90 percent of the tax liability was paid by the original due date (April 30 for taxpayers filing on a calendar-year basis).

The request for an alternative method should be filed with the Taxpayer Services and Policy Division, P.O. Box 10457, Des Moines, Iowa 50306. The request must set forth the alternative method for allocation to Iowa of the compensation of the nonresident professional team member. In addition, the request must specify, in detail, why the method for allocation of the compensation set forth in this rule is not equitable, as well as why the alternative method for allocation of the compensation is more equitable than the method provided in this rule. The burden of proof is on the nonresident professional team member to show that the alternative method is more equitable than the method provided in the rule.

If the department determines that the alternative method is more reasonable for allocation of the taxable portion of the team member's compensation than the method provided in this rule, the team member can use the alternative method on the current return and on subsequent returns.

If the department rejects the team member's use of the alternative method, the team member may file a protest within 60 days of the date of the department's letter of rejection. The nonresident team member's protest of the department's rejection of the alternate formula must be made in accordance with rule 701—7.41(17A) and must state, in detail, why the method provided in this rule is not equitable, as well as why the alternative method for allocation of the compensation is more equitable than the method set forth in this rule.

This rule is intended to implement Iowa Code sections 422.3, 422.7, and 422.8.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—40.47(422) Partial exclusion of pensions and other retirement benefits for disabled individuals, individuals who are 55 years of age or older, surviving spouses, and survivors. For tax years beginning on or after January 1, 1995, an individual who is disabled, is 55 years of age or older, is a surviving spouse, or is a survivor with an insurable interest in an individual who would have qualified for the exclusion is eligible for a partial exclusion of retirement benefits received in the tax year. For tax years beginning on or after January 1, 2001, the partial exclusion of retirement benefits received in the tax year is increased up to a maximum of $6,000 for a person other than a husband or wife who files a separate state return and up to a maximum of $12,000 for a husband and wife who file a joint Iowa return. For tax years beginning on or after January 1, 1998, the partial exclusion of retirement benefits received in the tax year was increased up to a maximum of $5,000 for a person, other than a husband or wife who files a separate state income tax return, and up to a maximum of $10,000 for a husband and wife who file a joint state income tax return. A husband and wife filing separate state income tax returns

or separately on a combined state return are allowed a combined exclusion of retirement benefits of up to a maximum of $10,000 for tax years beginning in 1998, 1999 and 2000 and a combined exclusion of up to a maximum of $12,000 for tax years beginning on or after January 1, 2001. The $10,000 or $12,000 exclusion may be allocated to the husband and wife in the proportion that each spouse's respective pension and retirement benefits received bear to the total combined pension and retirement benefits received by both spouses.

EXAMPLE 1. A married couple elected to file separately on the combined return form. Both spouses were 55 years of age or older. The wife received $95,000 in retirement benefits and the husband received $5,000 in retirement benefits. Since the wife received 95 percent of the retirement benefits, she would be entitled to 95 percent of the $10,000 retirement income exclusion or a retirement income exclusion of $9,500. The husband would be entitled to 5 percent of the $10,000 retirement income exclusion or an exclusion of $500.

EXAMPLE 2. A married couple elected to file separately on the combined return form. Both spouses were 55 years of age or older. The husband had $15,000 in retirement benefits from a pension. The wife received no retirement benefits. In this situation, the husband can use the entire $10,000 retirement income exclusion to exclude $10,000 of his pension benefits since the spouse did not use any of the $10,000 retirement income exclusion for the tax year.

For tax years beginning on or after January 1, 1995, but prior to January 1, 1998, the retirement income exclusion was up to $3,000 for single individuals, up to $3,000 for each married person filing a separate Iowa return, up to $3,000 for each married person filing separately on the combined return form, and up to $6,000 for married taxpayers filing joint Iowa returns. For example, a married couple elected to file separately on the combined return form and both spouses were 55 years of age or older. One spouse had $2,000 in pension income that could be excluded, since the pension income was $3,000 or less. The other spouse had $6,000 in pension income and could exclude $3,000 of that income due to the retirement income exclusion. This second spouse could not exclude an additional $1,000 of the up to $3,000 retirement income exclusion that was not used by the other spouse.

"Insurable interest" is a term used in life insurance which also applies to this rule and is defined to be "such an interest in the life of the person insured, arising from the relations of the party obtaining the insurance, either as credit of or surety for the assured, or from the ties of blood or marriage to him, as would justify a reasonable expectation of advantage or benefit from the continuance of his life." *Warnock v. Davis,* 104 U.S. 775, 779, 26 L.Ed. 924; *Connecticut Mut. Life Ins. Co. v. Luchs,* 2 S.Ct. 949, 952, 108 U.S. 498, 27 L.Ed. 800; Appeal of Corson, 6 A. 213, 215, 113 Pa. 438, 57 Am. Rep. 479; *Adams' Adm'r v. Reed,* Ky., 36 S.W. 568, 570; *Trinity College v. Travelers' Co.,* 18 S.E. 175, 176, 113 N.C. 244, 22 L.R.A. 291; *Opitz v. Karel,* 95 N.W. 948, 951, 118 Wis. 527, 62 L.R.A. 982. It is not necessary that the expectation of advantage or profit should always be capable of pecuniary estimation, for a parent has an insurable interest in the life of his child, and a child in the life of his parent, a husband in the life of his wife, and a wife in the life of her husband. The natural affection in cases of this kind is considered as more powerful, as operating the more efficaciously, to protect the life of the insured than any other consideration, but in all cases there must be a reasonable ground, founded on relations to each other, either pecuniary or of blood or affinity, to expect some benefit or advantage from the continuance of the life of the assured. *Warnock v. Davis,* 104 U.S. 775, 26 L.Ed. 924; Appeal of Corson, 6 A. 213, 215, 113 Pa. 438, 57 Am. Rep. 479; *Connecticut Mut. Life Ins. Co. v. Luchs,* 2 S.Ct. 949, 952, 108 U.S. 498, 27 L.Ed. 800.

For purposes of this rule, the term "insurable interest" will be considered to apply to a beneficiary receiving retirement benefits due to the death of a pensioner or annuitant under the same circumstances as if the beneficiary were receiving life insurance benefits as a result of the death of the pensioner or annuitant.

For purposes of this rule, the term "survivor" is a person other than the surviving spouse of an annuitant or pensioner who is receiving the annuity or pension benefits because the person was a beneficiary of the pensioner or annuitant at the time of death of the pensioner or annuitant. In addition, in order for this person to qualify for the partial exclusion of pensions or retirement benefits, this

survivor must have had an insurable interest in the pensioner or annuitant at the time of death of the annuitant or pensioner.

A survivor other than the surviving spouse will be considered to have an insurable interest in the pensioner or annuitant if the survivor is a son, daughter, mother, or father of the annuitant or pensioner. The relationship of these individuals to the pensioner or annuitant is considered to be so close that no separate pecuniary or monetary interest between the pensioner or annuitant and any of these relatives must be established.

A survivor may include relatives of the pensioner or annuitant other than those relatives that were mentioned above. However, before any of these relatives can be considered to be a survivor for purposes of this rule, the relative must have had some pecuniary interest in the continuation of the life of the pensioner or annuitant. That is, the relative must establish a relationship with the pensioner or annuitant that shows there was a reasonable expectation of an advantage or benefit which the person would have received with the continuance of the life of the pensioner or annuitant.

The fact that a niece of the pensioner or annuitant was named beneficiary of an uncle's pension where the uncle had no closer relatives does not in itself establish that the niece had an insurable interest in the pension benefits, if the niece was not receiving monetary benefits or the niece did not have some special relationship to the uncle at the time of the uncle's death.

If a grandson was receiving college tuition regularly from his grandfather and received the grandfather's pension as a beneficiary of the grandfather after the grandfather's death, the grandson would be deemed to have an insurable interest in the benefits and would be eligible for the partial retirement benefit exclusion.

A person who is not related to the pensioner or annuitant, such as a partner in a business or a creditor, may have an insurable interest in the pensioner or annuitant. However, the burden of proof is on a nonrelated person to show that the person had an insurable interest in the pensioner or the annuitant at the time of death of the pensioner or annuitant.

There are numerous court cases which deal with whether a person had established an insurable interest in the life of an individual that was insured. These cases may be used as a guideline to determine whether or not a person receiving a pension or annuity due to the death of an annuitant or pensioner had an insurable interest in the annuitant or pensioner at the time of death of the pensioner or annuitant. Thus, if a person would have met criteria for an insurable interest for purposes of an interest in a person's life insurance policy, the person would also be considered to be qualified for an insurable interest in a pensioner or annuitant.

Retirement benefits subject to the retirement income exclusion include, but are not limited to: benefits from defined benefit or defined contribution pension and annuity plans, benefits from annuities, incomes from individual retirement accounts, benefits from pension or annuity plans contributed by an employer or maintained or contributed by a self-employed person and benefits and earnings from deferred compensation plans. However, the exclusion does not apply to social security benefits. A surviving spouse who is not disabled or is not 55 years of age or older can only exclude retirement benefits received as a result of the death of the other spouse and on the basis that the deceased spouse would have been eligible for the exclusion in the tax year. In order for a survivor other than the surviving spouse to qualify for the partial exclusion of retirement benefits, the survivor must have received the retirement benefits as a result of the death of a pensioner or annuitant who would have qualified for the exclusion in the tax year on the basis of age or disability. In addition, the survivor other than the surviving spouse would have had to have an insurable interest in the pensioner or annuitant at the time of the death of the pensioner or annuitant.

For purposes of this rule, a disabled individual is a person who is receiving benefits as a result of retirement from employment or self-employment due to disability. In addition, a person is considered to be a disabled individual if the individual is determined to be disabled in accordance with criteria established by the Social Security Administration or other federal or state governmental agency.

Note that the pension or other retirement benefits that are excluded from taxation for certain individuals are to be considered as a part of net income for purposes of determining whether or not a particular individual's income is low enough to exempt that taxpayer from tax. In addition, the pension

or other retirement benefits that are excluded from taxation for certain individuals are to be considered as a part of net income for the alternative tax computation, which is available to all taxpayers except those taxpayers filing as single individuals.

Finally, the pension or other retirement benefits are to be considered as a part of net income for individuals using the single filing status whose tax liabilities are limited so the liabilities cannot reduce the person's net income plus exempt benefits below $9,000, or below $18,000 for taxpayers 65 years of age or older for the 2007 and 2008 tax years, or below $24,000 for taxpayers 65 years of age or older for the 2009 and subsequent tax years.

This rule is intended to implement Iowa Code sections 422.5 and 422.7.

701—40.48(422) Health insurance premiums deduction. For tax years beginning on or after January 1, 1996, the amounts paid by a taxpayer for health insurance for the taxpayer, the taxpayer's spouse, and the taxpayer's dependents are deductible in computing net income on the Iowa return to the extent the amounts paid were not otherwise deductible in computing adjusted gross income. However, amounts paid by a taxpayer for health insurance on a pretax basis whereby the portion of the wages of the taxpayer used to pay health insurance premiums is not included in the taxpayer's gross wages for income tax or social security tax purposes are not deductible on the Iowa return.

In situations where married taxpayers pay health insurance premiums from a joint checking or other joint account and the taxpayers are filing separate state returns or separately on the combined return form, the taxpayers must allocate the deduction between the spouses on the basis of the net income of each spouse to the combined net income unless one spouse can show that only that spouse's income was deposited to the joint account.

In circumstances where a taxpayer is self-employed and takes a deduction on the 1996 federal return for 30 percent of the premiums paid for health insurance on the federal return, the taxpayer would be allowed a deduction on the Iowa return for the portion of the health insurance premiums that was not deducted on the taxpayer's federal return, including any health insurance premiums deducted as an itemized medical deduction under Section 213 of the Internal Revenue Code.

For purposes of the state deduction for health insurance premiums, the same premiums for the same health insurance or medical insurance coverage qualify for this deduction as would qualify for the federal medical expense deduction. Thus, premiums paid for contact lens insurance qualify for the health insurance deduction. Also eligible for the deduction for tax years beginning in the 1996 calendar year are premiums paid by a taxpayer before the age of 65 for medical care insurance effective after the age of 65, if the premiums are payable (on a level payment basis) for a period of ten years or more or until the year the taxpayer attains the age of 65 (but in no case for a period of less than five years). For tax years beginning on or after January 1, 1997, premiums for long-term health insurance for nursing home coverage are eligible for this deduction to the extent the premiums for long-term health care services are eligible for the federal itemized deduction for medical and dental expenses, irrespective of the limitations set forth in Section 213(d)(10) of the Internal Revenue Code. For example, a 55-year-old taxpayer who paid $1,050 in premiums for long-term health insurance for nursing home coverage for the 2004 tax year would be allowed a deduction for Iowa purposes for the entire $1,050, even though the limitation for the federal itemized deduction for medical expenses in Section 213(d)(10) of the Internal Revenue Code for these premiums for this taxpayer is $980.

Amounts paid under an insurance contract for other than medical care (such as payment for loss of limb or life or sight) are not deductible, unless the medical charge is stated separately in the contract or provided in a separate statement.

This rule is intended to implement Iowa Code section 422.7 as amended by 1997 Iowa Acts, Senate File 129.

701—40.49(422) Employer social security credit for tips. Employers in the food and beverage industry are allowed a credit under Section 45B of the Internal Revenue Code for a portion of the social security taxes paid or incurred after 1993 on employee tips. The credit is equal to the employer's FICA obligation attributable to tips received which exceed tips treated as wages for purposes of satisfying

minimum wage standards of the Fair Labor Standards Act. The credit is allowed only for tips received by an employee in the course of employment from customers on the premises of a business for which the tipping of employees serving food or beverages is customary. To the extent that an employer takes the credit for a portion of the social security taxes paid or incurred, the employer's deduction for the social security tax is reduced accordingly. For Iowa income tax purposes, the full deduction for the social security tax paid or incurred is allowed for tax years beginning on or after January 1, 1994.

This rule is intended to implement Iowa Code Supplement section 422.7.

701—40.50(422) Computing state taxable amounts of pension benefits from state pension plans. For tax years beginning on or after January 1, 1995, a retired member of a state pension plan, or a beneficiary of a member, who receives benefits from the plan where there was a greater contribution to the plan for the member for state income tax purposes than for federal income tax purposes can report less taxable income from the benefits on the Iowa individual income tax return than was reported on the federal return for the same tax year. This rule applies only to a member of a state pension plan, or the beneficiary of a member, who received benefits from the plan sometime after January 1, 1995, and only in circumstances where the member received wages from public employment in 1995, 1996, 1997, or 1998, or possibly in 1999 for certain teachers covered by the state pension plan authorized in Iowa Code chapter 294 so the member had greater contributions to the state pension plan for state income tax purposes than for federal income tax purposes. Starting with wages paid on or after January 1, 1999, to employees covered by a state pension plan other than teachers covered by the state pension plan authorized in Iowa Code chapter 294, contributions made to the pension plan will be made on a pretax basis for state income tax purposes as well as for federal income tax purposes. However, in the case of teachers covered by the state pension plan authorized in Iowa Code chapter 294, contributions to the pension plan on behalf of these teachers on a pretax basis for state income tax purposes may start after January 1, 1999.

For example, in the case of a state employee who was covered by IPERS and had wages from covered public employment of $41,000 or more in 1995, that person would have made posttax contributions to IPERS of $1,517 for state income tax purposes for 1995 and zero posttax contributions to IPERS for federal income tax purposes for 1995. The $1,517 in contributions to IPERS for federal income tax purposes was made on a pretax basis and was considered to have been made by the employee's employer or the state of Iowa and not the employee. At the time this employee receives retirement benefits from IPERS, the retired employee will be subject to federal income tax on the portion of the benefits that is attributable to the $1,517 IPERS contribution made in 1995. However, this employee will not be subject to state income tax on the portion of the IPERS benefits received which is attributable to the $1,517 contribution to IPERS for 1995.

This rule does not apply to members or beneficiaries of members who elect to take a lump sum distribution of benefits from a state pension plan in lieu of receiving monthly payments of benefits from the plan.

The following subrules further clarify how the portion of certain state pension benefits that is taxable for state individual income tax purposes for tax years beginning on or after January 1, 1995, is determined.

40.50(1) *Definitions related to state taxation of benefits from state pension plan.* The following definitions clarify those terms and phrases that have a bearing on the state's taxation of certain individuals who receive retirement benefits from state pension plans:

a. For purposes of this rule, the terms "state pension," "state pensions," and "state pension plans" mean only those pensions and those pension plans authorized in Iowa Code chapter 97A for public safety peace officers, chapter 97B for Iowa public employees (IPERS), chapter 294 for certain teachers, and chapter 411 for police officers and firefighters. There are other pension plans available for some public employees in the state which may be described as "state pensions" or "state pension plans" in other contexts or situations, but these pension plans are not covered by this rule. An example of a pension plan that is not a "state pension plan" for purposes of this rule is the judicial retirement system for state judges authorized in Iowa Code section 602.9101.

b. For purposes of this rule, "member" is an individual who was employed in public service covered by a state pension plan and is either receiving or was receiving benefits from the pension plan.

c. For purposes of this rule, "beneficiary" is a person who has received or is receiving benefits from a state pension plan due to the death of an individual or member who earned benefits in a state pension plan.

d. For purposes of this rule, the term "IPERS" means the Iowa public employees retirement system.

e. For purposes of this rule, the term "pretax," when the term is applied to a contribution made to a state pension plan during a year from a public employee's compensation, means a contribution to a state pension plan that is not taxed on the employee's income tax return for the tax year in which the contribution is made. The contribution is considered to have been made by the state or the employee's employer and not by the employee so this contribution is not part of the employee's basis in the pension that is not taxed when the pension is received.

f. For purposes of this rule, the term "posttax," when the term is applied to a contribution made to a state pension plan during a year from a public employee's compensation, means the contribution is included in the employee's taxable income for the tax year of the contribution and the contribution is considered to have been made by the employee. That is, the contribution is part of the employee's basis in the pension which is not taxed at the time the pension is received.

40.50(2) *Computation of the taxable amount of the state pension for federal income tax purposes.* An individual who receives benefits in the tax year from one of the state pension plans is not subject to federal income tax on the benefits to the extent of the pensioner's or member's recovery of posttax contribution to the pension plan. The individual receiving benefits in the year from a state pension plan should get a Form 1099-R showing the total benefits received in the tax year from the pension plan. The individual can determine the federal taxable amount of the benefits by using the general rule or the simplified general rule which is described in federal publication 17 or federal publication 575. Note that members who first receive pension benefits after November 18, 1996, must compute the federal taxable amount of their pension benefits by using the simplified general rule shown in the federal tax publications. Note also that individuals receiving benefits in the tax year from IPERS who started receiving benefits in 1993 or in later years will receive information with the 1099-R form which shows the amount of gross benefits received in the tax year that is taxable for federal income tax purposes.

40.50(3) *Computing the taxable amount of state pension benefits for state individual income tax purposes.* An individual receiving state pension benefits in the tax year must have a number of facts about the state pension in order to be able to compute the taxable amount of the pension for Iowa income tax purposes. The individual must know the gross pension benefits received in the tax year, the taxable amount of the pension for federal income tax purposes, the employee's contribution to the pension for federal income tax purposes, and the employee's contribution to the pension for state income tax purposes. In situations where the employee's contribution for state income tax purposes is equal to the contribution for federal income tax purposes, the same amount of the pension will be taxable on the state income tax return as is taxable on the federal return.

In cases when all of an individual's employment covered by a state pension plan occurred on or after January 1, 1995, so that all the contributions to the pension plan (other than posttax service purchases) for the employee were made on a pretax basis for federal income tax purposes, all of the benefits received from the pension would be taxed on the federal income tax return. In this situation, the state taxable amount of the pension would be computed using the general rule or the simplified general rule shown in federal publication 17 or federal publication 575. The employee's state contribution or state basis would be entered on line 2 of the worksheet in the federal publication that is usually used to compute the taxable amount of the pension for the federal income tax return.

To compute the state taxable amount of the state pension in situations where the employee had a contribution to the pension for federal tax purposes, the federal taxable amount for the year is first subtracted from the gross pension benefit received in the year which leaves the amount of the pension received in the year which was not taxable on the federal return. Next, the member's posttax contribution or basis in the pension for federal tax purposes is divided by the member's posttax contribution or basis

in the pension for state income tax purposes which provides the ratio of the member's federal basis or contribution to the member's state contribution or basis. Next, the amount of the state pension received in the year that is not taxed on the federal return is divided by the ratio or percentage that was determined in the previous step, which provides the exempt amount of the pension for state tax purposes. Finally, the state exempt amount determined in the previous step is subtracted from the gross amount received in the year, which leaves the taxable amount for state income tax purposes. Note that individuals who retired in 1993 and in years after 1993 and are receiving benefits from IPERS will receive information from IPERS which will advise them of the taxable amount of the pension for state income tax purposes. The examples in subrule 40.50(4) are provided to illustrate how the state taxable amounts of state pension benefits received in the tax year are computed in different factual situations.

40.50(4) *Examples.*

a. A state employee retired in April 1996 and started receiving IPERS benefits in April 1996. The retired state employee received $1,794.45 in gross benefits from IPERS in 1996. The federal taxable amount of the benefits was $1,690.36. The employee's federal posttax contribution or basis in the pension was $4,907 and the state posttax contribution or basis was $7,194. The nontaxable amount of the IPERS benefits for federal income tax was $104.09 which was calculated by subtracting the federal taxable amount of $1,690.36 from the gross amount of the benefits of $1,794.45. The ratio of the employee's posttax contribution to the pension for federal income tax purposes was 68.21 percent of the employee's contribution to the pension for state income tax purposes. This was determined by dividing $4,907 by $7,194. The nontaxable amount of the IPERS benefit for federal income tax purposes of $104.09 was then divided by 68.21 percent, which is the ratio determined in the previous step, and which results in a total of $152.60. This was the nontaxable amount of the pension for state income tax purposes. When $152.60 is subtracted from the gross benefits of $1,794.45 paid in the year, the remaining amount is $1,641.85 which is the taxable amount of the pension that should be reported on the individual's Iowa individual income tax return for the 1996 tax year.

b. A state employee retired in July 1995. The retired employee received $1,881.88 in IPERS benefits in 1996 and $1,790.60 of the benefits was taxable on the individual's federal return for 1996. The person's federal posttax contribution to the IPERS pension was $3,130 and the posttax contribution for state income tax purposes was $3,821. The amount of benefits not taxable for federal income tax purposes was $91.28 which was computed by subtracting the amount of pension benefits of $1,790.60 that was taxable on the federal income tax return from the gross benefits of $1,881.88 received in 1996. The retiree's federal posttax contribution of $3,130 to IPERS was divided by the retiree's posttax contribution of $3,821 to IPERS for state income tax purposes which resulted in a ratio of 81.91 percent. The amount of IPERS benefits of $91.28 exempt for federal income tax purposes is divided by the 81.91 percent computed in the previous step which results in an amount of $111.44 which is the amount of IPERS benefits received in 1996 which is not taxable on the Iowa return. $111.44 is subtracted from the gross benefits of $1,881.88 received in 1996 which leaves the state taxable amount for 1996 of $1,770.44.

This rule is intended to implement Iowa Code section 422.7 as amended by 1998 Iowa Acts, House File 2513.

701—40.51(422) Exemption of active-duty military pay of national guard personnel and armed forces military reserve personnel for overseas services pursuant to military orders for peacekeeping in the Bosnia-Herzegovina area. For active duty military pay received on or after November 21, 1995, by national guard personnel and by armed forces military reserve personnel, the pay is exempt from state income tax to the extent the military pay was earned overseas for services performed pursuant to military orders related to peacekeeping in the Bosnia-Herzegovina area. In order for the active duty pay to qualify for exemption from tax, the military service had to have been performed outside the United States, but not necessarily in the Bosnia-Herzegovina area.

This rule is intended to implement Iowa Code section 422.7 as amended by 1997 Iowa Acts, House File 355.

701—40.52(422) Mutual funds. Iowa does not tax dividend or interest income from regulated investment companies to the extent that such income is derived from interest on United States Government obligations or obligations of this state and its political subdivisions. The exemption is also applicable to income from regulated investment companies which is derived from interest on government-sponsored enterprises and agencies where federal law specifically precludes state taxation of such interest. Income derived from interest on securities which are merely guaranteed by the federal government or from repurchase agreements collateralized by the United States Government obligations is not excluded and is subject to Iowa income tax. There is no distinction between Iowa's tax treatment of interest received by a direct investor as compared with a mutual fund shareholder. The interest retains its same character when it "flows-through" the mutual fund and is subject to taxation accordingly.

Taxpayers may subtract from federal adjusted gross income, income received from any of the obligations listed in 701—subrule 40.2(1) and rule 701—40.3(422) above, even if the obligations are owned indirectly through owning shares in a mutual fund:

1. If the fund invests exclusively in these state tax-exempt obligations, the entire amount of the distribution (income) from the fund may be subtracted.
2. If the fund invests in both exempt and nonexempt obligations, the amount represented by the percentage of the distribution that the mutual fund identifies as exempt may be subtracted.
3. If the mutual fund does not identify an exempt amount or percentage, taxpayers may figure the amount to be subtracted by multiplying the distribution by the following fraction: as the numerator, the amount invested by the fund in state-exempt United States obligations; as the denominator, the fund's total investment. Use the year-end amounts to figure the fraction if the percentage ratio has remained constant throughout the year. If the percentage ratio has not remained constant, take the average of the ratios from the fund's quarterly financial reports.

Therefore, if the federal adjusted gross income of an individual, taxable by Iowa, includes dividends or interest of this type, an adjustment must be made deducting the amount of the dividend or interest.

This rule is intended to implement Iowa Code section 422.7.

701—40.53(422) Deduction for contributions by taxpayers to the Iowa educational savings plan trust and addition to income for refunds of contributions previously deducted. The Iowa educational savings plan trust was created so that individuals can contribute funds on behalf of beneficiaries in accounts administered by the treasurer of state to cover future higher education costs of the beneficiaries. The Iowa educational savings plan trust includes the college savings Iowa plan and the Iowa advisor 529 plan. The following subrules provide details on how individuals' net incomes are affected by contributions to beneficiaries' accounts, interest and any other earnings earned on beneficiaries' accounts, and refunds of contributions which were previously deducted.

40.53(1) *Deduction from net income for contributions made to the Iowa educational savings plan trust on behalf of beneficiaries.* Effective with contributions made on or after July 1, 1998, an individual referred to as a "participant" can claim a deduction on the Iowa individual income tax return for contributions made by that individual to the Iowa educational savings plan trust on behalf of a beneficiary. The deduction on the 1998 Iowa return cannot exceed $2,000 per beneficiary for contributions made in 1998 or the adjusted maximum annual amount for contributions made after 1998. Note that the maximum annual amount that can be deducted per beneficiary may be adjusted or increased to an amount greater than $2,000 for inflation on an annual basis. Rollover contributions from other states' educational savings plans will qualify for the deduction, subject to the maximum amount allowable. Starting with tax years beginning in the 2000 calendar year, a participant may contribute an amount on behalf of a beneficiary that is greater than $2,000, but may claim a deduction on the Iowa individual return of the lesser of the amount given or $2,000 as adjusted by inflation. For example, if a taxpayer made a $5,000 contribution on behalf of a beneficiary to the educational savings plan in 2000, the taxpayer may claim a deduction on the IA 1040 return for 2000 in the amount of $2,054, as this amount is $2,000 as adjusted for inflation in effect for 2000.

For example, an individual has ten grandchildren from the age of six months to 12 years. In October 1998, the person became a participant in the Iowa educational savings plan trust by making $2,000

contributions to the trust on behalf of each of the ten grandchildren. When the participant files the 1998 Iowa individual income tax return, the participant can claim a deduction on the return for the $20,000 contributed to the Iowa educational savings plan trust on behalf of the individual's ten grandchildren.

40.53(2) *Exclusion of interest and earnings on beneficiary accounts in the Iowa educational savings plan trust.* To the extent that interest or other earnings accrue on a beneficiary's account in the Iowa educational savings plan trust, the interest or other earnings are excluded for purposes of computing net income on the Iowa individual income tax return of the participant or the return of the beneficiary.

40.53(3) *Including on the Iowa individual return amounts refunded to the participant from the Iowa educational savings plan trust that had previously been deducted.* If a participant cancels a beneficiary's account in the Iowa educational savings plan trust and receives a refund of the funds in the account made on behalf of the beneficiary, or if a participant makes a withdrawal from the Iowa educational savings plan trust for purposes other than the payment of qualified education expenses, the refund of the funds is to be included in net income on the participant's Iowa individual income tax return to the extent that contributions to the account had been deducted on prior state individual income tax returns of the participant.

For example, because a beneficiary of a certain participant died in the year 2000, this participant in the Iowa educational savings plan trust canceled the participant agreement for the beneficiary with the trust and received a refund of $4,200 of funds in the beneficiary's account. Because $4,000 of the refund represented contributions that the participant had deducted on prior Iowa individual income tax returns, the participant was to report on the Iowa return for the tax year 2000, $4,000 in contributions that had been deducted on the participant's Iowa returns for 1998 and 1999.

40.53(4) *Deduction for contributions made to the endowment fund of the Iowa educational savings plan trust.* To the extent that the contribution was not deductible for federal income tax purposes, an individual can deduct on the Iowa individual income tax return a gift, grant, or donation to the endowment fund of the Iowa educational savings plan trust. The contribution must be made on or after July 1, 1998, but before April 15, 2004. Effective April 15, 2004, the deduction for contributions made to the endowment fund is repealed.

This rule is intended to implement Iowa Code section 422.7 as amended by 2007 Iowa Acts, House File 923.

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701—40.54(422) Roth individual retirement accounts. Roth individual retirement accounts were authorized in the Taxpayer Relief Act of 1997 and are applicable for tax years beginning after December 31, 1997. Generally, no deduction is allowed on either the federal income tax return or the Iowa individual income tax return for a contribution to a Roth IRA. The following subrules include information about tax treatment of certain transactions for Roth IRAs.

40.54(1) *Taxation of income derived from rolling over or converting existing IRAs to Roth IRAs.* At the time existing IRAs are rolled over to or converted to Roth IRAs in the 1998 calendar year or in a subsequent year, any income realized from the rollover or conversion of the existing IRA is taxable. However, in the case of conversion of existing IRAs to Roth IRAs in 1998, the taxpayer can make an election to have all the income realized from the conversion subject to tax in 1998 rather than have the conversion income spread out over four years. If the conversion income is spread out over four years, one-fourth of the conversion income is included on the 1998 Iowa and federal returns of the taxpayer and one-fourth of the income is included on the taxpayer's Iowa and federal returns for each of the following three tax years. Note that if an existing IRA for an individual is converted to a Roth IRA for the individual in a calendar year after 1998, all the income realized from the conversion is to be reported on the federal return and the Iowa return for that tax year for the individual. That is, when conversion of existing IRAs to Roth IRAs occurs after 1998, there is no provision for having the conversion income taxed over four years.

For example, an Iowa resident converted three existing IRAs to one Roth IRA in 1998, realized $20,000 in income from the conversion, and did not elect to have all the conversion income taxed on the 1998 Iowa and federal returns. Because the taxpayer did not make the election so all the conversion

income was taxed in 1998, $5,000 in conversion income was to be reported on the taxpayer's federal and Iowa returns for 1998 and similar incomes were to be reported on the federal and Iowa returns for 1999, 2000, and 2001. Note that to the extent the recipient of the Roth IRA conversion income is eligible, the conversion income is subject to the pension/retirement income exclusion described in rule 40.47(422).

40.54(2) *Roth IRA conversion income for part-year residents.* To the extent that an Iowa resident has Roth IRA conversion income on the individual's federal income tax return, the same income will be included on the resident's Iowa income tax return. However, when an individual with Roth IRA conversion income in the tax year is a part-year resident of Iowa, the individual may allocate the conversion income on the Iowa return in the ratio of the taxpayer's months in Iowa during the tax year to 12 months. In a situation where an individual spends more than half of a month in Iowa, that month is to be reported to Iowa for purposes of the allocation.

For example, an individual moved to Des Moines from Omaha on June 12, 1998, and had $20,000 in Roth IRA conversion income in 1998. Because the individual spent 7 months in Iowa in 1998, 7/12, or 60 percent, of the $20,000 in conversion income is allocated to Iowa. Thus, $12,000 of the conversion income should be reported on the taxpayer's Iowa return for 1998.

This rule is intended to implement Iowa Code section 422.7 as amended by 1998 Iowa Acts, Senate File 2357.

701—40.55(422) Exemption of income payments for victims of the Holocaust and heirs of victims. For tax years beginning on or after January 1, 2000, income payments received by individuals because they were victims of the Holocaust or income payments received by individuals who are heirs of victims of the Holocaust are excluded in the computation of net incomes, to the extent the payments were included in the individuals' federal adjusted gross incomes. Victims of the Holocaust were victims of persecution in the World War II era for racial, ethnic or religious reasons by Nazi Germany or other Axis regime.

Holocaust victims may receive income payments for slave labor performed in the World War II era. Income payments may also be received by Holocaust victims as reparation for assets stolen from, hidden from, or otherwise lost in the World War II era, including proceeds from insurance policies of the victims. The World War II era includes the time of the war and the time immediately before and immediately after the war. However, income from assets acquired with the income payments or from the sale of those assets shall not be excluded from the computation of net income. The exemption of income payments shall only apply to the first recipient of the income payments who was either a victim of persecution by Nazi Germany or any other Axis regime or a person who is an heir of the victim of persecution.

This rule is intended to implement Iowa Code sections 217.39 and 422.7.

701—40.56(422) Taxation of income from the sale of obligations of the state of Iowa and its political subdivisions. For tax years beginning on or after January 1, 2001, income from the sale of obligations of the state of Iowa and its political subdivisions shall be added to Iowa net income to the extent not already included. Gains or losses from the sale or other disposition of bonds issued by the state of Iowa or its political subdivisions shall be included in Iowa net income unless the law authorizing these obligations specifically exempts the income from the sale or other disposition of the bonds from the Iowa individual income tax.

This rule is intended to implement Iowa Code section 422.7 as amended by 2001 Iowa Acts, chapter 116.

701—40.57(422) Installment sales by taxpayers using the accrual method of accounting. For tax years beginning on or after January 1, 2000, and prior to January 1, 2002, taxpayers who use the accrual method of accounting and who have sales or exchanges of property that they reported on the installment method for federal income tax purposes must report the total amount of the gain or loss from the transaction in the tax year of the sale or exchange pursuant to Section 453 of the Internal Revenue Code as amended up to and including January 1, 2000.

EXAMPLE 1. Taxpayer Jones uses the accrual method of accounting for reporting income. In 2001, Mr. Jones sold farmland he had held for eight years for $200,000 which resulted in a capital gain of $50,000. For federal income tax purposes, Mr. Jones elected to report the transaction on the installment basis, where he reported $12,500 of the gain on his 2001 federal return and will report capital gains of $12,500 on each of his federal returns for the 2002, 2003 and 2004 tax years.

However, for Iowa income tax purposes, Mr. Jones must report on his 2001 Iowa return the entire capital gain of $50,000 from the land sale. Although Taxpayer Jones must report a capital gain of $12,500 on each of his federal income tax returns for 2002, 2003 and 2004, from the installment sale of the farmland in 2001, he will not have to include the installments of $12,500 on his Iowa income tax returns for those three tax years because Mr. Jones had reported the entire capital gain of $50,000 from the 2001 transaction on his 2001 Iowa income tax return.

EXAMPLE 2. Taxpayer Smith uses the accrual method of accounting for reporting income. In 2002, Mr. Smith sold farmland he had held for eight years for $500,000 which resulted in a capital gain of $100,000. For federal income tax purposes, Mr. Smith elected to report the transaction on the installment basis, where he reported $20,000 of the gain on his 2002 federal return and will report the remaining capital gains on federal returns for the four subsequent tax years. Because this installment sale occurred in 2002, Mr. Smith shall report $20,000 of the capital gain on his Iowa income tax return for 2002 and will report the balance of the capital gains from the installment sale on Iowa returns for the next four tax years, the same as reported on his federal returns for those years.

This rule is intended to implement Iowa Code section 422.7 as amended by 2002 Iowa Acts, House File 2116.

701—40.58(422) Exclusion of distributions from retirement plans by national guard members and members of military reserve forces of the United States. For tax years beginning on or after January 1, 2002, members of the Iowa national guard or members of military reserve forces of the United States who are ordered to state military service or federal service or duty are not subject to Iowa income tax on the amount of distributions received during the tax year from qualified retirement plans of the members to the extent the distributions were taxable for federal income tax purposes. In addition, the members are not subject to state penalties on the distributions even though the members may have been subject to federal penalties on the distributions for early withdrawal of benefits. Because the distributions described above are not taxable for Iowa income tax purposes, a national guard member or armed forces reserve member who receives a distribution from a qualified retirement plan may request that the payer of the distribution not withhold Iowa income tax from the distribution.

This rule is intended to implement Iowa Code section 422.7 as amended by 2004 Iowa Acts, House File 2208.

701—40.59(422) Exemption of payments received by a beneficiary from an annuity purchased under an employee's retirement plan when the installment has been included as part of a decedent employee's estate. All payments received on or after July 1, 2002, by a beneficiary of a deceased pensioner or annuitant are exempt from Iowa income tax to the extent the payments are from an annuity purchased under an employee's pension or retirement plan when the commuted value of the installments has been included as a part of the decedent employee's estate for Iowa inheritance tax purposes. Thus, a lump sum payment received by a beneficiary from an annuity purchased under an employee's pension or retirement plan is exempt from Iowa income tax to the extent the commuted value of the annuity was included as part of the decedent employee's estate for Iowa inheritance tax purposes. Under prior law, only installment payments of an annuity received by a beneficiary were exempt from Iowa income tax if the commuted value of the installments had been included as part of the decedent employee's estate for Iowa inheritance tax purposes.

This rule is intended to implement Iowa Code section 422.7 as amended by 2002 Iowa Acts, Senate File 2305.

701—40.60(422) Additional first-year depreciation allowance.

40.60(1) *Assets acquired after September 10, 2001, but before May 6, 2003.* For tax periods ending after September 10, 2001, but beginning before May 6, 2003, the additional first-year depreciation allowance ("bonus depreciation") of 30 percent authorized in Section 168(k) of the Internal Revenue Code, as enacted by Public Law No. 107-147, Section 101, does not apply for Iowa individual income tax. Taxpayers who claim the bonus depreciation on their federal income tax return must add the total amount of depreciation claimed on assets acquired after September 10, 2001, but before May 6, 2003, and subtract the amount of depreciation taken on such property using the modified accelerated cost recovery system (MACRS) depreciation method applicable under Section 168 of the Internal Revenue Code without regard to Section 168(k).

If any such property was sold or disposed of during the tax year, the applicable depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of these assets for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of assets.

The adjustment for both depreciation and the gain or loss on the sale of qualifying assets acquired after September 10, 2001, but before May 6, 2003, can be calculated on Form IA 4562A.

See 701—subrule 53.22(1) for examples illustrating how this subrule is applied.

40.60(2) *Assets acquired after May 5, 2003, but before January 1, 2005.* For tax periods beginning after May 5, 2003, but beginning before January 1, 2005, the bonus depreciation of 50 percent authorized in Section 168(k) of the Internal Revenue Code, as amended by Public Law No. 108-27, Section 201, may be taken for Iowa individual income tax. If the taxpayer elects to take the 50 percent bonus depreciation, the depreciation deduction allowed on the Iowa individual income tax return is the same as the depreciation deduction allowed on the federal income tax return for assets acquired after May 5, 2003, but before January 1, 2005.

a. If the taxpayer elects to take the 50 percent bonus depreciation and had filed an Iowa return prior to February 24, 2005, which reflected the disallowance of 50 percent bonus depreciation, the taxpayer may choose between two options to reflect this change. Taxpayer may either file an amended return for the applicable tax year to reflect the 50 percent bonus depreciation provision, or taxpayer may reflect the change for 50 percent bonus depreciation on the next Iowa return filed subsequent to February 23, 2005. Taxpayer must choose only one of these two options. Regardless of the option chosen, taxpayer must complete and attach a revised Form IA 4562A to either the amended return or the return filed subsequent to February 23, 2005.

EXAMPLE 1: Taxpayer filed a 2003 Iowa individual income tax return on April 15, 2004, which reflected an adjustment of $50,000 for the difference between federal depreciation and Iowa depreciation relating to the disallowance of 50 percent bonus depreciation. Taxpayer now elects to take the 50 percent bonus depreciation for Iowa tax purposes. Taxpayer may either amend the 2003 Iowa return to reflect a $50,000 reduction in Iowa taxable income, or taxpayer may take the additional deduction of $50,000 on taxpayer's 2004 Iowa return that is filed after February 23, 2005.

EXAMPLE 2: Assume the same facts as given in Example 1, and taxpayer filed a 2004 Iowa return prior to February 24, 2005. Taxpayer did not take an additional $50,000 deduction on the 2004 Iowa return. Taxpayer may either amend the 2003 Iowa return to reflect a $50,000 reduction in Iowa taxable income, or taxpayer may take the additional deduction of $50,000 on taxpayer's 2005 Iowa return.

b. If the taxpayer elects not to take the 50 percent bonus depreciation, taxpayer must add the total amount of depreciation claimed on assets acquired after May 5, 2003, but before January 1, 2005, and subtract the amount of depreciation taken on such property using the modified accelerated cost recovery system (MACRS) depreciation method applicable under Section 168 of the Internal Revenue Code without regard to Section 168(k). If any such property was sold or disposed of during the tax year, the applicable depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of these assets for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of assets. The adjustment for both depreciation and the gain or loss on the sale of qualifying assets acquired after May 5, 2003, but before January 1, 2005, can be calculated on Form IA 4562A.

40.60(3) *Assets acquired after December 31, 2007, but before January 1, 2009.* For tax periods beginning after December 31, 2007, but beginning before January 1, 2009, the bonus depreciation of 50 percent authorized in Section 168(k) of the Internal Revenue Code, as amended by Public Law No. 110-185, Section 103, does not apply for Iowa individual income tax. Taxpayers who claim the bonus depreciation on their federal income tax return must add the total amount of depreciation claimed on assets acquired after December 31, 2007, but before January 1, 2009, and subtract the amount of depreciation taken on such property using the modified accelerated cost recovery system (MACRS) depreciation method applicable under Section 168 of the Internal Revenue Code without regard to Section 168(k).

If any such property was sold or disposed of during the tax year, the applicable depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of these assets for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of assets.

The adjustment for both depreciation and the gain or loss on the sale of qualifying assets acquired after December 31, 2007, but before January 1, 2009, can be calculated on Form IA 4562A.

See rule 701—53.22(422) for examples illustrating how this rule is applied.

This rule is intended to implement Iowa Code section 422.7.

701—40.61(422) Exclusion of active duty pay of national guard members and armed forces military reserve members for service under orders for Operation Iraqi Freedom, Operation Noble Eagle or Operation Enduring Freedom. For tax years beginning on or after January 1, 2003, active duty pay received by national guard members and armed forces reserve members is excluded to the extent the income is included in federal adjusted gross income and to the extent the active duty pay is for service under military orders for Operation Iraqi Freedom, Operation Noble Eagle or Operation Enduring Freedom. National guard members and military reserve members receiving active duty pay on or after January 1, 2003, for service not covered by military orders for one of the three operations specified above are subject to Iowa income tax on the active duty pay to the extent the active duty pay is included in federal adjusted gross income. An example of a situation where the active duty pay may not be included in federal adjusted gross income is when the active duty pay was received for service in an area designated as a combat zone or in an area designated as a hazardous duty area so the income may be excluded from federal adjusted gross income. That is, if an individual's active duty military pay is not subject to federal income tax, the active duty military pay will not be taxable on the individual's Iowa income tax return.

National guard members and military reserve members who are receiving active duty pay for service on or after January 1, 2003, that is exempt from Iowa income tax, may complete an IA W-4 Employee Withholding Allowance Certificate and claim exemption from Iowa income tax for active duty pay received during the time they are serving on active duty pursuant to military orders for Operation Iraqi Freedom, Operation Noble Eagle or Operation Enduring Freedom.

This rule is intended to implement Iowa Code section 422.7 as amended by 2003 Iowa Acts, House File 674.

701—40.62(422) Deduction for overnight expenses not reimbursed for travel away from home of more than 100 miles for performance of service as a member of the national guard or armed forces military reserve. A taxpayer may subtract, in computing net income, the costs not reimbursed that were incurred for overnight transportation, meals and lodging expenses for travel away from the taxpayer's home more than 100 miles, to the extent the travel expenses were incurred for the performance of services on or after January 1, 2003, by the taxpayer as a national guard member or an armed forces military reserve member. The deduction for Iowa tax purposes is the same that is allowed for federal income tax purposes.

This rule is intended to implement Iowa Code section 422.7 as amended by 2005 Iowa Acts, House File 186.

701—40.63(422) Exclusion of income from military student loan repayments. Individuals serving on active duty in the national guard, armed forces military reserve or the armed forces of the United States may subtract, to the extent included in federal adjusted gross income, income from military student loan repayments made on or after January 1, 2003.

This rule is intended to implement Iowa Code section 422.7 as amended by 2003 Iowa Acts, House File 674.

701—40.64(422) Exclusion of death gratuity payable to an eligible survivor of a member of the armed forces, including a member of a reserve component of the armed forces who has died while on active duty. An eligible survivor of a member of the armed forces, including a member of a reserve component of the armed forces, who has died while on active duty may subtract, to the extent included in federal adjusted gross income, a gratuity death payment made to the eligible survivor of a member of the armed forces who died while on active duty after September 10, 2001. This exclusion applies to a gratuity death payment made to the eligible survivor of any person in the armed forces or a reserve component of the armed forces who died while on active duty after September 10, 2001.

The purpose of the death gratuity is to provide a cash payment to assist a survivor of a deceased member of the armed forces to meet financial needs during the period immediately following a service member's death and before other survivor benefits, if any, become available.

This rule is intended to implement Iowa Code section 422.7 as amended by 2003 Iowa Acts, House File 674.

701—40.65(422) Section 179 expensing. For tax periods beginning on or after January 1, 2003, but beginning before January 1, 2006, the increase in the expensing allowance for qualifying property authorized in Section 179(b) of the Internal Revenue Code, as enacted by Public Law No. 108-27, Section 202, may be taken for Iowa individual income tax. If the taxpayer elects to take the increased Section 179 expensing, the Section 179 expensing allowance on the Iowa individual income tax return is the same as the Section 179 expensing allowance on the federal income tax return for tax years beginning on or after January 1, 2003, but beginning before January 1, 2006. In addition, for tax periods beginning on or after January 1, 2008, but beginning before January 1, 2009, the increase in the expensing allowance for qualifying property authorized in Section 179(b) of the Internal Revenue Code, as enacted by Public Law No.110-185, Section 102, may be taken for Iowa individual income tax.

40.65(1) If the taxpayer elects to take the increased Section 179 expensing and had filed an Iowa return prior to February 24, 2005, which reflected the disallowance of increased Section 179 expensing, the taxpayer may choose between two options to reflect this change. Taxpayer may either file an amended return for the applicable tax year to reflect the increased Section 179 expensing, or taxpayer may reflect the change for increased Section 179 expensing on the next Iowa return filed subsequent to February 23, 2005. Taxpayer must choose only one of these two options. Regardless of the option chosen, taxpayer must complete and attach a revised Form IA 4562A to either the amended return or the return filed subsequent to February 23, 2005.

EXAMPLE 1: Taxpayer filed a 2003 Iowa individual income tax return on April 15, 2004, which reflected an adjustment of $50,000 for the difference between the federal Section 179 expensing allowance and the Iowa Section 179 expensing allowance. Taxpayer now elects to take the increased Section 179 expensing allowance for Iowa tax purposes. Taxpayer may either amend the 2003 Iowa return to reflect a $50,000 reduction in Iowa taxable income, or taxpayer may take the additional deduction of $50,000 on taxpayer's 2004 Iowa return that is filed after February 23, 2005.

EXAMPLE 2: Assume the same facts as given in Example 1, and taxpayer filed a 2004 Iowa return prior to February 24, 2005. Taxpayer did not take an additional $50,000 deduction on the 2004 Iowa return. Taxpayer may either amend the 2003 Iowa return to reflect a $50,000 reduction in Iowa taxable income, or taxpayer may take the additional deduction of $50,000 on taxpayer's 2005 Iowa return.

40.65(2) If the taxpayer elects not to take the increased Section 179 expensing, the expensing allowance is limited to $25,000 for Iowa tax purposes. The difference between the federal Section 179 expensing allowance on such property, if in excess of $25,000, and the Iowa expensing allowance of

$25,000 can be depreciated using the modified accelerated cost recovery system (MACRS) applicable under Section 168 of the Internal Revenue Code without regard to the bonus depreciation provision in Section 168(k).

If any such property was sold or disposed of during the tax year, the applicable Section 179 and related depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of these assets for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of assets.

The adjustment for both the Section 179 expensing allowance and related depreciation, along with the gain or loss on the sale of qualifying assets for tax years beginning on or after January 1, 2003, but beginning before January 1, 2006, can be calculated on Form IA 4562A.

See 701—subrule 53.23(2) for examples illustrating how this subrule is applied.

This rule is intended to implement Iowa Code section 422.7 as amended by 2008 Iowa Acts, Senate File 2123.

701—40.66(422) Deduction for certain unreimbursed expenses relating to a human organ transplant. For tax years beginning on or after January 1, 2005, a taxpayer, while living, may subtract up to $10,000 in unreimbursed expenses that were incurred relating to the taxpayer's donation of all or part of a liver, pancreas, kidney, intestine, lung or bone marrow to another human being for immediate human organ transplantation. The taxpayer can claim this deduction only once, and the deduction can be claimed in the year in which the transplant occurred. The unreimbursed expenses must not be compensated by insurance to qualify for the deduction.

The unreimbursed expenses which are eligible for the deduction include travel expenses, lodging expenses and lost wages. If the deduction is claimed for travel expenses and lodging expenses, these expenses cannot also be claimed as an itemized deduction for medical expenses under Section 213(d) of the Internal Revenue Code for Iowa tax purposes. The deduction for lost wages does not include any sick pay or vacation pay reimbursed by an employer.

This rule is intended to implement Iowa Code section 422.7 as amended by 2005 Iowa Acts, House File 801.

701—40.67(422) Deduction for alternative motor vehicles. For tax years beginning on or after January 1, 2006, but beginning before January 1, 2011, a taxpayer may subtract $2,000 for the cost of a clean fuel motor vehicle if the taxpayer was eligible to claim for federal tax purposes the alternative motor vehicle credit under Section 30B of the Internal Revenue Code for this motor vehicle.

The vehicles eligible for this deduction include new qualified fuel cell motor vehicles, new advanced lean burn technology motor vehicles, new qualified hybrid motor vehicles and new qualified alternative fuel vehicles. These vehicles must be placed in service after December 31, 2005, but before January 1, 2011, to qualify for the deduction. A taxpayer must claim a credit on the taxpayer's federal income tax return on federal Form 8910 to claim the deduction on the Iowa return.

This rule is intended to implement Iowa Code section 422.7 as amended by 2006 Iowa Acts, House File 2461.

701—40.68(422) Injured veterans grant program.

40.68(1) For tax years beginning on or after January 1, 2006, a taxpayer who receives a grant under the injured veterans grant program provided in 2006 Iowa Acts, Senate File 2312, section 1, may subtract, to the extent included in federal adjusted gross income, the amount of the grant received. The injured veterans grant program is administered by the Iowa department of veterans affairs, and grants of up to $10,000 are provided to veterans who are residents of Iowa and are injured in the line of duty in a combat zone or in a zone where the veteran was receiving hazardous duty pay after September 11, 2001.

40.68(2) For tax years beginning on or after January 1, 2006, a taxpayer may subtract, to the extent not otherwise deducted in computing adjusted gross income, the amounts contributed to the department of veterans affairs for the purpose of providing grants under the injured veterans grant program established in 2006 Iowa Acts, Senate File 2312, section 1. If a deduction is claimed for these

amounts contributed to the injured veterans grant program, this deduction cannot also be claimed as an itemized deduction for charitable contributions under Section 170 of the Internal Revenue Code for Iowa tax purposes.

This rule is intended to implement Iowa Code section 422.7 as amended by 2006 Iowa Acts, Senate File 2312.

701—40.69(422) Exclusion of ordinary or capital gain income realized as a result of involuntary conversion of property due to eminent domain. For tax years beginning on or after January 1, 2006, a taxpayer may exclude the amount of ordinary or capital gain income realized as a result of the involuntary conversion of property due to eminent domain for Iowa individual income tax. Eminent domain refers to the authority of government agencies or instrumentalities of government to requisition or condemn private property for any public improvement, public purpose or public use. The exclusion for Iowa individual income tax can only be claimed in the year in which the ordinary or capital gain income was reported on the federal income tax return.

In order for an involuntary conversion to qualify for this exclusion, the sale must occur due to the requisition or condemnation, or its threat or imminence, if it takes place in the presence of, or under the threat or imminence of, legal coercion relating to a requisition or condemnation. There are numerous federal revenue rulings, court cases and other provisions relating to the definitions of the terms "threat" and "imminence," and these are equally applicable to the exclusion of ordinary or capital gains realized for tax years beginning on or after January 1, 2006.

40.69(1) *Reporting requirements.* In order to claim an exclusion of ordinary or capital gain income realized as a result of involuntary conversion of property due to eminent domain, the taxpayer must attach a statement to the Iowa individual income tax return in the year in which the exclusion is claimed. The statement should state the date and details of the involuntary conversion, including the amount of the gain being excluded and the reasons why the gain meets the qualifications of an involuntary conversion relating to eminent domain. In addition, if the gain results from the sale of replacement property as outlined in subrule 40.69(2), information must be provided in the statement on that portion of the gain that qualified for the involuntary conversion.

40.69(2) *Claiming the exclusion when gain is not recognized for federal tax purposes.* For federal tax purposes, an ordinary or capital gain is not recognized when the converted property is replaced with property that is similar to, or related in use to, the converted property. In those cases, the basis of the old property is simply transferred to the new property, and no gain is recognized. In addition, when property is involuntarily converted into money or other unlike property, any gain is not recognized when replacement property is purchased within a specified period for federal tax purposes.

For Iowa individual income tax purposes, no exclusion will be allowed for ordinary or capital gain income when there is no gain recognized for federal tax purposes. The exclusion will only be allowed in the year in which ordinary or capital gain income is realized due to the disposition of the replacement property for federal tax purposes, and the exclusion is limited to the amount of the ordinary or capital gain income relating to the involuntary conversion. The basis of the property for Iowa individual income tax purposes will remain the same as the basis for federal tax purposes and will not be altered because of the exclusion allowed for Iowa individual income tax.

EXAMPLE: In 2007, taxpayer sold some farmland as a result of an involuntary conversion relating to eminent domain and realized a gain of $50,000. However, the taxpayer purchased similar farmland immediately after the sale, and no gain was recognized for federal tax purposes. Therefore, no exclusion is allowed on the 2007 Iowa individual income tax return. In 2009, taxpayer sold the replacement farmland that was not subject to an involuntary conversion and realized a total gain of $70,000, which was reported on the 2009 federal income tax return. The taxpayer can claim a deduction of $50,000 on the 2009 Iowa individual income tax return relating to the gain that resulted from the involuntary conversion.

This rule is intended to implement Iowa Code section 422.7.

701—40.70(422) Exclusion of income from sale, rental or furnishing of tangible personal property or services directly related to production of film, television or video projects. For tax years beginning on or after January 1, 2007, a taxpayer who is a resident of Iowa may exclude, to the extent included in federal adjusted gross income, income received from the sale, rental or furnishing of tangible personal property or services directly related to the production of film, television, or video projects that are registered with the film office of the Iowa department of economic development.

Income which can be excluded on the Iowa return must meet the criteria of a qualified expenditure for purposes of the film qualified expenditure tax credit as set forth in rule 701—42.35(15,422). See rule 701—38.17(422) for the determination of Iowa residency.

However, if a taxpayer claims this income tax exclusion, the same taxpayer cannot also claim the film qualified expenditure tax credit as described in rule 701—42.35(15,422). In addition, any taxpayer who claims this income tax exclusion cannot have an equity interest in a business which received a film qualified expenditure tax credit. Finally, any taxpayer who claims this income tax exclusion cannot participate in the management of the business which received the film qualified expenditure tax credit.

EXAMPLE: A production company which registers with the film office for a project is a limited liability company with three members, all of whom are Iowa residents. If any of the three members receives income that is a qualified expenditure for purposes of the film qualified expenditure tax credit, such member(s) cannot exclude this income on the Iowa income tax return because the member(s) has an equity interest in the business which received the credit.

This rule is intended to implement Iowa Code section 422.7 as amended by 2007 Iowa Acts, House File 892, section 4.

701—40.71(422) Exclusion for certain victim compensation payments. Effective for tax years beginning on or after January 1, 2007, a taxpayer may exclude from Iowa individual income tax any income received from certain victim compensation payments to the extent this income was reported on the federal income tax return. The amounts which may be excluded from income include the following:

1. Victim compensation awards paid under the victim compensation program administered by the department of justice in accordance with Iowa Code section 915.81, and received by the taxpayer during the tax year.
2. Victim restitution payments received by a taxpayer during the tax year in accordance with Iowa Code chapter 910 or 915.
3. Damages awarded by a court, and received by a taxpayer, in a civil action filed by a victim against an offender during the tax year.

This rule is intended to implement Iowa Code section 422.7 as amended by 2007 Iowa Acts, Senate File 70.

701—40.72(422) Exclusion of Vietnam Conflict veterans bonus.

40.72(1) For tax years beginning on or after January 1, 2007, a taxpayer who received a bonus under the Vietnam Conflict veterans bonus program may subtract, to the extent included in federal adjusted gross income, the amount of the bonus received. The Vietnam Conflict veterans bonus is administered by the Iowa department of veterans affairs, and bonuses of up to $500 are awarded to residents of Iowa who served on active duty in the armed forces of the United States between July 1, 1973, and May 31, 1975.

40.72(2) For tax years beginning on or after January 1, 2008, a taxpayer who received a bonus under the Vietnam Conflict veterans bonus program may subtract, to the extent included in federal adjusted gross income, the amount of the bonus received. The Vietnam Conflict veterans bonus is administered by the Iowa department of veterans affairs. Bonuses of up to $500 are awarded to veterans who were inducted into active duty service from the state of Iowa, who served on active duty in the United States armed forces from July 1, 1958, through May 31, 1975, and who have not received a bonus for that service from Iowa or another state.

This rule is intended to implement Iowa Code section 422.7 as amended by 2008 Iowa Acts, House File 2283.

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◊ Two or more ARCs

CHAPTER 79
REAL ESTATE TRANSFER TAX AND DECLARATIONS OF VALUE
[Prior to 12/17/86, Revenue Department[730]]

701—79.1(428A) Real estate transfer tax: Responsibility of county recorders.

79.1(1) *Forms.* County recorders shall use only forms provided by the department of revenue for the collection of real estate transfer tax and the recording and reporting of such tax collections.

79.1(2) *Monthly reports.* County recorders shall submit a report to the department of revenue on or before the tenth day of each month enumerating real estate transfer tax collection information for the preceding month. This report shall be submitted on forms prescribed by the department of revenue and shall contain such information as is deemed necessary by the department.

79.1(3) *Evidence of payment.* The recorder or authorized employee of the recorder must enter the tax payment amount on the face of the instrument of conveyance presented for recording.

79.1(4) *Recording refused.* The county recorder shall refuse to record any deed, instrument, or writing regardless of any statement by the grantor, grantee, or their agents that the transaction is exempt pursuant to Iowa Code section 428A.2, if, in the recorder's judgment, additional facts are necessary to clarify the taxable status of the transfer or determine the full consideration paid for the property. The county recorder may request from the grantor, grantee, or their agents, any information necessary to determine the taxable status of the transfer or the full amount of consideration involved in the transaction. County recorders under no circumstance shall record any deed or instrument of conveyance for which the proper amount of real estate transfer tax has not been collected. This applies to the collection of tax in excess of the amount due for the actual amount of consideration as well as situations in which an insufficient amount of tax has been collected.

79.1(5) *Refunds or underpayments.*

a. Refunds. County recorders shall not refund any overpayment of a real estate transfer tax. The grantor of the real property for which the real estate transfer tax has been overpaid shall petition the state appeal board for a refund of the overpayment amount paid to the treasurer of state. A refund of the remaining portion of the overpayment shall be petitioned from the board of supervisors of the county in which the tax was paid.

b. Underpayments. The county recorder shall collect any amount of tax found to be due. If the county recorder is unable to collect the tax, the director of revenue shall collect the tax in the same manner as income taxes are collected and pay the county its proportionate share.

79.1(6) *Multiple parcels.* If the real estate conveyance contains multiple parcels and the parcels are located in more than one county, the tax is to be paid to each county in which the property parcels are located based on the consideration paid for each property parcel or proportionate parcel located in each county.

This rule is intended to implement Iowa Code chapter 428A as amended by 2009 Iowa Acts, Senate File 288, section 17.

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701—79.2(428A) Taxable status of real estate transfers.

79.2(1) *Federal rules and regulations.* In factual situations not covered by these rules and involving those portions of Iowa law which are consistent with the former federal statutes (26 USCA 4361) that imposed a real estate transfer tax, the department of revenue and county recorders shall follow the federal rules and regulations in administering the provisions of Iowa Code chapter 428A. (1968 O.A.G. 643)

79.2(2) *Transfer of realty to a corporation or partnership.* Capital stock, partnership shares and debt securities received in exchange for real property constitutes consideration which is subject to the real estate transfer tax. Where the value of the capital stock is definite or may be definitely determined in a dollar amount, the specific dollar amount is subject to the tax. Where the value of the capital stock is not definitely measurable in a dollar amount, the tax imposed is to be calculated on the fair market value of the realty transferred. For purposes of this rule, fair market value shall be as defined in Iowa Code section 441.21. (1976 O.A.G. 776)

Real estate transfer tax is not due when real property is conveyed to a family corporation, partnership, limited partnership, limited liability partnership, or limited liability company as defined in Iowa Code section 428A.2 in an incorporation or organization action where the only consideration is the issuance of capital stock, partnership shares, or debt securities of the corporation, partnership, limited partnership, limited liability partnership, or limited liability company. Actual consideration other than these shares or debt securities is subject to real estate transfer tax.

79.2(3) *Trades of real estate.* Real estate transfers involving the exchange of one piece of real property for another are transfers subject to the real estate transfer tax. Each grantor of the real estate is liable for the tax based on the fair market value of the property received in the trade as well as other consideration including but not limited to cash and assumption of debt. (1972 O.A.G. 654)

For purposes of this rule, fair market value shall be as defined in Iowa Code section 441.21.

79.2(4) *Conveyance to the United States government or the state of Iowa.* Any conveyance of real estate to the United States or any agency or instrumentality thereof or to the state of Iowa or any agency, instrumentality, or political subdivision thereof not exempt from the real estate transfer tax pursuant to Iowa Code section 428A.2, is subject to the real estate transfer tax. (1968 O.A.G. 579) An exception to this rule is any conveyance to the United States Department of Agriculture, Farmers Home Administration, which is specifically exempted by federal law (7 USCS §1984).

79.2(5) *Conveyance of property on leased land.* The transfer of buildings or other structures located on leased land is subject to the real estate transfer tax. The fact that the person who owns a building or other structure does not own the land upon which the property is located does not exempt this type of conveyance from the real estate transfer tax. (1972 O.A.G. 318)

79.2(6) *Mortgage default.* In the factual situation where a defaulting mortgagor issues a deed or other conveyance instrument to the mortgagee as satisfaction of the mortgage debt, the transaction is subject to the real estate transfer tax. The consideration upon which the tax is calculated is the outstanding unsatisfied mortgage debt.

However, as an exception to this rule, a conveyance of real property to lienholders in lieu of forfeiture or foreclosure action is exempt from real estate transfer tax.

79.2(7) *Completion of contract.* A deed or other conveyance instrument given at the time of completion of a single real estate contract is subject to the real estate transfer tax. The tax is to be computed on the full amount of the purchase price as stated in the contract and not solely on the last installment payment made prior to the issuance of the deed or other conveyance instrument. If the original contract is assigned to a third party or parties prior to fulfillment of such contract, the tax is to be computed only on the original contract price upon completion of the contract.

When a single deed or other conveyance instrument is given at the time of completion of multiple successive real estate contracts, separate taxes are to be computed and paid based upon the full purchase price stated in each contract. For example, if A sells real estate to B on an installment contract, and then B sells the same property to C on another installment contract, and subsequently both A and B transfer their respective interests in the property to C via one deed, A is liable for a tax computed on the full purchase price stated in the original contract to which A was a party and B is liable for a tax computed on the full purchase price stated in the subsequent contract to which B was a party.

79.2(8) *Assignments of contract.* Assignments of real estate contracts by contract sellers and contract buyers are not subject to the real estate transfer tax. (1970 O.A.G. 605)

79.2(9) *Corporate and partnership dissolution.* A conveyance of realty by a corporation or partnership in liquidation or in dissolution to its shareholders or partners subject to the debts of the corporation or partnership is a conveyance subject to the real estate transfer tax. However, if there are no debts and the conveyance is made solely for the cancellation and retirement of the capital stock or dissolution, the tax does not apply.

Real estate transfer tax is not due when real property is conveyed from a family corporation, partnership, limited partnership, limited liability partnership, or limited liability company as defined in Iowa Code section 428A.2 to its shareholders, partners, or members in a dissolution action where the only consideration is capital stock, partnership shares, or debt securities of the corporation, partnership, limited partnership, limited liability partnership, or limited liability company, including the assumption

of debts by the shareholders, partners, or members. Actual consideration other than these shares or debt securities is subject to the real estate transfer tax.

79.2(10) *Security instruments.* Any deed or instrument given exclusively to secure a loan or debt is not subject to the real estate transfer tax.

79.2(11) *Marriage dissolution exemption.* Marriage dissolution exemption from the real estate transfer tax provided in Iowa Code section 428A.2(16) applies only to real property conveyances between former spouses specifically mandated by a dissolution decree.

79.2(12) *Family debt cancellation exemption.* The family debt cancellation exemption from the real estate transfer tax provided in Iowa Code section 428A.2(11) applies only to real estate conveyances between husband and wife, or parent and child and indebtedness between these parties.

The amount of indebtedness subject to exemption shall not exceed the fair market value of the property being transferred.

EXAMPLE 1. A son is indebted to his father for $10,000. The son transfers real property with a fair market value of $12,000 to his father as satisfaction of the indebtedness. No real estate transfer tax is due in this situation.

EXAMPLE 2. A son is indebted to his father for $10,000. The son transfers real property with a fair market value of $4,000 to his father as satisfaction of the indebtedness. Real estate transfer tax is due on $6,000 in this situation.

79.2(13) *Assumption of debt.* Any outstanding debt on the property conveyed that is not assumed by the grantee is not to be included as consideration in computing the amount of real estate transfer tax due.

EXAMPLE. Property with a mortgage of $40,000 is transferred from A to B. B pays A $60,000 but does not assume the $40,000 mortgage. The real estate transfer tax is to be computed on the $60,000 cash payment only. If B had assumed the mortgage in addition to making the cash payment, the real estate transfer tax would be computed on $100,000 (the sum of the payment and mortgage).

79.2(14) *Mergers, consolidations, and reorganizations.* Conveyances of real estate resulting from corporate or limited liability company mergers, consolidations, or reorganizations are exempt from the real estate transfer tax. The following definitions are intended to be general guidelines in determining eligibility for exemption under this subsection.

"Merger" means the uniting of two or more corporations or companies into one corporation or company in such manner that the corporation or company resulting from the merger retains its existence and absorbs the other constituent corporation(s) or company(ies) which thereby lose its or their existence.

"Consolidation" means the uniting of two or more corporations or companies into a single new corporation or company, all of the constituent corporations or companies thereby ceasing to exist as separate entities.

"Reorganization" means the transfer of substantially all of the assets of one corporation or company to another corporation or company where the persons having an interest in the old corporation or company maintain substantially the same interest in the new corporation or company.

This rule is intended to implement Iowa Code section 428A.1 as amended by 1996 Iowa Acts, chapter 1167, and section 428A.2 as amended by 1996 Iowa Acts, chapter 1170.

701—79.3(428A) Declarations of value: Responsibility of county recorders and city and county assessors.

79.3(1) *Forms and procedures.* County recorders and county and city assessors shall use only the declaration of value forms and procedures prescribed and provided by the director of revenue for reporting real estate transfers.

79.3(2) *Report of sales.* County recorders and city and county assessors shall complete the appropriate portions of the real estate transfer-declaration of value form for each real estate transfer for which a declaration of value has been completed by the buyer, seller, or agent. The completed real estate transfer-declaration of value forms shall be used in preparing the quarterly sales report to be submitted to the department as required by Iowa Code section 421.17(6).

79.3(3) *Transmittal of forms.* Real estate transfer-declaration of value forms filed with the county recorder shall be transmitted promptly to the appropriate assessor. City and county assessors shall

transmit to the department of revenue within 60 days of the end of each calendar quarter all real estate transfer-declaration of value forms received from the county recorder during that calendar quarter. Under no circumstances shall the assessor retain any real estate transfer-declaration of value form longer than designated in this subrule.

79.3(4) *Completion of forms.* County recorders and city and county assessors shall complete declaration of value forms in accordance with instructions issued by the department. The assessed values entered on the forms are to be the final values as of January 1 of the year in which the transfer occurred.

This rule is intended to implement Iowa Code section 428A.1.

[**ARC 7726B**, IAB 4/22/09, effective 5/27/09]

701—79.4(428A) Certain transfers of agricultural realty.

79.4(1) In determining whether agricultural realty is purchased by a corporation, limited partnership, trust, alien, or nonresident alien for purposes of providing information required for such transfers by Iowa Code section 428A.1, the definitions in this rule shall apply.

79.4(2) Corporation defined. "Corporation" means a domestic or foreign corporation and includes a nonprofit corporation and cooperatives.

79.4(3) Limited partnership defined. "Limited partnership" means a partnership as defined in Iowa Code section 488.102(13) and which owns or leases agricultural land or is engaged in farming.

79.4(4) Trust defined. "Trust" means a fiduciary relationship with respect to property, subjecting the person by whom the property is held to equitable duties to deal with the property for the benefit of another person, which arises as a result of a manifestation of an intention to create it. A trust includes a legal entity holding property as a trustee, agent, escrow agent, attorney-in-fact, and in any similar capacity.

Trust does not include a person acting in a fiduciary capacity as an executor, administrator, personal representative, guardian, conservator or receiver.

79.4(5) Alien defined. "Alien" means a person born out of the United States and unnaturalized under the Constitution and laws of the United States. (*Breuer v. Beery,* 189 N.W. 714, 194 Iowa 243, 244 (1922).)

79.4(6) Nonresident alien defined. "Nonresident alien" means an alien as defined in subrule 79.4(5) who is not a resident of the state of Iowa.

This rule is intended to implement Iowa Code section 428A.1.

[**ARC 7726B**, IAB 4/22/09, effective 5/27/09]

701—79.5(428A) Form completion and filing requirements.

79.5(1) *Real estate transfer—declaration of value form.* A real estate transfer—declaration of value form must be completed for any deed, contract, instrument or writing that grants, assigns, transfers or otherwise conveys real property, except those specifically exempted by law, if the document presented for recording clearly states on its face that it is a document exempt from the reporting requirements as enumerated in Iowa Code section 428A.2, subsections 2 through 5, 7 through 13, and 16 through 21, or subsection 6, except in the case of a federal agency or instrumentality, or if a transfer is the result of acquisition of property for public purposes through eminent domain, or is a deed given in fulfillment of a previously recorded real estate contract. A real estate transfer—declaration of value form is not required for any transaction that does not grant, assign, transfer or convey real property.

79.5(2) *Real estate transfer—declaration of value: Real estate transfer tax.* Requirements for completing real estate transfer-declaration of value forms or exceptions from filing the forms shall not be construed to alter the liability for the real estate transfer tax or the amount of such tax as provided in Iowa Code chapter 428A.

79.5(3) *Agent defined.* As used in Iowa Code section 428A.1, an agent is defined as any person designated or approved by the buyer or seller to act on behalf of the buyer or seller in the real estate transfer transaction.

79.5(4) *Government agency filing requirements.* The real estate transfer-declaration of value form does not have to be completed for any real estate transfer document in which the state of Iowa or any agency, instrumentality or political subdivision thereof is the grantor, assignor, transferor or conveyor

or for any transfer in which the state of Iowa or any agency, instrumentality or political subdivision thereof is the grantee or assignee where there is no consideration. However, any transfer in which any unit of government is the grantee or assignee where there is consideration is subject to the real estate transfer-declaration of value filing requirements (1980 O.A.G. 92) and any transfer to which the United States or any agency or instrumentality thereof is a party to the transfer is subject to the real estate transfer-declaration of value filing requirements. An exception to this subrule is conveyances for public purposes occurring through the exercise of the power of eminent domain.

79.5(5) *Recording refused.* The county recorder shall refuse to record any document for which a real estate transfer-declaration of value is required if the form is not completed accurately and completely by the buyer or seller or the agent of either. The declaration of value shall include the social security number or federal identification number of the buyer and seller and all other information required by the director of revenue, *(Iowa Association of Realtors et al v. Iowa Department of Revenue,* CE 18-10479, Polk County District Court, February 4, 1983.) However, if having made good faith effort, the person or person's agent completing the declaration of value is unable to obtain the social security or federal identification number of the other party to the transaction due to factors beyond the control of the person or person's agent, a signed affidavit stating that the effort was made and the reasons why the number could not be obtained shall be submitted with the incomplete declaration of value. The declaration of value with attached affidavit shall be considered sufficient compliance with Iowa Code section 428A.1 and the affidavit shall be considered a part of the declaration of value subject to the provisions of Iowa Code section 428A.15.

79.5(6) *Multiple parcels.* Separate declarations of value are to be submitted to each county recorder if the real estate conveyed consists of parcels located in more than one county. The consideration paid for each property must be separately stated on the declaration of value or the recorder shall refuse to record the instrument of conveyance.

This rule is intended to implement Iowa Code sections 428A.1 and 428A.2, and section 428A.4 as amended by 2009 Iowa Acts, Senate File 288, section 16.
[**ARC 8358B**, IAB 12/2/09, effective 1/6/10]

701—79.6(428A) Public access to declarations of value. Declarations of value are public records and must be made available for public inspection in accordance with Iowa Code chapter 22. However, if the declaration of value contains the social security number or federal tax identification number of the buyer or seller, the social security number or the federal tax identification number must be redacted by the government official in possession of the declaration of value form prior to its being released to the public.

This rule is intended to implement Iowa Code section 428A.7 as amended by 2009 Iowa Acts, House File 477, section 1.
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[1] Effective date of subrule 79.1(4) was delayed by the Administrative Rules Review Committee 70 days and delay was lifted on November 14, 1979.

CHAPTER 80
PROPERTY TAX CREDITS AND EXEMPTIONS
[Prior to 12/17/86, Revenue Department[730]]

701—80.1(425) Homestead tax credit.

80.1(1) *Application for credit.*

a. No homestead tax credit shall be allowed unless the first application for homestead tax credit is signed by the owner of the property or the owner's qualified designee and filed with the city or county assessor on or before July 1 of the current assessment year. (1946 O.A.G. 37) Once filed, the claim for credit is applicable to subsequent years and no further filing shall be required provided the homestead is owned and occupied by the claimant or the claimant's spouse on July 1 of each year and, in addition, the claimant or the claimant's spouse occupies the homestead for at least six months during each calendar year in which the fiscal year for which the credit is claimed begins. It is not a requirement that the six-month period of time be consecutive. If the credit is disallowed and the claimant failed to give written notice to the assessor that the claimant ceased to use the property as a homestead, a civil penalty equal to 5 percent of the amount of the disallowed credit shall be assessed against the claimant in addition to the amount of credit allowed. The assessor, county auditor, and county board of supervisors shall act on the claim in accordance with Iowa Code section 425.3. A claim filed after July 1 of any calendar year applies to the following assessment year.

b. In the event July 1 falls on either a Saturday or Sunday, applications for the homestead tax credit may be filed the following Monday.

c. In the event July 1 falls on either a Saturday or Sunday, applications submitted by mail shall be accepted if postmarked on the following Monday.

d. An assessor may not refuse to accept an application for homestead tax credit. If it is the opinion of the assessor that a homestead tax credit should not be allowed, the assessor shall accept the application for credit and recommend disallowance.

e. If the owner of the homestead is on active duty in the armed forces of this state or of the United States, or is 65 years of age or older or is disabled, the application for homestead tax credit may be signed and delivered by a member of the owner's family or the owner's guardian, conservator or designated attorney-in-fact. For purposes of this rule, any person related to the owner by blood, marriage or adoption shall be considered a member of the owner's family.

f. If a person makes a false application for credit with fraudulent intent to obtain the credit, the person is guilty of a fraudulent practice and the claim shall be disallowed. If the credit has been paid, the amount of the credit plus a penalty equal to 25 percent of the amount of the disallowed credit and interest shall be collected by the county treasurer.

g. For purposes of the homestead tax credit statute, the occupancy of the homestead may constitute actual occupancy or constructive occupancy. However, more than one homestead cannot be simultaneously occupied by the claimant and multiple simultaneous homestead tax credits are not allowable. (Op. St. Bd. Tax Rev. No. 212, February 29, 1980.) Generally, a homestead is occupied by the claimant if the premises constitute the claimant's usual place of abode. Once the claimant's occupancy of the homestead is established, such occupancy is not lost merely because the claimant, for some valid reason, is temporarily absent from the homestead premises with an intention of returning thereto (1952 O.A.G. 78).

80.1(2) *Eligibility for credit.*

a. If homestead property is owned jointly by persons who are not related or formerly related by blood, marriage or adoption, no homestead tax credit shall be allowed unless all the owners actually occupy the homestead property on July 1 of each year. (1944 O.A.G. 26; Letter O.A.G. October 18, 1941)

b. No homestead tax credit shall be allowed if the homestead property is owned or listed and assessed to a corporation, other than a family farm corporation, partnership, company or any other business or nonbusiness organization. (1938 O.A.G. 441; *Verne Deskin v. Briggs,* State Board of Tax Review, No. 24, February 1, 1972)

c. A person acquiring homestead property under a contract of purchase remains eligible for a homestead tax credit even though such person has assigned his or her equity in the homestead property as security for a loan. (1960 O.A.G 263)

d. A person occupying homestead property pursuant to Iowa Code chapter 499A or 499B is eligible for a homestead tax credit. (1978 O.A.G. 78-2-5; 1979 O.A.G. 79-12-2)

e. A person who has a life estate interest in homestead property shall be eligible for a homestead tax credit, provided the remainderman is related or formerly related to the life estate holder by blood, marriage or adoption or the reversionary interest is held by a nonprofit corporation organized under Iowa Code chapter 504A. (1938 O.A.G. 193)

f. A homestead tax credit may not be allowed upon a mobile home which is not assessed as real estate. (1962 O.A.G. 450)

g. A person occupying homestead property under a trust agreement is considered the owner of the property for purposes of the homestead tax credit. (1962 O.A.G. 434)

h. A remainder is not eligible to receive a homestead tax credit until expiration of the life estate to which such person has the remainder interest. (1938 O.A.G. 305)

i. In order for a person occupying homestead property under a contract of purchase to be eligible for a homestead tax credit, the contract of purchase must be recorded in the office of the county recorder where the property is located. A recorded memorandum or summary of the actual contract of purchase is not sufficient evidence of ownership to qualify a person for a homestead tax credit.

j. An owner of homestead property who is in the military service or confined in a nursing home, extended-care facility or hospital shall be considered as occupying the property during the period of service or confinement. The fact that the owner rents the property during the period of military service is immaterial to the granting of the homestead tax credit. (1942 O.A.G. 45) However, no homestead tax credit shall be allowed if the owner received a profit for the use of the property from another person while such owner is confined in a nursing home, extended-care facility or hospital.

k. A person owning a homestead dwelling located upon land owned by another person or entity is not eligible for a homestead tax credit. (1942 O.A.G. 160, O.A.G. 82-4-9) This rule is not applicable to a person owning a homestead dwelling pursuant to Iowa Code chapter 499B or a person owning a homestead dwelling on land owned by a community land trust pursuant to 42 U.S.C. Section 12773.

l. An heir occupying homestead property that is part of an estate in the process of administration is considered an owner of the property and is eligible for the homestead credit. (1938 O.A.G. 272)

80.1(3) *Disabled veteran's homestead tax credit.* The disabled veteran's homestead tax credit may be claimed by any person who acquired homestead property under 38 U.S.C. Sections 21.801 and 21.802 or Sections 2101 and 2102 provided the veteran's annual income and that of the veteran's spouse do not exceed $35,000. The amount of the credit is equal to the entire amount of tax payable on the homestead. Even though this financial assistance is available to disabled veterans on only one homestead during their lifetime, the credit may be claimed upon the acquisition of other homesteads for which no financial assistance is available providing all qualifications have been met.

80.1(4) *Application of credit.*

a. Except as provided in 80.1(1)*"a,"* if the homestead property is conveyed to another person prior to July 1 of any year, the new owner must file a claim for credit on or before July 1 to obtain the credit for that year. If the property is conveyed on or after July 1, the credit shall remain with the property for that year provided the previous owner was entitled to the credit. However, when the property is transferred as part of a distribution made pursuant to Iowa Code chapter 598 (Dissolution of Marriage) the transferee spouse retaining ownership and occupancy of the homestead is not required to refile for the credit.

b. A homestead tax credit may be allowed even though the property taxes levied against the homestead property have been suspended by the board of supervisors. (1938 O.A.G. 288)

c. A homestead tax credit shall not be allowed if the property taxes levied against the homestead property have been canceled or remitted by the board of supervisors. (1956 O.A.G. 78)

d. Only one homestead tax credit can be allowed per legally described tract of land. For purposes of this rule, a legally described tract of land shall mean all land contained in a single legal description. (1962 O.A.G. 435)

e. If the owner of homestead property is also eligible for a military service tax exemption and claims the exemption on the homestead property, the military service tax exemption shall be applied prior to the homestead tax credit when computing net property tax. (*Ryan v. State Tax Commission,* 235 Iowa 222, 16 N.W.2d 215)

f. If the homestead property contains two dwelling houses and one of the dwelling houses and a portion of the land is sold after a valid application for homestead tax credit has been filed, the assessor shall prorate the assessment so as to allow the seller a homestead tax credit on that portion of the property which is retained and also allow the purchaser a homestead tax credit on that portion of the property which is purchased, provided the purchaser files a valid application for homestead tax credit by July 1 of the claim year.

g. A homestead tax credit shall be allowed against the assessed value of the land on which a dwelling house did not exist as of January 1 of the year in which the credit is claimed provided a dwelling house is owned and occupied by the claimant on July 1 of that year.

h. The county treasurer shall, pursuant to Iowa Code section 25B.7, be required to extend to the claimant only that portion of the credit estimated by the department to be funded by the state appropriation.

This rule is intended to implement Iowa Code chapter 425 as amended by 2006 Iowa Acts, House File 2794.

701—80.2(22,35,426A) Military service tax exemption.

80.2(1) *Application for exemption.*

a. No military service tax exemption shall be allowed unless the first application for the military service tax exemption is signed by the owner of the property or the owner's qualified designee and filed with the city or county assessor on or before July 1 of the current assessment year (1970 O.A.G. 437). Once filed, the claim for exemption is applicable to subsequent years and no further filing shall be required provided the claimant or the claimant's spouse owns the property on July 1 of each year. The assessor, county auditor, and county board of supervisors shall act on the claim in accordance with Iowa Code section 426A.14. A claim filed after July 1 of any calendar year applies to the following assessment year.

b. In the event July 1 falls on either a Saturday or Sunday, applications for the military service tax exemption may be filed the following Monday.

c. In the event July 1 falls on either a Saturday or Sunday, applications submitted by mail shall be accepted if postmarked on the following Monday.

d. An assessor may not refuse to accept an application for a military service tax exemption. If it is the opinion of the assessor that a military service tax exemption should not be allowed, the assessor shall accept the application for exemption and recommend disallowance.

e. If the owner of the property is on active duty in the armed forces of this state or of the United States, or is 65 years of age or older or is disabled, the application for military service tax exemption may be signed and delivered by a member of the owner's family or the owner's guardian, conservator or designated attorney-in-fact. For purposes of this rule, any person related to the owner by blood, marriage or adoption shall be considered a member of the owner's family.

80.2(2) *Eligibility for exemption.*

a. A person who was discharged from the draft is not considered a veteran of the military service and is not entitled to a military service tax exemption. (1942 O.A.G. 79)

b. A military service tax exemption shall not be allowed to a person whose only service in the military was with a foreign government. (1932 O.A.G. 242; 1942 O.A.G. 79)

c. Former members of the United States armed forces, including members of the Coast Guard, who were on active duty for less than 18 months must have served on active duty during one of the war or conflict time periods enumerated in Iowa Code Supplement section 35.1. If former members were on active duty for at least 18 months, it is not necessary that their service be performed during one of the war or conflict time periods. Former members who opted to serve five years in the reserve forces of the United States qualify if any portion of their enlistment would have occurred during the Korean

Conflict (June 25, 1950, to January 31, 1955). There is no minimum number of days a former member of the armed forces of the United States must have served on active duty if the service was performed during one of the war or conflict time periods, nor is there a minimum number of days a former member of the armed forced of the United States must have served on active duty if the person was honorably discharged because of a service-related injury sustained while on active duty.

Former and current members of the Iowa national guard and reserve forces of the United States need not have performed any active duty if they served at least 20 years. Otherwise, they must have been activated for federal duty, for purposes other than training, for a minimum of 90 days. Also, it is not a requirement for a member of the Iowa national guard or a reservist to have performed service within a designated war or conflict time period.

d. With the exception of members of the Iowa national guard and members of the reserve forces of the United States who have served at least 20 years and continue to serve, a military service tax exemption shall not be allowed unless the veteran has received a complete and final separation from active duty service. (*Jones v. Iowa State Tax Commission,* 247 Iowa 530, 74 N.W.2d 563, 567-1956; *In re Douglas A. Coyle,* State Board of Tax Review, No. 197, August 14, 1979; 1976 O.A.G. 44)

e. As used in Iowa Code subsection 426A.12(3), the term minor child means a person less than 18 years of age or less than 21 years of age and enrolled as a full-time student at an educational institution.

f. A veteran of more than one qualifying war period is entitled to only one military service tax exemption, which shall be the greater of the two exemptions. (1946 O.A.G. 71)

g. The person claiming a military service tax exemption must be an Iowa resident. However, the veteran need not be an Iowa resident if such person's exemption is claimed by a qualified individual enumerated in Iowa Code section 426A.12. (1942 O.A.G. 140)

h. A person who has a life estate interest in property may claim a military service tax exemption on such property. (1946 O.A.G. 155; 1976 O.A.G. 125)

i. A remainder is not eligible to receive a military service tax exemption on property to which a remainder interest is held until expiration of the life estate. (1946 O.A.G. 155)

j. A military service tax exemption shall not be allowed on a mobile home which is not assessed as real estate. (1962 O.A.G. 450)

k. A divorced person may not claim the military service tax exemption of a former spouse who qualifies for the exemption. (Letter O.A.G. August 8, 1961)

l. A surviving spouse of a qualified veteran, upon remarriage, loses the right to claim the deceased veteran's military exemption as the surviving spouse is no longer an unremarried surviving spouse of the qualified veteran. (1950 O.A.G. 44)

m. An annulled marriage is considered to have never taken place and the parties to such a marriage are restored to their former status. Neither party to an annulled marriage can thereafter be considered a spouse or surviving spouse of the other party for purposes of receiving the military service tax exemption. (Op. Att'y. Gen. 61-8-10(L))

n. No military service tax exemption shall be allowed on property that is owned by a corporation, except for a family farm corporation where a shareholder occupies a homestead as defined in Iowa Code section 425.11(1), partnership, company or any other business or nonbusiness organization. (1938 O.A.G. 441)

o. In the event both a husband and wife are qualified veterans, they may each claim their military service tax exemption on their jointly owned property. (1946 O.A.G. 154) If property is solely owned by one spouse, the owner spouse may claim both exemptions on the property providing the nonowner spouse's exemption is not claimed on other property.

p. No military service tax exemption shall be allowed if on July 1 of the claim year, the claimant or the claimant's unremarried surviving spouse is no longer the owner of the property upon which the exemption was claimed.

q. A person shall not be denied a military service tax exemption even though the property upon which the exemption is claimed has been pledged to another person as security for a loan. (1960 O.A.G. 263)

r. A qualified veteran who has conveyed property to a trustee shall be eligible to receive a military service tax exemption on such property providing the trust agreement gives the claimant a beneficial interest in the property. (1962 O.A.G. 434)

s. A person owning property pursuant to Iowa Code chapter 499A or 499B is eligible for a military service tax exemption. (1978 O.A.G. 78-2-5; 1979 O.A.G. 79-12-2)

t. The person claiming the exemption shall have recorded in the office of the county recorder evidence of property ownership and either the military certificate of satisfactory service or, for a current member of the Iowa national guard or a member of the reserve forces of the United States, the veteran's retirement points accounting statement issued by the armed forces of the United States or the state adjutant general. The military certificate of satisfactory service shall be considered a confidential record pursuant to Iowa Code section 22.7.

u. An heir of property that is part of an estate in the process of administration is considered an owner of the property and is eligible for the military exemption.

80.2(3) *Application of exemption.*

a. When the owner of homestead property is also eligible for a military service tax exemption and claims the exemption on the homestead property, the military service tax exemption shall be applied prior to the homestead tax credit when computing net property tax. (*Ryan v. State Tax Commission,* 235 Iowa 222, 16 N.W.2d 215)

b. If a portion of the property upon which a valid military service tax exemption was claimed is sold on or before July 1 of the year in which the exemption is claimed, the seller shall be allowed a military service tax exemption on that portion of the property which is retained by the seller on July 1. The purchaser is also eligible to receive a military service tax exemption on that portion of the property which was purchased, provided the purchaser is qualified for the exemptions and files a valid application for the exemption on or before July 1 of the claim year.

c. A military service tax exemption may be allowed even though the taxes levied on the property upon which the exemption is claimed have been suspended by the board of supervisors. (1938 O.A.G. 288)

d. A military service tax exemption shall not be allowed if the taxes levied on the property upon which the exemption is claimed have been canceled or remitted by the board of supervisors. (1956 O.A.G. 78)

e. The county treasurer shall, pursuant to Iowa Code section 25B.7, be required to extend to the claimant only that portion of the exemption estimated by the department to be funded by the state appropriation.

This rule is intended to implement Iowa Code sections 22.7, 35.1, and 35.2 and chapter 426A.

[**ARC 7726B**, IAB 4/22/09, effective 5/27/09]

701—80.3(427) Pollution control and recycling property tax exemption.

80.3(1) To secure an exemption for pollution control or recycling property, an application must be filed with the assessing authority on or before February 1 of the assessment year for which the exemption is first claimed. It is the responsibility of the taxpayer to secure the necessary certification from the department of natural resources in sufficient time to file the application for exemption with the assessing authority on or before February 1. An exemption for new pollution control or recycling property can be secured by filing an application with the assessing authority by February 1 of the assessment year following the year in which the property is installed or constructed. If no application is timely filed in that year, the property will first qualify for exemption in any subsequent year in which an application is filed with the assessing authority on or before February 1.

80.3(2) In the event February 1 falls on either a Saturday or Sunday, applications for the exemption may be filed the following Monday.

80.3(3) In the event February 1 falls on either a Saturday or Sunday, applications submitted by mail shall be accepted if postmarked on the following Monday.

80.3(4) No exemption shall be allowed unless the application is signed by the owner of the property or the owner's qualified designee.

80.3(5) An assessor may not refuse to accept an application for a pollution control exemption if timely filed and if the necessary certification has been obtained from the department of natural resources.

80.3(6) The sale, transfer, or lease of property does not affect its eligibility for exemption as long as the requirements of Iowa Code subsection 427.1(19) and rule 701—80.3(427), Iowa Administrative Code, are satisfied.

80.3(7) No exemption shall be allowed unless the department of natural resources has certified that the primary use of the property for which the taxpayer is seeking an exemption is to control or abate air or water pollution or to enhance the quality of any air or water in this state or that the primary use of the property is for recycling. Recycling property is property used primarily in the manufacturing process and resulting directly in the conversion of waste glass, waste plastic, wastepaper products, waste paperboard, or waste wood products into new raw materials or products composed primarily of recycled material.

80.3(8) In the event that qualified property is assessed as a unit with other property not having a pollution control or recycling function, the exemption shall be limited to the increase in the assessed valuation of the unit which is attributable to the pollution control or recycling property.

EXAMPLE

Valuation of unit with pollution control or recycling property	$100,000
Valuation of unit without pollution control or recycling property	50,000
Allowable amount of exemption	$ 50,000

80.3(9) The value of property to be exempt from taxation shall be the fair and reasonable market value of such property as of January 1 of each year for which the exemption is claimed, rather than the original cost of such property.

80.3(10) An assessor shall not exempt property from taxation without first assessing the property for taxation and subsequently receiving an application for tax exemption from the taxpayer.

This rule is intended to implement Iowa Code Supplement section 427.1(19) as amended by 2006 Iowa Acts, House File 2633, and Iowa Code sections 427.1(18) and 441.21(1)(i).
[**ARC 7726B**, IAB 4/22/09, effective 5/27/09]

701—80.4(427) Low-rent housing for the elderly and persons with disabilities.

80.4(1) As used in Iowa Code subsection 427.1(21), the term "nonprofit organization" means an organization, no part of the net income of which is distributable to its members, directors or officers.

80.4(2) As used in Iowa Code subsection 427.1(21), the term "low-rent housing" means housing the rent for which is less than that being received or which could be received for similar properties on the open market in the same assessing jurisdiction. Federal rent subsidies received by the occupant shall be excluded in determining whether the rental fee charged meets this definition.

80.4(3) As used in Iowa Code subsection 427.1(21), the term "elderly" means any person at least 62 years of age.

80.4(4) As used in Iowa Code subsection 427.1(21), the term "persons with physical or mental disabilities" means a person whose physical or mental condition is such that the person is unable to engage in substantial gainful employment.

80.4(5) The exemption granted in Iowa Code subsection 427.1(21) extends only to property which is owned and operated, or controlled, by a nonprofit organization recognized as such by the Internal Revenue Service. Property owned and operated, or controlled, by a private person is not eligible for exemption under Iowa Code subsection 427.1(21).

80.4(6) The income of persons living in housing eligible for exemption under Iowa Code subsection 427.1(21) shall not be considered in determining the property's taxable status.

80.4(7) An organization seeking an exemption under Iowa Code subsection 427.1(21) shall file a statement with the local assessor pursuant to Iowa Code subsection 427.1(14).

80.4(8) The exemption authorized by Iowa Code subsection 427.1(21) extends only until the final payment due date of the borrower's original low-rent housing development mortgage on the property or

until the borrower's original low-rent housing development mortgage is paid in full or expires, whichever is sooner. If the original mortgage is refinanced, the exemption shall apply only until what would have been the final payment due date under the original mortgage or until the refinanced mortgage is paid in full or expires, whichever is sooner. This exemption for refinanced projects applies to those projects refinanced on or after January 1, 2005.

80.4(9) In complying with the requirements of Iowa Code subsection 427.1(14), the provisions of rule 701—78.4(427) shall apply.

80.4(10) In determining the taxable status of property for which an exemption is claimed under Iowa Code subsection 427.1(21), the appropriate assessor shall follow rules 701—78.1(427,441) to 701—78.5(427).

80.4(11) If a portion of a structure is used to provide low-rent housing units to elderly persons and persons with disabilities and the other portion is used to provide housing to persons who are not elderly or disabled, the exemption for the property on which the structure is located shall be limited to that portion of the structure used to provide housing to the elderly and disabled. Vacant units and projects under construction that are designated for use to provide housing to elderly and disabled persons shall be considered as being used to provide housing to elderly and disabled persons. The valuation exempted shall bear the same relationship to the total value of the property as the area of the structure used to provide low-rent housing for the elderly and persons with disabilities bears to the total area of the structure unless a better method for determining the exempt valuation is available. The valuation of the land shall be exempted in the same proportion.

80.4(12) The property tax exemption provided in Iowa Code subsection 427.1(21) shall be based upon occupancy by elderly or persons with disabilities as of July 1 of the assessment year. However, nothing in this subrule shall prevent the taxation of such property in accordance with the provisions of Iowa Code section 427.19.

This rule is intended to implement Iowa Code section 427.1(14) and Supplement section 427.1(21).
[**ARC 7726B**, IAB 4/22/09, effective 5/27/09]

701—80.5(427) Speculative shell buildings.

80.5(1) *Authority of city council and board of supervisors.* A city council or county board of supervisors may enact an ordinance granting property tax exemptions for value added as a result of new construction of speculative shell buildings or additions to existing buildings or structures, or may exempt the value of an existing building or structure being reconstructed or renovated and the value of the land on which the building or structure is located, if the reconstruction or renovation constitutes complete replacement or refitting of an existing building or structure owned by community development organizations, not-for-profit cooperative associations under Iowa Code chapter 499A, or for-profit entities. See Iowa Code Supplement section 427.1(27) as amended by 2008 Iowa Acts, Senate File 2419, for definitions. The value added exemption for new construction includes reconstruction and renovation constituting complete replacement or refitting of existing buildings and structures if the reconstruction or renovation is required due to economic obsolescence, or to implement industry standards in order to competitively manufacture or process products, or to market a building or structure as a speculative shell building. The exemption for reconstruction or renovation not constituting new construction does not have to meet these requirements but has to meet only the requirements set forth in the definition of a speculative shell building. The council or board in the ordinance authorizing the exemption shall specify if the exemption will be allowed to community development organizations, not-for-profit cooperative associations under Iowa Code chapter 499B, or for-profit entities, and the length of time the exemption is to be allowed.

80.5(2) *Eligibility for exemption.* The value added by new construction, reconstruction, or renovation and first assessed prior to January 1 of the calendar year in which an ordinance authorizing a tax exemption becomes effective is not eligible for exemption. However, the value added as of January 1 of the calendar year in which the ordinance becomes effective is eligible for exemption if the ordinance is in effect on February 1 of that calendar year. This subrule does not apply to new construction projects having received prior approval. For reconstruction and renovation projects not

constituting new construction, the ordinance authorizing the exemption must be in effect by February 1 of the year the project commences for the exemption to be allowable in the subsequent assessment year.

80.5(3) *Application for exemption.*

a. A community development organization, not-for-profit cooperative association, or for-profit entity must file an application for exemption with the assessor between January 1 and February 1, inclusive, of the year in which the value added for new construction is first assessed for the exemption to be allowable for that assessment year. For reconstruction and renovation projects not constituting new construction, an application for exemption must be filed by February 1 of the assessment year in which the project commences for the exemption to be allowable the following assessment year. If approved, no application for exemption is required to be filed in subsequent years for the value added exemption or the reconstruction or renovation exemption not constituting new construction. An application cannot be filed if a valid ordinance has not been enacted. If an application is not filed by February 1 of the year in which the value added for new construction is first assessed, the organization, association, or entity cannot receive, in subsequent years, the exemption for that value added. However, if the organization, association, or entity has received prior approval, the application must be filed by February 1 of the year in which the total value added for the new construction is first assessed.

b. If February 1 falls on either a Saturday or Sunday, applications for exemption may be filed the following Monday.

c. Applications submitted by mail must be accepted if postmarked on or before February 1 or, if February 1 falls on either a Saturday or Sunday, a postmark date of the following Monday is acceptable.

80.5(4) *Prior approval.* To obtain prior approval for a project, the proposal of the organization, association, or entity must be approved by a specific ordinance addressing the proposal and passed by the city council or board of supervisors. The original ordinance providing for the exemption does not constitute the granting of prior approval for a project. If an organization, association, or entity has obtained a prior approval ordinance from a city council or board of supervisors, the exemption for new construction cannot be obtained until the year in which all value added for the completed project is first assessed. Reconstruction and renovation projects constituting new construction must receive prior approval to qualify for exemption. Reconstruction and renovation projects that do not constitute new construction need not receive prior approval.

80.5(5) *Termination of exemption.* The exemption continues until the property is leased or sold, the time period for the exemption specified in the ordinance elapses, or the exemption is terminated by ordinance of the city council or board of supervisors. If the ordinance authorizing the exemption is repealed, all existing exemptions continue until their expiration and any projects having received prior approval for exemption for new construction are to be granted an exemption upon completion of the project. If the shell building or any portion of the shell building is leased or sold, the exemption for new construction shall not be allowed on that portion of the shell building leased or sold in subsequent years. If the shell building or any portion of the shell building is leased or sold, the exemption for reconstruction or renovation not constituting new construction shall not be allowed on that portion of the shell building leased or sold and a proportionate share of the land on which the shell building is located in subsequent years.

This rule is intended to implement Iowa Code Supplement section 427.1(27) as amended by 2008 Iowa Acts, Senate File 2419.

701—80.6(427B) Industrial property tax exemption.

80.6(1) *Authority of city council and board of supervisors.* A partial exemption ordinance enacted pursuant to Iowa Code section 427B.1 shall be available to all qualifying property. A city council or county board of supervisors does not have the authority to enact an ordinance granting a partial exemption to only certain qualifying properties (1980 O.A.G. 639). As used in this rule, the term "qualifying property" means property classified and assessed as real estate pursuant to subrule 701—71.1(6), warehouses and distribution centers, research service facilities, and owner-operated cattle facilities. "Warehouse" means a building or structure used as a public warehouse for the storage of goods pursuant to Iowa Code sections 554.7101 to 554.7603, except that it does not mean a building

or structure used primarily to store raw agricultural products or from which goods are sold at retail. "Distribution center" means a building or structure used primarily for the storage of goods which are intended for subsequent shipment to retail outlets. Distribution center does not mean a building or structure used primarily to store raw agricultural products, used primarily by a manufacturer to store goods to be used in the manufacturing process, used primarily for the storage of petroleum products, or used for the retail sale of goods. A "research service facility" is one or more buildings devoted primarily to research and development activities or corporate research services. Research and development activities include, but are not limited to, the design and production or manufacture of prototype products for experimental use. A research service facility does not have as its primary purpose the providing of on-site services to the public. "Owner-operated cattle facility" means a building or structure used primarily in the raising of cattle and which is operated by the person owning the facility.

80.6(2) *Prior approval.* Only upon enactment of a partial property tax exemption ordinance in accordance with Iowa Code section 427B.1 may a city council or board of supervisors enact a prior approval ordinance for pending individual projects in accordance with Iowa Code section 427B.4. To obtain prior approval for a project, a property owner's proposal must be approved by a specific ordinance addressing the proposal and passed by the city council or board of supervisors. The original ordinance providing for the partial exemption does not constitute the granting of prior approval for a project. Also, prior approval for a project can only be granted by ordinance of the city council or board of supervisors; an official or representative of a city or county does not have the independent authority to grant prior approval for a project. If a taxpayer has obtained a prior approval ordinance from a city council or board of supervisors, the partial exemption cannot be obtained until the year in which all value added for the project is first assessed. (1980 O.A.G. 639)

80.6(3) *Repeal of ordinance.* A new construction project having received prior approval for exemption in accordance with subrule 80.6(2) shall be granted such exemption upon completion of the project even if the city council or board of supervisors subsequently repeals the ordinance passed in accordance with Iowa Code section 427B.1. (1980 O.A.G. 639)

80.6(4) *Annexation of property previously granted exemption.* A partial property tax exemption which has been granted and is in existence shall not be discontinued or disallowed in the event that the property upon which such exemption has been previously granted is located in an area which is subsequently annexed by a city or becomes subject to the jurisdiction of a county in which an ordinance has not been passed by the city council or county board of supervisors allowing such exemptions within that jurisdiction. The existing exemption shall continue until its expiration.

80.6(5) *Eligibility for exemption.*

a. The value added by new construction or reconstruction and first assessed prior to January 1 of the calendar year in which an ordinance authorizing a partial property tax exemption becomes effective, and new machinery and equipment assessed as real estate acquired and utilized prior to January 1 of the calendar year in which the ordinance or resolution becomes effective, are not eligible for exemption. However, the value added as of January 1 of the calendar year in which the ordinance becomes effective is eligible for exemption if the ordinance is in effect prior to February 1 of that calendar year and if all other eligibility and application requirements are satisfied.

EXAMPLE 1: A $1,000,000 new construction project on qualifying property is begun in July 1984. $500,000 in value of the partially completed project is completed in 1984 and first assessed as of January 1, 1985. The project is completed in 1985 adding an additional value of $500,000 which is first assessed as of January 1, 1986, bringing the total assessed value of the completed project to $1,000,000 as of the January 1, 1986, assessment.

A city ordinance authorizing the partial exemption program is passed and becomes effective January 15, 1987. This project is not eligible for a property tax exemption for any value added as a result of the new construction project.

EXAMPLE 2: Assuming the same factual situation as in Example 1, except that the ordinance authorizing the partial exemption program becomes effective on January 15, 1986, the $500,000 in assessed value added as of the January 1, 1986, assessment is eligible for the partial exemption if an application is filed with the assessor between January 1 and February 1, 1986, inclusive.

EXAMPLE 3: Assuming the same factual situation as in Example 1, except that the ordinance authorizing the partial exemption program becomes effective on February 15, 1986. Since the statutory application filing deadline is February 1, no value added and first assessed as of January 1, 1986, is eligible for a partial exemption. The project in this example would receive no exemption for any value added as a result of the new construction.

This subrule does not apply to new construction projects having received prior approval in accordance with subrule 80.6(2).

b. New machinery and equipment assessed as real estate shall be eligible for partial exemption only if used primarily in the manufacturing process. For example, computer equipment used primarily to maintain payroll records would not be eligible for exemption, whereas computer equipment utilized primarily to control or monitor actual product assembly would be eligible.

c. If any other property tax exemption is granted for the same assessment year for all or any of the property which has been granted a partial exemption, the partial property tax exemption shall be disallowed for the year in which the other exemption is actually received.

d. Only qualifying property is eligible to receive the partial property tax exemption (O.A.G. 81-2-18).

e. A taxpayer cannot receive the partial property tax exemption for industrial machinery or equipment if the machinery or equipment was previously assessed in the state of Iowa. Industrial machinery and equipment previously used in another state may qualify for the partial exemption if all criteria for receiving the partial exemption are satisfied.

f. Industrial machinery and equipment is eligible to receive the partial property tax exemption if it changes the existing operational status other than by merely maintaining or expanding the existing operational status. This rule applies whether the machinery and equipment is placed in a new building, an existing building, or a reconstructed building. If new machinery is used to produce an existing product more efficiently or to produce merely a more advanced version of the existing product, the existing operational status would only be maintained or expanded and the machinery would not be eligible for the exemption. However, if the new machinery produces a product distinctly different from that currently produced, the existing operational status has been changed.

80.6(6) *Application for exemption.*

a. An eligible property owner shall file an application for exemption with the assessor between January 1 and February 1, inclusive, of the year for which the value added is first assessed for tax purposes. The amount of "actual value added" shall be the difference between the assessed value of the property on January 1 of the year value is added to the property and the assessed value of the property the following assessment year. An application cannot be filed if a valid ordinance has not been enacted in accordance with Iowa Code section 427B.1 (O.A.G. 82-3-5). If an application is not filed by February 1 of the year for which the value added is first assessed, the taxpayer cannot receive in subsequent years the partial exemption for that value added (O.A.G. 82-1-17). However, if a taxpayer has received prior approval in accordance with Iowa Code section 427B.4 and subrule 80.6(2), the application is to be filed by not later than February 1 of the year for which the total value added is first assessed as the approved completed project.

b. In the event that February 1 falls on either a Saturday or Sunday, applications for the industrial property tax exemption may be filed the following Monday.

c. Applications submitted by mail shall be accepted if postmarked on or before February 1, or in the event that February 1 falls on either a Saturday or Sunday, a postmark date of the following Monday shall be accepted.

80.6(7) *Change in use of property.* If property ceases to be used as qualifying property, no partial exemption shall be allowed as of January 1 of the year following the calendar year in which the change in use takes place or for subsequent years. If property under construction ceases to be constructed for use as qualifying property, no partial exemption shall be allowed as of January 1 of the year following the calendar year in which this cessation occurs. However, such a change in the use of the property

does not affect the validity of any partial exemption received for the property while it was used or under construction as qualifying property.

This rule is intended to implement Iowa Code sections 427B.1 to 427B.7.

[**ARC 7726B**, IAB 4/22/09, effective 5/27/09]

701—80.7(427B) Assessment of computers and industrial machinery and equipment.

80.7(1) Computers and industrial machinery and equipment are to be assessed at 30 percent of the property's net acquisition cost through the 1998 assessment year, 22 percent of the net acquisition cost in the 1999 assessment year, 14 percent of the net acquisition cost in the 2000 assessment year, and 6 percent of the net acquisition cost in the 2001 assessment year. The property will be exempt from tax beginning with the 2002 assessment year.

Computers and industrial machinery and equipment acquired after December 31, 1993, and not previously assessed in Iowa, are exempt from tax.

Computers and industrial machinery and equipment assessed pursuant to Iowa Code section 427B.17 are not eligible to receive the partial property tax exemption under Iowa Code sections 427B.1 to 427B.7.

80.7(2) Computers assessed under Iowa Code section 427A.1(1)*"j"* are limited to the percent of the computer's net acquisition cost as provided in Iowa Code section 427B.17 regardless of the classification of the real estate in which the computer is located.

80.7(3) For computers and industrial machinery and equipment, the net acquisition cost shall be the acquired cost of the property.

80.7(4) Computation of taxpayer's value. Assume a machine is acquired at a net acquisition cost of $10,000. Assume also that the actual depreciated value of the machine is $9,000. The value on which taxes would be levied would be limited to $3,000 ($10,000 × .30). This percent will change over the course of the phaseout of the tax.

80.7(5) If all or a portion of the value of property assessed pursuant to Iowa Code section 427B.17 is eligible to receive an exemption from taxation, the amount of value to be exempt shall be subtracted from the net acquisition cost of the property before the taxpayer's value prescribed in Iowa Code section 427B.17 is determined. For example, if property has a net acquisition cost of $30,000 and is eligible to receive a pollution exemption for $15,000 of value, the taxable net acquisition cost would be $15,000 and the taxpayer's value would be $4,500 ($15,000 × .30). This percent will change over the course of the phaseout of the tax.

80.7(6) In the event the actual depreciated fair market value of property assessed pursuant to Iowa Code section 427B.17 is less than the valuation determined as a percent of the net acquisition cost of the property as provided in Iowa Code section 427B.17, the taxpayer's assessed value would be equal to the actual depreciated fair market value of the property.

80.7(7) Property ineligible for phaseout and exemption. Computers and industrial machinery and equipment, the taxes on which are used to fund a new jobs training project approved on or before June 30, 1995, do not qualify for the exemption provided in Iowa Code section 427B.17(2) nor the phaseout contained in Iowa Code section 427B.17(3) until the assessment year following the calendar year in which the funding obligations have been retired, refinanced, or refunded. At that time, the property will be subject to phaseout if acquired prior to January 1, 1994, or exempt from tax if acquired after December 31, 1993, and not previously assessed in Iowa. See subrule 80.7(1). The community college must notify the assessor by February 15 of each assessment year if the community college will be using a taxpayer's machinery and equipment taxes to finance a project that year. In any year in which the community college does rely on a taxpayer's machinery and equipment taxes for funding, the phaseout and exemption will not apply to that taxpayer that year.

80.7(8) County replacement.

a. For fiscal years beginning July 1, 1996, and ending June 30, 2001, the county replacement amount shall be equal to the difference between the assessed value of computers and industrial machinery and equipment as of January 1 of the previous calendar year and the assessed value of such property as of January 1, 1994, multiplied by the tax levy rate for that fiscal year. If there is an increase in valuation (the January 1, 1994, value is less), there will be no replacement for that fiscal year.

b. For fiscal years beginning July 1, 2001, and ending June 30, 2004, the county replacement amount shall be equal to the difference between the assessed value of computers and industrial machinery and equipment as of January 1 of the previous calendar year and the assessed value of such property as of January 1, 1994, less, if any, the increase in the assessed value of commercial and industrial property as of January 1 of the previous calendar year and the assessed value of such property as of January 1, 1994, multiplied by the tax levy rate for that fiscal year. If the calculation results in a negative amount, there will be no replacement for that fiscal year.

c. The replacement amounts shall be determined for each taxing district and a replacement claim summarizing the total amounts for the county prepared and submitted by the county auditor to the department of revenue by September 1 of each year. The department shall pay the replacement amount to the county treasurer in September and March of each year.

d. No replacement is allowable if a community college elects not to fund a new jobs training project with a tax on computers and industrial machinery and equipment.

This rule is intended to implement Iowa Code chapter 427B as amended by 2003 Iowa Acts, Senate File 453.

701—80.8(404) Urban revitalization partial exemption.

80.8(1) *Area designated.* An area containing only one building or structure cannot be designated as an urban revitalization area (1980 O.A.G. 786).

80.8(2) *Prior approval.* To obtain prior approval for a project, a property owner's proposal must be approved by a specific resolution addressing the proposal and passed by the city council or county board of supervisors. The original ordinance providing for the urban revitalization area does not constitute the granting of prior approval for any particular project. Also, prior approval for a project can only be granted by resolution of the city council or county board of supervisors; an official or representative of a city or county does not have the independent authority to grant prior approval for a project.

80.8(3) *Eligibility for exemption.* Improvements made as a result of a project begun more than one year prior to a city's or county's adoption of an urban revitalization ordinance are not eligible to receive the partial exemption even though some of the improvements are added during the time the area was designated as an urban revitalization area. For a project commenced within one year prior to the adoption of an urban revitalization ordinance, the partial exemption can be allowed only for those improvements constructed on or after the effective date of the ordinance. (1982 O.A.G. 358)

80.8(4) *Minimum value added.* Once the minimum value added required by Iowa Code section 404.3(7) has been assessed, any amount of additional value added to the property in subsequent years is eligible for the partial exemption. The value added subject to partial exemption for the first year for which an exemption is claimed and allowed shall include value added to the property for a previous year even if the value added in the previous year was not by itself sufficient to qualify for the partial exemption.

For example, assume that an urban revitalization project is begun on commercial property having an actual value of $50,000 as of January 1, 1984. As a result of improvements made during 1984, the actual value of the property as of January 1, 1985, is determined to be $55,000. Additional improvements made during 1985 increase the actual value of the property to $70,000 for the 1986 assessment. In this example, no partial exemption can be allowed for 1985 since the value added for that year is less than 15 percent of the actual value of the property prior to construction of the improvements. A partial exemption can be allowed for 1986 and subsequent years for the $20,000 value added in both 1985 and 1986, providing a valid application for the partial exemption is filed between January 1, 1986, and February 1, 1986, inclusive.

80.8(5) *Application for partial exemption.*

a. Prior approval. If a taxpayer has secured a prior approval resolution from the city council or the county board of supervisors, the partial exemption cannot be obtained until the year in which all value added for the project is first assessed. A partial exemption can be allowed only if an application is filed between January 1 and February 1, inclusive, of the year in which all value added for the project is first assessed. If an application is not filed during that period, no partial exemption can be allowed for that

year or any subsequent year. The submission to the city council or the county board of supervisors of a proposal to receive prior approval does not by itself constitute an application for the partial exemption.

For example, assume a city council or county board of supervisors approves a prior approval resolution in April 1984 for a revitalization project to be completed in September 1986. Assuming all construction on the project is completed in 1986, no partial exemption can be allowed until 1987 since that would be the year in which all value added for the project is first assessed. To receive the partial exemption, a valid application would have to be filed between January 1, 1987, and February 1, 1987, inclusive.

b. No prior approval. If a project has not received a prior approval resolution, a taxpayer has the option of receiving the partial exemption beginning with any year in which value is added to the property or waiting until all value added to the property is first assessed in its entirety. To secure a partial exemption prior to the completion of the project, an application must be filed between January 1 and February 1, inclusive, in each year for which the exemption is claimed.

For example, assume a revitalization project is begun in June 1984 and completed in September 1985, that no prior approval resolution for the project has been approved, and that a ten-year exemption period has been selected. Assume further that as a result of construction on the project, value is added for the assessment years 1985 and 1986. If an application is filed between January 1, 1985, and February 1, 1985, inclusive, a partial exemption could be allowed for the value added for 1985 beginning with the 1985 assessment and ending with the 1994 assessment. If an application is filed between January 1, 1986, and February 1, 1986, inclusive, a partial exemption could be allowed for the value added for 1986 beginning with the 1986 assessment and ending with the 1995 assessment. The partial exemption allowable for the years 1986 through 1995 would be against the value added for 1986 as a result of improvements made during calendar year 1985.

In the example above, the taxpayer may elect not to file an application for the partial exemption in 1985. In this situation, if an application is filed between January 1, 1986, and February 1, 1986, inclusive, a partial exemption could be allowed for the total value added for 1985 and 1986 and would apply to assessments for the years 1986 through 1995.

c. Filing deadline. If February 1 falls on a Saturday or Sunday, an application for the partial exemption may be filed the following Monday. Applications submitted by mail must be postmarked on or before February 1, or on or before the following Monday if February 1 falls on a Saturday or Sunday.

d. Extended filing deadline. The exemption is allowable for the total number of years in the exemption schedule if a claim for exemption is filed within two years of the original February 1 filing deadline. The city council or county board of supervisors may by resolution provide that an application for the partial exemption can be filed by February 1 of any assessment year the area is designated as an urban revitalization area. The exemption shall be allowed for the same number of years remaining in the exemption schedule selected as would have been remaining had the claim for exemption been timely filed.

80.8(6) *Value exempt.* The partial exemption allowed for a year in which an application is filed shall apply to the value added and first assessed for that year and any value added to the project and assessed for a preceding year or years and for which a partial exemption had not been received.

80.8(7) *Minimum assessment.* The partial exemption shall apply only to the value added in excess of the actual value of the property as of the year immediately preceding the year in which value added was first assessed. If the actual value of the property is reduced for any year during the period in which the partial exemption applies, any reduction in value resulting from the partial exemption shall not reduce the assessment of the property below its actual value as of January 1 of the assessment year immediately preceding the year in which value added was first assessed. This subrule applies regardless of whether the reduction in actual value is made by the assessor, the board of review, a court order, or an equalization order of the director of revenue.

80.8(8) *Value added.* As used in this rule, the term "value added" means the amount of increase in the actual value of real estate directly attributable to improvements made as part of a revitalization project. The amount of "actual value added" shall be the difference between the assessed value of the property on

January 1 of the year value is added to the property and the assessed value of the property the following assessment year. "Value added" does not include any increase in actual (market) value attributable to that portion of the real estate assessed prior to the year in which revitalization improvements are first assessed. The sales price of the property rather than the assessed value of the property may be used in determining the percentage increase required to qualify for exemption if the improvements were begun within one year of the date the property was purchased.

80.8(9) *Repeal of ordinance.* An urban revitalization project which has received proper prior approval shall be eligible to receive the partial exemption following completion of the project even if the city council or county board of supervisors subsequently repeals the urban revitalization ordinance before improvements in the project are first assessed (1980 O.A.G. 639).

This rule is intended to implement Iowa Code chapter 404 as amended by 2002 Iowa Acts, House File 2622.

[**ARC 7726B**, IAB 4/22/09, effective 5/27/09]

701—80.9(427C,441) Forest and fruit-tree reservations.

80.9(1) *Determination of eligibility for exemption.* Property for which an application for exemption as a forest or fruit-tree reservation has been filed shall be inspected by the assessor or county conservation board. The county board of supervisors designates whether all inspections in the county are to be made by the assessor, including any city assessor, or by the county conservation board. When appropriate, aerial photographs may be used in place of an on-site inspection of the property. The assessment or exemption of the property is to be based upon criteria established by the state conservation commission and findings obtained by the inspection of the property or the examination of aerial photographs of the property.

80.9(2) *Application for exemption.*

a. An application for exemption must be filed with the appropriate assessor between January 1 and February 1, inclusive, of the assessment year for which the exemption is first claimed. If the inspection of the property is to be made by the county conservation board, the assessor shall forward the application to the board for its recommendation. Once the application has been accepted, the exemption is applicable to the current and subsequent assessment years and no further application shall be required so long as the property remains eligible for the exemption.

b. If February 1 falls on a Saturday or Sunday, an application for exemption may be filed the following Monday.

c. An application shall be considered to be timely filed if postmarked on or before February 1 or the following Monday if February 1 falls on a Saturday or Sunday.

80.9(3) *Notification to property owner.* If the property is to be inspected by the county conservation board, the board shall make every effort to submit its recommendation to the assessor in sufficient time for the assessor to notify the claimant by April 15. The assessor shall notify the claimant by April 15 of the disposition of the application for exemption. If because of the date on which an application is filed a determination of eligibility for the exemption cannot be made in sufficient time for notification to be made by April 15, the assessor shall assess the property and notify the property owner of the inability to act on the application. The notification shall contain the actual value and classification of the property and a statement of the claimant's right of appeal to the local board of review.

80.9(4) *Appeal of eligibility determination.* If a property for which a claim for exemption as a forest or fruit-tree reservation is assessed for taxation, the property owner may appeal the assessment to the board of review under Iowa Code section 441.37.

80.9(5) *Valuation of property.* For each assessment year for which property is exempt as a forest or fruit-tree reservation, the assessor shall determine the actual value and classification that would apply to the property were it assessed for taxation that year. In any year for which the actual value or classification of property so determined is changed, the assessor shall notify the property owner pursuant to Iowa Code sections 441.23, 441.26 and 441.28.

80.9(6) *Recapture tax.*

a. Assessment of property. If the county conservation board or the assessor determines a property has ceased to meet the eligibility criteria established by the state conservation commission, the property shall be assessed for taxation and subject to the recapture tax. The property shall be subject to taxes levied against the assessment made as of January 1 of the calendar year in which the property ceased to qualify for exemption. In addition, the property shall be subject to the tax which would have been levied against the assessment made as of January 1 of each of the five preceding calendar years for which the property received an exemption.

b. Assessment procedure. If the determination that a property has ceased to be eligible for exemption is made by the assessor by April 15, the assessor shall notify the property owner of the assessment as of January 1 of the year in which the determination is made in accordance with Iowa Code sections 441.23, 441.26, and 441.28. The assessment of the property for any of the five preceding years and for the current year, if timely notice by April 15 cannot be given, shall be by means of an omitted assessment as provided in Iowa Code section 443.6 (*Talley v. Brown,* 146 Iowa 360, 125 N.W. 243(1910)). Appeal of the omitted assessment may be taken pursuant to Iowa Code sections 443.7 and 443.8.

c. Computation of tax. The county auditor shall compute the tax liability for each year for which an assessment has been made pursuant to subrule 80.9(6), paragraph *"b."* The tax liability shall be the amount of tax that would have been levied against each year's assessment had the property not received the exemption. In computing the tax, the valuations established by the assessor shall be adjusted to reflect any equalization order or assessment limitation percentage applicable to each year's assessment.

d. Entry on tax list. The tax liability levied against assessments made as of January 1 of any year preceding the calendar year in which the property ceased to qualify for exemption shall be entered on the tax list for taxes levied against all assessments made as of January 1 of the year immediately preceding the calendar year in which the property ceased to qualify for exemption. However, if those taxes have already been certified to the county treasurer, the recapture taxes shall be entered on the tax list for taxes levied against assessments made as of January 1 of the year in which the property ceased to qualify for exemption. The tax against the assessment made as of January 1 of the year in which the property ceased to qualify for exemption shall be levied at the time taxes are levied against all assessments made as of that date.

e. Delinquencies. Recapture taxes shall not become delinquent until the time when all other unpaid taxes entered on the same tax list become delinquent.

f. Exceptions to recapture tax.

(1) Fruit-tree or forest reservations. Property which has received an exemption as a fruit-tree or forest reservation is not subject to the recapture tax if the property is maintained as a fruit-tree or forest reservation for at least five full calendar years following the last calendar year for which the property was exempt as a fruit-tree or forest reservation.

(2) Property which has been owned by the same person or the person's direct descendants or antecedents for at least ten years prior to the time the property ceases to qualify for exemption shall not be subject to the recapture tax.

(3) Property described in subparagraphs 80.9(6)*"f"*(1) and 80.9(6)*"f"*(2) is subject to assessment as of January 1 of the calendar year in which the property ceases to qualify for exemption.

This rule is intended to implement Iowa Code chapter 427C as amended by 2001 Iowa Acts, House File 736, and Iowa Code section 441.22.

[**ARC 7726B**, IAB 4/22/09, effective 5/27/09]

701—80.10(427B) Underground storage tanks.

80.10(1) *Authority of city councils and county boards of supervisors.* A city council or county board of supervisors may provide by ordinance to grant property tax credits to small business owners for payment of underground storage tank cleanup costs. The ordinance is to designate the period of time over which the credit is to be granted (not to exceed ten years) and the percentage of credit to be granted each

year. If the ordinance is repealed, existing credits are to continue through their designated expiration date. A small business means a business with gross receipts of less than $500,000 per year.

80.10(2) *Application for credit.* The small business owner is required to file an application for credit with the respective city council or county board of supervisors by September 30 of the year following the calendar year in which cleanup costs were paid and each succeeding year the credit is applicable. The application for credit shall be prescribed by the director of revenue and shall contain, but not be limited to, the small business owner's cleanup costs and gross receipts for the most recent tax year.

80.10(3) *Allowance of credit.* Credits granted by a county board of supervisors are applicable only to property located outside the corporate limits of a city and credits granted by a city council are only applicable to property located within the corporate limits of the city. The amount of the credit granted cannot exceed the small business owner's cleanup costs nor the amount of city or county taxes paid on the property where the underground storage tank is located for any fiscal year the credit is applicable. Upon approval of the application for credit, the city council or county board of supervisors shall direct its city clerk or county treasurer to reimburse the small business owner in the amount of the designated credit.

This rule is intended to implement Iowa Code sections 427B.20 to 427B.22.

701—80.11(425A) Family farm tax credit.

80.11(1) *Eligibility for credit.* Generally, the family farm tax credit is only intended to benefit tracts of agricultural land that are owned by certain individuals or enumerated legal entities if the owner or other specified persons are actively engaged in farming.

a. In order for a tract of land to qualify for the family farm tax credit, the following three criteria must be satisfied:

(1) The tract of land must be an "eligible tract of agricultural land" as defined in Iowa Code subsection 425A.2(5). This means the tract must be ten acres or more or contiguous to a tract of more than ten acres and used in good faith for agricultural or horticultural purposes. More than half of the acres in the tract must be devoted to the production of crops or livestock by a designated person. Contiguous tracts under the same legal ownership and located within the same county are considered one tract. Only tracts of land that are classified as agricultural real estate qualify for the credit.

(2) The tract of land must be owned by:

1. An individual or persons related or formerly related to each other, or
2. A partnership where all the partners are related or formerly related to each other, or
3. A family farm corporation as defined in Iowa Code subsection 9H.1(8), or
4. An authorized farm corporation as defined in Iowa Code subsection 9H.1(3).

The ownership criteria must be met on June 30 of the fiscal year prior to the fiscal year in which the application for credit is filed. For example, the ownership criteria must be met on June 30, 1990, for applications for credit filed in 1990.

(3) A designated person must be "actively engaged in farming" the tract during the fiscal year prior to the fiscal year in which the application for credit is filed. If the tract is owned by an individual or related persons, the designated person who is actively engaged in farming must be an owner of the tract, the owner's spouse, or the owner's relative within the third degree of consanguinity or their spouses. This includes the owner's child, stepchild, grandchild, great-grandchild, parent, grandparent, great-grandparent, brother, sister, uncle, aunt, niece, or nephew or their spouses. The only step relative that may qualify as a designated person is a stepchild. If the owner of the tract is a partnership, the designated person who is actively engaged in farming must be a partner or a partner's spouse. If the owner of the tract of land is a family farm corporation, the designated person who is actively engaged in farming must be a family member who is a shareholder of the family farm corporation or the shareholder's spouse. If the owner of the tract of land is an authorized farm corporation, the designated person who is actively engaged in farming must be the shareholder who owns at least 51 percent of the stock of the authorized farm corporation or that shareholder's spouse.

If the owner is an individual who leases the land to a family farm corporation or partnership, a shareholder of the corporation or a partner of the partnership shall be considered a designated person if

the combined stock of the family farm corporation or the combined partnership interest owned by the owner, the owner's spouse and persons related to the owner within the third degree of consanguinity and their spouses is equal to at least 51 percent of the stock of the family farm corporation or the ownership interest in the partnership.

b. In order to be "actively engaged in farming" the designated person must be personally involved in the production of crops or livestock on the "eligible tract" on a regular, continuous and substantial basis. Personal involvement in the production of crops or livestock includes not only field activities such as soil preparation and testing, planting, fertilizing, spraying, inspecting, cultivating and harvesting but also managerial decision-making activities relating to hybrid selection, crop rotation planning, crop selection, equipment purchases and marketing strategies. Personal involvement in the production of crops or livestock also includes activities pertaining to crop insurance selection, loan selection, and financial record maintenance and preparation. A person performing activities in the capacity of a lessor, whether under a cash or crop-share lease and whether under a written or oral lease, is not actively engaged in farming on the area of the tract covered by the lease.

c. Tracts subject to a federal program pertaining to agricultural land. In lieu of satisfying the "actively engaged in farming" test, a designated person may demonstrate that the person was in general control of the tract which was subject to a federal program pertaining to agricultural land during the prior fiscal year. This alternative test is intended to apply in circumstances where the active farming criteria cannot be met because the land is in the Conservation Reserve Program (commonly referred to as the CRP) or a program substantially similar to the 0/92 option where the tract has been taken out of production.

d. The following examples illustrate family farm tax credit eligibility under various circumstances:

EXAMPLE 1. A and B jointly own land and were both personally involved in the farming operation. They are not related. No credit is allowable because it is a requirement that individual owners be related. If A and B were brothers, the land would qualify for the credit.

EXAMPLE 2. A owns the land and is retired. A leased the land to B, his son. B was personally involved in the farming operation. The land is eligible for the credit even though a lease arrangement existed because the actively engaged in farming requirement can be satisfied through the activities of the owner's spouse, or the owner's relative within the third degree of consanguinity or the relative's spouse. See paragraph *"a,"* subparagraph (3), of this subrule. No credit would be allowable if A and B were not related.

EXAMPLE 3. A owns two contiguous 40-acre tracts. A farmed all of one tract but only 15 acres of the other tract. The other 25 acres of the second tract were leased to a nondesignated person. Both tracts qualify for the credit because contiguous tracts under the same legal ownership are considered one tract and more than half of the total of 80 acres (40 + 15 = 55) were farmed by A.

EXAMPLE 4. The land is owned by a partnership in which the partners A, B, C and D are brothers. A and B farm the land but C and D have no involvement in the farming operation. The land is eligible for the credit because it makes no difference what level of involvement each partner had nor does it matter that one or more of the partners were not personally involved in the farming operation. The only requirement for qualifying for the credit is that at least one of the partners or one of the partners' spouses was personally involved in the farming operation. No credit would be allowable if all the partners were not related to each other.

EXAMPLE 5. The land is owned by a family farm corporation in which the stock is owned equally by A, B and C. A and B are brothers but not related to C. All three partners were personally involved in the farming operation. The land qualifies for the credit because it is only a requirement that a family member who is a shareholder in the family farm corporation be involved in the farming operation. The land would qualify for the credit even if B was not involved in the farming operation. However, no credit would be allowable if only C was involved in the farming operation.

EXAMPLE 6. The land is owned by an authorized farm corporation in which 60 percent of the stock is owned by A and 40 percent of the stock is owned by B. Both A and B were personally involved in the farming operation. The credit is allowable as long as the stockholder who owns at least 51 percent of

the stock was personally involved in the farming operation. No credit would be allowable if A was not personally involved in the farming operation.

80.11(2) *Application for credit.* To obtain the credit, the owner must file an application for credit with the assessor by November 1. If the claim for credit is approved, no further filing shall be required provided the ownership and the designated person actively engaged in farming the property remain the same during successive years. A new application for credit shall be required only if the property is sold or the designated person changes. The county board of supervisors shall review all claims and make a determination as to eligibility. The claimant may appeal a decision of the board to district court by giving written notice to the board within 20 days of the board's notice.

80.11(3) *Application of credit.* The county auditor shall certify to the department of revenue by April 1 the total amount of family farm tax credits due the county. The county auditor shall apply the credit to each eligible tract of land in an amount equal to the school district tax rate which is in excess of $5.40 multiplied by the taxable value of the eligible tract.

80.11(4) *Penalty.* The owner shall provide written notice to the assessor if the designated person changes. Failure to do so shall result in the owner's being liable for the amount of the credit plus a penalty equal to 5 percent of the amount of the credit granted.

This rule is intended to implement Iowa Code chapter 425A as amended by 2001 Iowa Acts, House Files 712 and 713.

701—80.12(427) Methane gas conversion property.

80.12(1) *Application for exemption.* An application for exemption is required to be filed with the appropriate assessing authority by February 1 of each year. The assessed value of the property is to be prorated to reflect the appropriate amount of exemption if the property used to convert the methane gas to energy also uses another fuel. The first year exemption shall be equal to the estimated ratio that the methane gas consumed bears to the total fuel consumed times the assessed value of the property. The exemption for subsequent years shall be based on the actual ratio for the previous year.

80.12(2) *Eligibility for exemption.* To qualify for exemption, the property must be used either in an operation that decomposes waste and converts it to methane gas or other gases produced as a byproduct of waste decomposition, then collects the gases and converts them to energy; or in an operation that collects waste in order to decompose it to produce methane gas or other gases for conversion into energy. The exemption applies to both property used in connection with, or in conjunction with, a publicly owned sanitary landfill and to property not used in connection with, or in conjunction with, a publicly owned sanitary landfill.

The exemption for property not used in an operation connected with, or in conjunction with, a publicly owned sanitary landfill is limited to property originally placed in operation on or after January 1, 2008, and on or before December 31, 2012, and will be available for the ten-year period following the date the property was originally placed in operation.

This rule is intended to implement Iowa Code section 427.1(29) as amended by 2009 Iowa Acts, Senate File 478, section 224.

[**ARC 7726B**, IAB 4/22/09, effective 5/27/09; **ARC 8358B**, IAB 12/2/09, effective 1/6/10]

701—80.13(427B,476B) Wind energy conversion property.

80.13(1) *Special valuation allowed by ordinance.* A city council or county board of supervisors may provide by ordinance for the special valuation of wind energy conversion property. If the ordinance is repealed, the special valuation applies through the nineteenth assessment year following the first year the property was assessed. Once the ordinance has been repealed and the special valuation is no longer applicable, the property must be valued at market value rather than at 30 percent of net acquisition cost. The special valuation applies to property first assessed on or after the effective date of the ordinance. The local assessor must value the property in accordance with the schedule provided in Iowa Code section 427B.26(2). The property qualifies for special valuation provided the taxpayer files a declaration of intent with the local assessor by February 1 of the assessment year in which the property is first assessed for tax to have the property locally assessed. The property must not be assessed until the assessment

year following the year the entire wind plant is completed. A wind plant is completed when it is placed in service.

80.13(2) *Special valuation not allowed by ordinance.* If a city council or county board of supervisors has not passed an ordinance providing for the special valuation of wind energy conversion property, the property is to be assessed by the department of revenue for a period of 12 years, and the taxes payable on the facilities are to be paid to the department at the same time as regular property taxes. The owner of the facility must file an annual report with the department by May 1 of each year during the 12-year assessment period, and the department must certify the assessed value of the facility by November 1 of each year to the county auditor. The board of supervisors must notify the county treasurer to state on the tax statement that the property taxes are to be paid to the department. The board must also notify the department of those facilities that are required to pay the property taxes to the department. The department must notify the county treasurer of the date the taxes were paid within five business days of receipt, and the notification is authorization for the county treasurer to mark the record as paid in the county system.

This rule is intended to implement Iowa Code section 427B.26 and chapter 476B as amended by 2009 Iowa Acts, Senate File 456, sections 2 and 4.

[**ARC 7726B**, IAB 4/22/09, effective 5/27/09; **ARC 8358B**, IAB 12/2/09, effective 1/6/10]

701—80.14(427) Mobile home park storm shelter.

80.14(1) *Application for exemption.* An application for exemption must be filed with the assessing authority by February 1 of the first year the exemption is requested. Applications for exemption are not required in subsequent years if the property remains eligible for exemption.

80.14(2) *Eligibility for exemption.* The structure must be located in a mobile home park as defined in Iowa Code section 435.1.

80.14(3) *Valuation exempted.* If the structure is used exclusively as a storm shelter, it shall be fully exempt from taxation. If the structure is not used exclusively as a storm shelter, the exemption shall be limited to 50 percent of the structure's commercial valuation.

This rule is intended to implement Iowa Code Supplement section 427.1(30).

701—80.15(427) Barn and one-room schoolhouse preservation. The increase in value added to a farm structure constructed prior to 1937 or one-room schoolhouse as a result of improvements made is exempt from tax. An application must be filed with the assessor by February 1 of the first assessment year only and the exemption is to continue as long as the structure continues to be used as a barn or in the case of a one-room schoolhouse is not used for dwelling purposes. A "barn" is an agricultural structure that is used for the storage of farm products or feed or the housing of farm animals, poultry, or farm equipment.

This rule is intended to implement Iowa Code sections 427.1(31) and 427.1(32) as amended by 2000 Iowa Acts, House File 2560.

701—80.16(426) Agricultural land tax credit.

80.16(1) *Eligibility for credit.* The credit shall be allowed on land in tracts of ten acres or more, or land of less than ten acres if part of other land of more than ten acres, and used for agricultural or horticultural purposes.

80.16(2) *Application for credit.* No application for credit is required.

80.16(3) *Application of credit.* The county auditor shall certify to the department of revenue by April 1 the total amount of agricultural land tax credits due the county. The county auditor shall apply the credit to each eligible tract of land in an amount equal to the school district tax rate which is in excess of $5.40 multiplied by the taxable value of the eligible tract.

This rule is intended to implement Iowa Code chapter 426 as amended by 2001 Iowa Acts, House File 713.

701—80.17(427) Indian housing property. Property owned and operated by an Indian housing authority, as defined in 24 CFR 950.102, is exempt from taxation provided the exemption has been

approved by the city council or county board of supervisors, whichever is applicable, and a valid claim for exemption has been filed pursuant to Iowa Code section 427.1(14) by February 1.

This rule is intended to implement Iowa Code section 427.1 as amended by 2001 Iowa Acts, Senate File 449.

701—80.18(427) Property used in value-added agricultural product operations. Fixtures used for cooking, refrigeration, or freezing of value-added agricultural products used in value-added agricultural processing or used in direct support of value-added agricultural processing are exempt from tax. Direct support includes storage by public refrigerated warehouses for processors of value-added agricultural products prior to the start of the value-added agricultural processing operation. The exemption does not apply to fixtures used primarily for retail sale or display. If the taxpayer is a retailer, there is a presumption that the fixtures are being used primarily for retail sale or display. The exemption applies only to fixtures that are attached in a manner set forth in Iowa Code section 427A.1(2).

The following definitions apply to this rule:

"Fixture" means property which was originally personal property but which by being physically attached to the realty becomes part of the realty and upon removal does not destroy the property to which it is attached.

"Value-added agricultural processing" means an operation whereby an agricultural product is subjected to some special treatment by artificial or natural means which changes its form, context, or condition, and results in a marketable agricultural product to be sold at retail. These operations are commonly associated with fabricating, compounding, germinating, or manufacturing.

"Value-added agricultural product" means an agricultural product which, through a series of activities or processes, may be sold at a higher price than its original purchase price.

This rule is intended to implement Iowa Code section 427A.1 as amended by 2001 Iowa Acts, House File 715.

701—80.19(427) Dwelling unit property within certain cities. Dwelling unit property owned and managed by a nonprofit community housing development organization that owns and manages more than 150 dwelling units in a city with a population of more than 110,000 is exempt from tax. The organization must be recognized by the state and the federal government pursuant to criteria contained in the HOME program of the federal National Affordable Housing Act of 1990 and must be exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code. The exemption does not extend to dwelling units located outside the city. The organization must file an application for exemption with the assessing authority not later than February 1 of the assessment year. Applications for exemption are not required in successive years if the property continues to qualify for the exemption.

This rule is intended to implement Iowa Code Supplement section 427.1(21A) as amended by 2006 Iowa Acts, House File 2792.

701—80.20(427) Nursing facilities. If the assessor determines that property is being used for a charitable purpose pursuant to Iowa Code section 427.1(8), it shall be fully exempt from tax if it is licensed under Iowa Code section 135C.1(13) by the department of inspections and appeals, exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code, and a valid application for exemption has been filed with the assessor by February 1 of the assessment year.

This rule is intended to implement Iowa Code Supplement section 427.1(14).

701—80.21(368) Annexation of property by a city. A city council may provide a partial tax exemption from city taxes against annexed property for a period of ten years. The exemption schedule is contained in Iowa Code Supplement section 368.11(3)*"m."* All property owners included in the annexed area must receive the exemption if the city elects to allow the exemption.

This rule is intended to implement Iowa Code Supplement section 368.11(3)*"m"* as amended by 2006 Iowa Acts, House File 2794.

701—80.22(427) Port authority. The property of a port authority created pursuant to Iowa Code Supplement section 28J.2 when devoted to public use and not held for pecuniary profit is exempt from taxation.

This rule is intended to implement Iowa Code Supplement section 427.1(34).

701—80.23(427A) Concrete batch plants and hot mix asphalt facilities. A concrete batch plant includes the machinery, equipment, and fixtures used at a concrete mixing facility to process cement dry additive and other raw materials into concrete. A hot mix asphalt facility is any facility used to manufacture hot mix asphalt by heating and drying aggregate and mixing it with asphalt cements. These facilities shall not be assessed and taxed as real property regardless of the property's attachment to real estate. The land on which the facilities are located is taxable.

This rule is intended to implement Iowa Code section 427A.1 as amended by 2006 Iowa Acts, Senate File 2391.

701—80.24(427) Airport property. Property owned by a city or county at an airport and leased to a fixed base operator providing aeronautical services to the public is exempt from taxation.

This rule is intended to implement Iowa Code section 427.1(2) as amended by 2006 Iowa Acts, House File 2794.

701—80.25(427A) Car wash equipment. Property that is equipment used for the washing, waxing, drying, or vacuuming of motor vehicles and point-of-sale equipment necessary for the purchase of car wash services shall not be assessed and taxed as real property.

This rule is intended to implement Iowa Code section 427A.1 as amended by 2006 Iowa Acts, House File 2794.

701—80.26(427) Web search portal and data center business property. This exemption includes computers and equipment necessary for the maintenance and operation of a web search portal or data center business, including cooling systems, cooling towers, and other temperature control infrastructure; power infrastructure for transformation, distribution, or management of electricity, including but not limited to exterior dedicated business-owned substations, and power distribution systems which are not subject to assessment under Iowa Code chapter 437A; back-up power generation systems, battery systems, and related infrastructure; and racking systems, cabling, and trays. The exemption does not apply to land, buildings, and improvements. The web search portal or data center business must meet the requirements contained in Iowa Code section 423.3, subsection 92, subsection 93, or subsection 95, for the exemption to be allowable. The owner of the property must file a claim for exemption with the assessor by February 1 of the first year the exemption is claimed. Claims for exemption in successive years will be required only for property additions.

This rule is intended to implement Iowa Code sections 427.1(35) and 427.1(36) and section 427.1 as amended by 2009 Iowa Acts, Senate File 478, section 200.
[**ARC 8358B**, IAB 12/2/09, effective 1/6/10]

701—80.27(427) Privately owned libraries and art galleries. Claims for exemption for libraries and art galleries owned and kept by private individuals, associations, or corporations for public use and not for private profit must be filed with the local assessor by February 1 of the first year the exemption is requested. Once the exemption is granted, the exemption shall continue to be granted for subsequent assessment years without further filing of claims as long as the property continues to be used as a library or art gallery for public use and not for private profit.

This rule is intended to implement Iowa Code Supplement section 427.1(7) as amended by 2008 Iowa Acts, Senate File 2400.

701—80.28(404B) Disaster revitalization area. The governing body of a city or county may, by ordinance, designate an area of the city or county a disaster revitalization area if that area is within a county or portion of a county in which the governor has proclaimed a disaster emergency or the

United States president has declared a major disaster. All real property within a disaster revitalization area is eligible to receive a 100 percent exemption from taxation on the increase in assessed value of the property if the increase in assessed value is attributable to revitalization of the property occurring between May 25, 2008, and December 31, 2013. The amount of increase in value shall be the difference between the assessed value of the property on January 1, 2007, and the assessed value of the property on January 1, 2010, and subsequent assessment years. The exemption is for a period not to exceed five years, starting with an assessment year beginning on or after January 1, 2010. A city or county may adopt a tax exemption percentage different from the 100 percent exemption. The different percentage adopted must not allow a greater exemption, but may allow a smaller exemption. If the homeowner elects to take the exemption provided in this rule, the homeowner may not claim any other value-added exemption. An application must be filed for each revitalization project resulting in increased assessed value for which an exemption is claimed. The application for exemption must be filed by the owner of the property with the local assessor by February 1 of the first assessment year for which the exemption is requested. After the tax exemption is granted, the exemption will continue for succeeding years without the taxpayer's having to file an application for exemption unless additional revitalization projects occur on the property. The ordinance must expire or be repealed no later than December 31, 2016.

This rule is intended to implement 2009 Iowa Acts, Senate File 457, sections 23 to 30.

[**ARC 8358B**, IAB 12/2/09, effective 1/6/10]

701—80.29 to **80.49** Reserved.

701—80.50(427,441) Responsibility of local assessors.

80.50(1) The assessor shall determine the taxable status of all property. If an application for exemption is required to be filed, the assessor shall consider the information contained in the application in determining the taxable status of the property. The assessor may also request from any property owner or claimant any additional information necessary to the determination of the taxable status of the property. For property subject to Iowa Code subsection 427.1(14), the assessor shall not base the determination of the taxable status of property solely on the statement of objects or purposes of the organization, institution, or society seeking an exemption. The use of the property rather than the objects or purposes of the organization, institution, or society shall be the controlling factor in determining the taxable status of property. (*Evangelical Lutheran G.S. Society v. Board of Review of Des Moines,* 200 N.W.2d 509; *Northwest Community Hospital v. Board of Review of Des Moines,* 229 N.W.2d 738.)

80.50(2) In determining the taxable status of property, the assessor shall construe the appropriate exemption statute and these rules in a strict manner. If there exists any doubt as to the taxable status of property, the property shall be subject to taxation. The burden shall be upon the claimant to show that the exemption should be granted. (*Evangelical Lutheran G.S. Society v. Board of Review of Des Moines,* 200 N.W.2d 509; *Southside Church of Christ of Des Moines v. Des Moines Board of Review,* 243 N.W.2d 650; *Aerie 1287, Fraternal Order of Eagles v. Holland,* 226 N.W.2d 22.)

80.50(3) If the assessor determines that all or part of a property is subject to taxation, the assessor shall notify the taxpayer by the issuance of an assessment roll as provided in Iowa Code sections 441.26 and 441.27. If the assessor determines that property has been erroneously exempted from taxation, the assessor shall revoke the exemption for the current assessment year but not for prior assessment years.

80.50(4) The assessor's determination of the taxable status of property may be appealed to the local board of review pursuant to Iowa Code section 441.37.

This rule is intended to implement Iowa Code chapter 427 and sections 441.17(11), 441.26, and 441.27.

[**ARC 7726B**, IAB 4/22/09, effective 5/27/09]

701—80.51(441) Responsibility of local boards of review.

80.51(1) If the board of review determines that property has been erroneously exempted from taxation, the board of review shall revoke the exemption for the current assessment year, but not for prior assessment years, and shall give notice to the taxpayer as provided in Iowa Code section 441.36.

80.51(2) If the board of review acts in response to a protest arising from an assessor's determination of the taxable status of property, the board of review shall notify the taxpayer of its disposition of the protest in accordance with the provisions of Iowa Code section 441.37.

This rule is intended to implement Iowa Code sections 441.35, 441.36, and 441.37.
[**ARC 7726B**, IAB 4/22/09, effective 5/27/09]

701—80.52(427) Responsibility of director of revenue. The director may revoke or modify an exemption on property if the exemption is found to have been erroneously granted by the local taxing officials. Any taxpayer or taxing district may request that the director revoke or modify an exemption, or the director may on the director's own determination revoke or modify an exemption. The director may revoke or modify an exemption for the tax year commencing in the tax year in which the request is made to the director or for the tax year commencing in the tax year in which the director's own motion is filed. The director shall hold a hearing on the appropriateness of the exemption prior to issuing an order for revocation or modification. The director's order to revoke or modify an exemption may be appealed in accordance with Iowa Code chapter 17A or in the district court of the county in which the property is located.

This rule is intended to implement Iowa Code section 427.1(16).
[**ARC 7726B**, IAB 4/22/09, effective 5/27/09]

701—80.53(427) Application for exemption.

80.53(1) Each society or organization seeking an exemption under Iowa Code subsection 427.1(5), 427.1(8), 427.1(21), or 427.1(33) shall file with the appropriate assessor a statement containing the following information:

a. The legal description of the property for which an exemption is requested.

b. The use of all portions of the property, including the percentage of space not used for the appropriate objects of the society or organization and the percentage of time such space is so utilized.

c. A financial statement showing the income derived and the expenses incurred in the operation of the property.

d. The name of the organization seeking the exemption.

e. If the exemption is sought under Iowa Code subsection 427.1(8), the appropriate objects of the society or organization.

f. The book and page number on which is recorded the contract of purchase or the deed to the property and any lease by which the property is held.

g. An oath that no persistent violations of the laws of the state of Iowa will be permitted or have been permitted on such property.

h. The signature of the president or other responsible official of the society or organization showing that information contained in the claim has been verified under oath as correct.

80.53(2) The statement of objects and uses required by Iowa Code subsection 427.1(14) shall be filed only on forms prescribed by the director of revenue and made available by assessors.

80.53(3) Applications for exemptions required under Iowa Code subsection 427.1(14) must be filed with the assessor not later than February 1 of the year for which the exemption is requested.

80.53(4) If a properly completed application is not filed by February 1 of the assessment year for which the exemption would apply, no exemption shall be allowed against the property for that year (1964 O.A.G. 437).

This rule is intended to implement Iowa Code section 427.1, subsections 5, 8, 14, 19 to 24, 27, and 29 to 33.
[**ARC 7726B**, IAB 4/22/09, effective 5/27/09]

701—80.54(427) Partial exemptions. In the event a portion of property is determined to be subject to taxation and a portion of the property exempt from taxation, the taxable value of the property shall be an amount which bears the same relationship to the total value of the entire property as the area of the portion subject to taxation bears to the area of the entire property. If a portion of a structure is subject

to taxation, a proportionate amount of the value assigned to the land upon which the structure is located shall also be subject to taxation.

This rule is intended to implement Iowa Code subsection 427.1(14).
[**ARC 7726B**, IAB 4/22/09, effective 5/27/09]

701—80.55(427,441) Taxable status of property.

80.55(1) The status of property on July 1 of the fiscal year which commences during the assessment year determines eligibility of the property for exemption in situations where no claim is required to be filed to procure a tax exemption. If the property is in a taxable status on July 1, no exemption is allowable for that fiscal year. If the property is in an exempt status on July 1, no taxes are to be levied against the property during that fiscal year. Exceptions to this rule are as follows:

a. Land acquired by the state of Iowa or a political subdivision thereof after July 1 in connection with the establishment, improvement, or maintenance of a public road shall be taxable for that portion of the fiscal year in which the property was privately owned.

b. All current and delinquent tax liabilities are to be canceled and no future taxes levied against property acquired by the United States or its instrumentalities, regardless of the date of acquisition, unless the United States Congress has authorized the taxation of specific federally owned property (1980 O.A.G. 80-1-19). The following exceptions apply:

(1) Property owned by the Federal Housing Authority (FHA) and property owned by the Federal Land Bank Association are subject to taxation, and any tax liabilities existing at the time of the acquisition are not to be canceled (1982 O.A.G. 82-1-16; 12 USCS §2055).

(2) Existing tax liabilities against property acquired by the Small Business Administration are not to be canceled if the acquisition takes place after the date of levy. However, no taxes are to be levied if the acquisition takes place prior to the levy date or for subsequent fiscal years in which the Small Business Administration owns the property on July 1 (15 USCS §646).

c. Land owned by the state and leased by the department of corrections or the department of human services pursuant to Iowa Code section 904.302, 904.705, or 904.706 to an entity that is not exempt from property tax is subject to taxation for the term of the lease. This provision applies to leases entered into on or after July 1, 2003. The lessor shall file a copy of the lease with the county assessor of the county where the land is located.

80.55(2) The status of property during the fiscal year for which an exemption was claimed determines eligibility of the property for exemption in situations where a claim is required to be filed to procure a tax exemption. If the property is used for an appropriate purpose for which an exemption is allowable for all of the fiscal year for which the exemption is claimed, no taxes are to be levied against the property during that fiscal year. If the property for which an exemption has been claimed and received is used for an appropriate purpose for which an exemption is allowable for only a portion of the fiscal year for which the exemption is claimed, the taxes shall be prorated in accordance with the period of time the property was in a taxable status during the fiscal year.

This rule is intended to implement Iowa Code sections 427.1(1), 427.1(2), 427.2, 427.18, and 427.19.
[**ARC 7726B**, IAB 4/22/09, effective 5/27/09]

701—80.56(427) Abatement of taxes. The board of supervisors may abate the taxes levied against property acquired by gift or purchase if the property was acquired after the deadline for filing a claim for property tax exemption if the property would have been exempt under Iowa Code section 427.1, subsection 7, 8, or 9, if a timely claim had been filed.

This rule is intended to implement Iowa Code section 427.3.
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◊ Two or more ARCs

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Rules transferred from agency number [820] to [761] to conform with the reorganization numbering scheme in general IAC Supp. 6/3/87.

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CHAPTER 601
APPLICATION FOR LICENSE

761—601.1(321) Application for license.

601.1(1) *General.* In addition to the information required under Iowa Code sections 321.182 and 321.196, the information in this rule is required from an applicant for a driver's license. Additional requirements for a commercial driver's license are found in 761—Chapter 607.

601.1(2) *Name.* The applicant's full name shall be given on the application. Civilian and military titles and nicknames shall not be used.

601.1(3) *Out-of-state verification.* If a person is licensed in another licensing jurisdiction but does not have a current out-of-state license to surrender, the department may require an official letter from the out-of-state licensing agency before issuing a license. The official letter must verify the person's driving record to assist the department in determining whether it is safe to grant the person a license.

601.1(4) *Disabilities.* The applicant shall indicate and explain any mental or physical disabilities which might affect the applicant's ability to operate a motor vehicle safely.

601.1(5) *Physical description.* Physical description shall include the applicant's weight to the nearest pound.

601.1(6) *Address.* The applicant shall provide the applicant's residential address and mailing address, if different from the residential address.

601.1(7) *Signature.*

a. The applicant's signature shall be without qualification and shall contain only the applicant's usual signature without any other titles, characters or symbols.

b. The applicant's signature certifies that the statements on the application are true and the fee collected was correct.

c. The applicant's signature acknowledges that the applicant is aware of the requirement to notify the department of a change in mailing address within 30 days of the change.

d. A driver's license clerk or examiner will initial the application as witness.

This rule is intended to implement Iowa Code sections 321.182, 321.196 and 321C.1, Article V.

761—601.2(321) Surrender of license and nonoperator's identification card. An applicant for a driver's license shall surrender all other driver's licenses and nonoperator's identification cards. This includes those issued by jurisdictions other than Iowa.

This rule is intended to implement Iowa Code section 321.182.

761—601.3 and **601.4** Reserved.

761—601.5(321) Proofs submitted with application. A person who applies for a new driver's license or nonoperator's identification card or a duplicate license or card to replace one that is lost or destroyed shall submit proof of age, identity and social security number.

601.5(1) *Social security number verification.* One or more of the following documents may be accepted as verification of an applicant's social security number. The documents must be issued in the United States.

a. Social security card issued by the Social Security Administration. A metal version of the card is not acceptable.

b. Letter from the Social Security Administration.

c. Document issued by the Internal Revenue Service or a state tax agency. Form W-2 tax form completed by the employer is acceptable.

d. Financial statement containing the social security number.

e. Payroll stub containing the social security number.

f. Military identification card containing the social security number.

601.5(2) *Proof of age and identity.* An applicant shall submit one primary document and one secondary document from the following lists as proof of age and identity. The documents must be issued in the United States unless otherwise specified.

a. Acceptable primary documents include:

(1) An Iowa photo driver's license.

(2) An Iowa photo identification card.

(3) Birth certificate issued in the United States. It must be a certified copy, have the stamp or raised seal of the issuing authority, and be issued by the state bureau of vital statistics, the state board of health, or a comparable agency. A hospital-issued certificate is not acceptable.

(4) United States Citizenship and Immigration Service document from the following list:

1. Certificate of Naturalization (N-550, N-570 or N-578).
2. Certificate of Citizenship (N-560, N-561 or N-645).
3. Permanent Resident Card (I-551).
4. Record of Arrival and Departure (I-94) with attached photo that is stamped "Temporary Proof of Lawful Permanent Resident."
5. "Processed for I-551" stamp in a valid foreign passport.
6. Travel Document indicating Permit to Re-enter (I-327) or Refugee Travel Document (I-571).
7. Record of Arrival and Departure (I-94) in a Certificate of Identity.
8. Employment Authorization Card (I-688A, I-688B, or I-766).
9. Record of Arrival and Departure (I-94) stamped "Refugee," "Parole," "Parolee," or "Asylee."
10. Record of Arrival and Departure (I-94) coded Section 207 (Refugee), Section 208 (Asylum), Section 209 (Refugees), Section 212d(5) (Parolee), HP (Humanitarian Parolee), or PIP (Public Interest Parolee).

(5) Military identification card. This does not include a military dependent identification card.

(6) Valid United States passport.

(7) Inmate Descriptor Inquiry, Client Information Inquiry or Offender Snapshot document issued by the Iowa department of corrections. The document must contain the full name and date of birth and be notarized.

b. Acceptable secondary documents include:

(1) Any primary document.

(2) Bureau of Indian Affairs or Indian Treaty Card. A tribal identification card is not acceptable.

(3) Photo driver's license or state-issued photo identification card that has not been expired for more than one year.

(4) Court order that does not contain the applicant's date of birth but does contain the full name.

(5) Foreign birth certificate. It must be translated by an approved translator, if translation is necessary.

(6) Military discharge, military orders or separation papers.

(7) Military dependent identification card.

(8) Employer identification card.

(9) Health insurance card.

(10) Document issued by the Internal Revenue Service or a state tax agency. Form W-2 tax form completed by the employer is acceptable.

(11) Marriage certificate.

(12) Gun permit.

(13) Pilot's license.

(14) School record or transcript. It must be certified.

(15) Social security card issued by the Social Security Administration. A metal version of the card is not acceptable.

(16) Social insurance card issued by the Canadian government.

(17) Photo student identification card.

(18) Voter registration card.

(19) Welfare card.

(20) Prison release document.

(21) Parent or guardian affidavit. The parent or guardian must appear in person, submit proof of the parent's or guardian's age and identity, and submit a certified or notarized affidavit regarding the child's identity. This applies only to minors.

c. The department may require additional documentation if the department believes that the documentation submitted is questionable or if the department has reason to believe that the person is not who the person claims to be.

601.5(3) *Name change verification.* The name listed on the license or nonoperator's identification card that is issued shall be identical to the name contained on the primary document submitted unless the applicant submits an affidavit of name change on Form 430043. The affidavit must be accompanied by one of the following documents:

a. Court-ordered name change. It must contain the full name, date of birth, and court seal.

b. Divorce decree.

c. Marriage certificate.

This rule is intended to implement Iowa Code sections 321.182 and 321.189.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—601.6(321) Parental consent. An unmarried person under the age of 18 who applies for an Iowa license shall submit parental consent and birth date confirmation on Form 430018, Parent's Written Consent to Issue Privilege to Drive or Affidavit to Obtain Duplicate. The parent's signature must be notarized; however, in lieu of notarization it may be witnessed by a driver's license examiner or clerk. No exception shall be made for parental absence from Iowa. A married person under the age of 18 shall submit an original or certified copy of a marriage certificate to avoid submission of the consent form.

This rule is intended to implement Iowa Code section 321.184.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—601.7(321) REAL ID driver's license. A person who seeks a driver's license that is compliant with the REAL ID Act of 2005, 49 U.S.C. § 30301 note, as further defined in 6 CFR Part 37 ("REAL ID driver's license"), must meet and comply with all lawful requirements for an Iowa driver's license, and must also meet and comply with all application and documentation requirements set forth at 6 CFR Part 37, including but not limited to documentation of identity, date of birth, social security number, address of principal residence, and evidence of lawful status in the United States. Documents and information provided to fulfill REAL ID requirements must be verified as required in 6 CFR 37.13. An applicant for a REAL ID driver's license is subject to a mandatory facial image capture that meets the requirements of 6 CFR 37.11(a). A REAL ID driver's license may not be issued, reissued, or renewed except as permitted in 6 CFR Part 37 and may not be issued, reissued, or renewed by any procedure, in any circumstance, to any person, or for any term prohibited under 6 CFR Part 37. The information on the front of any REAL ID driver's license must include all information and markings required by 6 CFR 37.17. Nothing in this rule requires a person to obtain a REAL ID driver's license.

This rule is intended to implement Iowa Code chapter 321, the REAl ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[**ARC 8339B**, IAB 12/2/09, effective 12/21/09]

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[Filed Emergency ARC 8339B, IAB 12/2/09, effective 12/21/09]

CHAPTER 630
NONOPERATOR'S IDENTIFICATION

[Prior to 6/3/87, see Transportation Department[820]—(07,C)Ch 12]

761—630.1(321) General information.

630.1(1) The department shall issue a nonoperator's identification card only to an Iowa resident who does not have a driver's license. However, a card may be issued to a person holding a temporary permit under Iowa Code section 321.181.

630.1(2) Information concerning the nonoperator's identification card is available at any driver's license examination station, or at the address in 761—600.2(17A).

761—630.2(321) Application and issuance.

630.2(1) An applicant for a nonoperator's identification card shall complete and sign an application form at a driver's license examination station. The signature shall be without qualification and shall contain only the applicant's usual signature without any other titles, characters or symbols.

630.2(2) The applicant shall present proof of age, identity and social security number as required by rule 761—601.5(321). Submission of parental consent is also required in accordance with rule 761—601.6(321).

630.2(3) The nonoperator's identification card shall be coded for identification only, as explained on the reverse side of the card. The county number shall indicate the county of residence. The card shall expire five years from the date of issue if the applicant is under the age of 70.

630.2(4) Upon the request of the cardholder, the department shall indicate on the nonoperator's identification card the presence of a medical condition, that the cardholder is a donor under the uniform anatomical gift law, or that the cardholder has in effect a medical advance directive.

630.2(5) The issuance fee is $5. However, no issuance fee shall be charged for a person whose license has been suspended for incapability pursuant to rule 761—615.14(321) or who has been denied further licensing in lieu of a suspension for incapability pursuant to rule 761—615.4(321).

630.2(6) This subrule establishes the criteria for waiver or refund of fees.

a. The department may waive payment of or refund the fee for a renewal or duplicate of a nonoperator's identification card if:

(1) An error occurs during the issuance process and is discovered by the applicant at the time of issuance. However, the fee shall not be waived or refunded if the error is discovered by department staff and is corrected within the 30-minute time period specified in subparagraph (3).

(2) An error occurs during the issuance process and is discovered during the edit process of updating the identification record, and the error requires the applicant to return to the driver's license station to have the error corrected.

(3) The applicant is required to wait more than 30 minutes to renew a nonoperator's identification card or obtain a duplicate card. This 30-minute time period is determined by using an automated customer numbering system that monitors waiting time.

b. The department shall not waive payment of or refund a fee if the applicant does not have in the applicant's possession at the time of application the previously issued nonoperator's identification card.

c. The department shall not waive payment of or refund fees for new applications.

d. Rescinded IAB 11/8/06, effective 12/13/06.

630.2(7) A person who seeks a nonoperator's identification card that is compliant with the REAL ID Act of 2005, 49 U.S.C. § 30301 note, as further defined in 6 CFR Part 37 ("REAL ID nonoperator's identification card"), must meet and comply with all lawful requirements for an Iowa nonoperator's identification card, and must also meet and comply with all application and documentation requirements set forth at 6 CFR Part 37, including but not limited to documentation of identity, date of birth, social security number, address of principal residence, and evidence of lawful status in the United States. Documents and information provided to fulfill REAL ID requirements must be verified as required in 6 CFR 37.13. An applicant for a REAL ID nonoperator's identification card is subject to a mandatory facial image capture that meets the requirements of 6 CFR 37.11(a). A REAL ID nonoperator's identification

card may not be issued, reissued, or renewed except as permitted in 6 CFR Part 37 and may not be issued, reissued, or renewed by any procedure, in any circumstance, to any person, or for any term prohibited under 6 CFR Part 37. The information on the front of any REAL ID nonoperator's identification card must include all information and markings required by 6 CFR 37.17. Nothing in this subrule requires a person to obtain a REAL ID nonoperator's identification card.
[**ARC 8339B**, IAB 12/2/09, effective 12/21/09]

761—630.3(321) Duplicate card.

630.3(1) *Lost or destroyed card.* To replace a nonoperator's identification card that is lost or destroyed, the cardholder shall submit Form 430052 and proof of age, identity and social security number. The replacement fee is $3.

630.3(2) *Voluntary replacement.* To voluntarily replace a nonoperator's identification card, the cardholder shall surrender to the department the card to be replaced. The reasons a card may be voluntarily replaced and any additional supporting documentation required are the same as those listed in subrule 761—605.11(2), paragraphs *"a"* to *"f."* The fee for voluntary replacement is $1.

761—630.4(321) Cancellation. The department shall cancel a nonoperator's identification card upon receipt of evidence that the person was not entitled or is no longer entitled to a card, failed to give correct information, committed fraud in applying or used the card unlawfully.

These rules are intended to implement Iowa Code sections 321.189, 321.190, 321.192, 321.195, 321.216, 321.216A, 321.216B and 321.216C.

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[Filed Emergency ARC 8339B, IAB 12/2/09, effective 12/21/09]

CHAPTER 9
IOWA SUMMER YOUTH CORPS

817—9.1(83GA,SF482) Purpose and program description. The purpose of the Iowa summer youth corps is to provide youth with meaningful community service opportunities along with instruction and reflection activities to enrich the learning experience, teach civic responsibility, and strengthen communities. On a competitive basis, Iowa summer youth corps grants will give support to summer youth corps projects in Iowa. The program is established under the authority of the Iowa commission on volunteer service, pursuant to Iowa Code chapter 15H as amended by 2009 Iowa Acts, Senate File 482.
[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

817—9.2(83GA,SF482) Applications. Appropriate forms and applications for grants are available from the commission at www.volunteeriowa.org.
[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

817—9.3(83GA,SF482) Incentives. Incentives will be determined by federal funding guidelines or restrictions depending on the source of funds utilized for the Iowa summer youth corps in a given grant year. Types of incentives may include:

1. Education awards that may be used to further educational attainment and that may be earned upon completion of a defined number of hours;
2. Living allowances that are not considered wages but are paid evenly over the course of a service period; or
3. Wages that are based on the hours worked.

Types of incentives or combinations of incentives that may be used for a program design will be described in the application instructions.
[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

817—9.4(83GA,SF482) Grant criteria. To respond to funding priorities, as funds are made available, the executive director of the commission will establish criteria consistent with federal regulations. If federal funds are being offered, applicants will be considered on a competitive basis. At a minimum, the criteria will contain the following:

1. Goals and objectives of the project;
2. Qualifications of the applicant to manage funds;
3. For new and recompeting applicants, letters of local support verifying coordination and communitywide cooperation;
4. Total project budget;
5. For previous grantees, evidence of ability to submit timely and accurate reports;
6. Description and time line of planned activities;
7. Agreement to develop for the project a community partnership group whose membership should include a cross section of the community served;
8. Description of the applicant organization, including staffing pattern; and
9. Documentation of the applicant's ability to provide the required local match.

[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

817—9.5(83GA,SF482) Designated funds. A percentage of the grants will be designated by the commission to address the needs of the city enterprise zones that meet the distress criteria outlined in Iowa Code section 15E.194.
[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

817—9.6(83GA,SF482) Application process for new grants.

9.6(1) The commission shall issue a request for proposals containing project criteria and application forms for the appropriate fiscal year.

9.6(2) The applicant shall submit the completed application to the commission according to the time line identified in the request for proposals.

9.6(3) Applications submitted will be reviewed by a grant review committee, which is composed of members of the commission grant review committee, individuals with expertise in youth programming, and the citizens of Iowa. Using the criteria in rule 817—9.4(83GA,SF482), the committee will review the applications for appropriateness and to determine the merit of the project.

9.6(4) Applicants whose projects have been selected for funding shall be notified by the commission.
[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

817—9.7(83GA,SF482) Administration of grants.

9.7(1) *Contracts.* The commission shall prepare contractual agreements for the grants.

a. The contract shall be executed by the executive director of the commission and the duly authorized official of the project.

b. The contract shall include due dates and the process for the submission of project reports and financial reports.

9.7(2) *Reporting.* All grant recipients shall submit progress and financial reports to the commission as outlined in the contract.

9.7(3) *Availability of funds.* Separate request for proposals will only be issued when there are funds available for this program. To the extent allowable by federal regulations, summer youth corps will always be an acceptable program model for annual AmeriCorps grants and will be listed in the annual AmeriCorps program request for proposals.
[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

817—9.8(83GA,SF482) Reversion of funds. Grant funds not expended by the project closeout date shall revert to the commission.
[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

These rules are intended to implement 2009 Iowa Acts, Senate File 482, section 1.

[Filed Emergency ARC 8158B, IAB 9/23/09, effective 9/2/09]
[Filed ARC 8315B (Notice ARC 8159B, IAB 9/23/09), IAB 12/2/09, effective 1/6/10]

CHAPTER 10
IOWA GREEN CORPS

817—10.1(83GA,SF482) Purpose and program description. The purpose of the Iowa green corps is to provide youth with meaningful community service opportunities in addition to providing capacity-building activities, training, and implementation of major transformative projects in communities, which emphasize energy efficiency, historic preservation, neighborhood development, and stormwater reduction and management. On a competitive basis, Iowa green corps grants will give support to AmeriCorps or summer youth corps projects in Iowa. The program is established under the authority of the Iowa commission on volunteer service, pursuant to Iowa Code chapter 15H as amended by 2009 Iowa Acts, Senate File 482.
[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

817—10.2(83GA,SF482) Applications. Appropriate forms and applications for grants are available from the commission at www.volunteeriowa.org.
[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

817—10.3(83GA,SF482) Incentives. Incentives will be determined by federal funding guidelines or restrictions depending on the source of funds utilized for the Iowa green corps in a given grant year. Types of incentives may include:

1. Education awards that may be used to further educational attainment and that may be earned upon completion of a defined number of hours;
2. Living allowances that are not considered wages but are paid evenly over the course of a service period; or
3. Wages that are based on the hours worked.

Types of incentives or combinations of incentives that may be used for a program design will be described in the application instructions.
[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

817—10.4(83GA,SF482) Grant criteria. To respond to funding priorities, as funds are made available, the executive director of the commission will establish criteria consistent with federal regulations. If federal funds are being offered, applicants will be considered on a competitive basis. At a minimum, the criteria will contain the following:

1. Goals and objectives of the project;
2. Qualifications of the applicant to manage funds;
3. For new and recompeting applicants, letters of local support verifying coordination and communitywide cooperation;
4. Total project budget;
5. For previous grantees, evidence of ability to submit timely and accurate reports;
6. Description and time line of planned activities;
7. Agreement to develop for the project a community partnership group whose membership should include a cross section of the community served;
8. Description of the applicant organization, including staffing pattern; and
9. Documentation of the applicant's ability to provide the required local match.

[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

817—10.5(83GA,SF482) Designated funds. A percentage of the grants may be designated by the commission to address capacity-building activities that target communities that are already working with existing community improvement programs, including but not limited to the Iowa great places program established under Iowa Code section 303.3C, the green streets and main street Iowa programs administered by the Iowa department of economic development, and disaster remediation activities by communities located within an area declared to be a disaster area by the President of the United States or the governor of the state of Iowa.
[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

817—10.6(83GA,SF482) Application process for new grants.

10.6(1) The commission shall issue a request for proposals containing project criteria and application forms for the applicable fiscal year.

10.6(2) The applicant shall submit the completed application to the commission according to the time line identified in the request for proposals.

10.6(3) Applications submitted will be reviewed by a grant review committee, which is composed of members of the commission grant review committee, individuals with expertise in youth programming, and the citizens of Iowa. Using the criteria in rule 817—10.4(83GA,SF482), the committee will review the applications for appropriateness and to determine the merit of the project.

10.6(4) Applicants whose projects have been selected for funding shall be notified by the commission.

[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

817—10.7(83GA,SF482) Administration of grants.

10.7(1) *Contracts.* The commission shall prepare contractual agreements for the grants.

a. The contract shall be executed by the executive director of the commission and the duly authorized official of the project.

b. The contract shall include due dates and the process for the submission of project reports and financial reports.

10.7(2) *Reporting.* All grant recipients shall submit progress and financial reports to the commission.

10.7(3) *Availability of funds.* Separate request for proposals will only be issued when there are available funds for this program. To the extent allowable by federal regulations, Iowa green corps will always be an acceptable program model for annual AmeriCorps grants and will be listed in the annual AmeriCorps program request for proposals.

[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

817—10.8(83GA,SF482) Reversion of funds. Grant funds not expended by the project closeout date shall revert to the commission.

[**ARC 8158B**, IAB 9/23/09, effective 9/2/09; **ARC 8315B**, IAB 12/2/09, effective 1/6/10]

These rules are intended to implement 2009 Iowa Acts, Senate File 482, section 2.

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